Northamptonshire Healthcare NHS Foundation Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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

Summary of findings

Background to the trust

Northamptonshire Healthcare NHS Foundation Trust (NHFT) started as a mental health trust before expanding to incorporate both physical and mental health community services. The trust was formed in April 2001 following the merger of Northampton Community Healthcare NHS Trust and Rockingham Forest NHS Trust and achieved Foundation Trust status in May 2009.

NHFT is one of the Foundation Trusts in the country which offers an integrated provision across all ages including mental health, learning disability, community health and prison health services. The trust provides services across the area of Northamptonshire to a population of 733,000 and employs more than 5,000 staff to deliver care and treatment.

The trust works closely with NHS providers, including Northampton General Hospital NHS Trust, Kettering General Hospital NHS Foundation Trust and local GPs. As a Trust, they hold contracts with four main commissioners – Corby CCG, Nene CCG, NHS England, and Northamptonshire County Council (NCC). The trust also partnered with NCC and the University of Northampton to launch a new community interest company called First for Wellbeing in April 2016. Contracts with these commissioners range from universal services for children, young people and families to specialist services for older people with complex physical and mental health needs.

The trust offers a comprehensive range of physical, mental health and specialist services, many of which are provided in hospital, or from general practitioner surgeries or clinics. Services are delivered from a total of 25 locations. The trust has sites located in Northampton, Corby, Daventry, Kettering and East Northamptonshire.

The trust delivers the following mental health services:

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

The trust delivers the following community health services:

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

Summary of findings

The trust had four Mental Health Act Monitoring visits since the last inspection in 2018. Across all visits, there were three actions the trust was required to address.

The trust has been inspected three times under the comprehensive mental health and community health inspection programme, in February 2015 (published September 2015), January 2017 (published March 2017) and July 2018 (published in August 2018). Following the 2018 inspection, the trust received an overall rating of outstanding. The safe, effective and responsive domains were rated as good, the caring and well led domains were rated as outstanding. We issued two requirement notices against mental health core services relating to four must do actions. The trust had addressed all breaches at the time of this inspection.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Outstanding 

What this trust does

Northamptonshire Healthcare NHS Foundation Trust provides a variety of mental health and community health services, across Northamptonshire for adults of working age, older adults and Tier 4 services for children and young people. The trust provides these services across 25 registered locations. The trust serves a population of approximately 733,000 people across Northampton, Corby, Daventry, Kettering and East Northamptonshire. It had a budget in excess of £212 million for 2018/19 and for 2019/2020 it will be in excess of £215 million. The trust completed 1,826,817,000 contacts and employs over 5,000 staff in a wide variety of roles.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Where necessary, we take action against service providers who do not meet the regulations and help them to improve the quality of their services.

What we inspected and why

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

We inspected five complete services, which were previously rated as requires improvement or which our intelligence suggested we should inspect this time. Those inspected were:

- Acute wards for adults of working age and psychiatric intensive care units
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism
- Forensic inpatient or secure wards
- Long stay rehabilitation mental health wards for working age adults.

Summary of findings

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. However, the overall rating of mental health services improved at this inspection due to an aggregation of core service ratings.

We rated the trust as outstanding because:

- Since our last inspection, the trust continued to deliver high quality, safe services across the five mental health services we inspected.
- There was a strong focus on patient and staff safety as a priority agenda. The trust had made improvements to how they learnt from investigations into serious incidents and engaged and supported families and relatives throughout the process.
- There was a strong culture of openness, honesty and learning. There was evidence of sharing practice with others, and an ethos for embracing constant opportunity for learning and improving. The trust had formed a strong relationship with a neighbouring trust and embraced a 'buddy' relationship. The trust board were clear that this was not only an opportunity to support another NHS organisation, but an opportunity to improve and learn for themselves.
- We heard how the trust had continued to prioritise their values in every interaction every day, and the culture of staff in the trust was one of kindness, teamwork and pride to work for the organisation. The trust had embedded the importance of training, supervision, talent management and development of staff. Staff had access to numerous opportunities to learn and develop within their roles.
- All services we visited had continued to engage with carers and received positive feedback from the users of services. It was clear that co-production, involvement and engagement had continued to go from strength to strength across the trust. 'I want great care' continued to be integral to obtaining feedback from service users and carers.
- We found staff completed thorough and detailed risk assessments, and the trust had effective processes for reviewing and updating them. We saw staff assessed and monitored physical healthcare well and teams had multi-disciplinary approaches that promoted healthy lifestyles. Staff completed person-centred, collaborative care plans which involved families and carers.
- Quality improvement was embedded around the trust. The trust consistently encouraged and supported staff to innovate and develop new ideas. Staff were consulted and felt included in strategic changes and developments.
- Staff felt valued by the trust, their managers and by each other. There was an emphasis on staff well-being and leaders saw this as a priority focus for those who worked at the trust. The board had invested in well-being events, changed policies, well-being conversations and promoted work-life balance as integral to 'teamNHFT'. The culture was one of encouraging distributed and collected leadership throughout the trust. Staff felt supported to make decisions where appropriate.

Summary of findings

- Equality, diversity and inclusion had developed further since our last inspection. The trust had taken steps to promote further inclusion and collaboration of minority groups. Links with the community, the wider system and stakeholders was very strong and survey data showed an improvement in most areas of workforce equality. Directors told us that reverse mentoring had had a profound effect on their working and personal lives. The trust had robust plans for a wider roll out of this programme within the trust.
- The trust had won several national and local awards throughout 2018 to 2019. The trust was shortlisted for other awards. The board made a conscious decision to celebrate such success internally, which positively impacted on morale of teams, staff and ultimately patient care.

However:

- We had concerns about safe practice in isolated areas at some locations. We found an infection, prevention and control measure issue at one location, environmental concerns at both Health-based Places of Safety and high levels of restraint and seclusion in Acute Wards for adults of working age and PICU services. Across two services, we had concerns over safe management of medicines.
- Two services had experienced organisational changes which had impacted on staff morale. The trust had plans in place to address this, but staff told us it had been a challenge.
- Staff in Wheatfield Unit had not correctly documented Section 17 leave in 13 of 17 cases.
- In community mental health services for people with a learning disability or autism, we found that both adults and children in the ADHD pathway, waited over 18 weeks for assessment or treatment.

Are services safe?

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

- The trust had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. The number of patients on the caseloads of the mental health crisis teams, and learning disability community teams, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis and contingency plans. Community staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviours. Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. The ward staff participated in the provider's restrictive interventions reduction programme.
- Safeguarding people at risk was given sufficient priority by staff. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff had training on how to recognise and report abuse and knew how to apply it.
- All teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt within their own teams and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

Summary of findings

- Incidents of restraint and seclusion had increased across the acute and PICU services compared to those at our last inspection. The restraint overall had increased by 6% and seclusion had increased by 14.5%. However, the trust had successfully reduced the use of prone restraint by 13%.
- The physical environment of the Health-Based Place of Safety at Northampton did not meet the requirements of the Royal College of Psychiatrists standards on the use of Section 136 of the Mental Health Act 1983. The Health-Based Place of Safety at St Mary's hospital did not have an observational panel or CCTV, in line with the Mental Health Act Code of Practice.
- The Warren crisis house did not adhere fully to infection control principles. Staff compliance with Infection Prevention and Control training was just 70% across this core service.
- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We identified some issues within the acute service and the community learning disability service.
- Meadowbank ward used a number of different bank staff which led to inconsistency in care delivery. In the month prior to inspection, 27 bank shifts had been filled by 24 different people.
- Staff compliance with manual handling training on Meadowbank ward was 63%, which fell below the trust target.

Are services effective?

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery-oriented.
- 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 used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The trust had access to the full range of specialists required to meet the needs of patients in four of the five services we inspected. Managers made sure that staff had the range of skills needed to provide high quality care. Staff received meaningful and timely supervision and appraisals. The trust provided a robust induction programme for all new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Each team had effective working relationships with other relevant teams within the organisation, and with relevant services outside of the organisation. Staff proactively engaged with patients early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them regularly and in a way that they understood.
- 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. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- The training compliance for Mental Capacity Act in community mental health services for people with a learning disability or autism, was 53% which fell below the trust target of 90%.

Summary of findings

- In Wheatfield unit, medical staff had not recorded an expiry or review date on nine patients' 'authorisation for leave of absence form - section 17'.
- On acute wards for adults of working age, we identified that when a transgender patient was identifying as female, their preferred name and preferred pronoun was not always used in their care records.
- In crisis services, 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%.
- Managers on Meadowbank Ward had not reviewed the multidisciplinary staffing establishment since April 2017. Key staffing posts had not been recruited to.

Are services caring?

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

- We saw that staff across the trust treated patients with genuine levels of compassion and kindness. Patients, families, carers and stakeholders consistently gave really positive feedback about how staff treated people. We heard examples where some staff teams had delivered care which had exceeded expectations of both patients and families.
- Staff understood the totality of individual patient need. Staff always considered people's personal, cultural, social and religious needs when planning care and treatment. People's emotional and social needs were highly valued by staff and respected. Staff reflected individual preferences and needs in how care was delivered.
- The trust had truly embedded that patients were active partners in their care. Staff across the trust worked in partnership with patients and those close to them. Patients were involved in shaping their care and reviewing this regularly with the multi-disciplinary team. Staff involved patients in care planning and risk assessments. Managers had involved patients in recruitment of posts and with service development. Staff and patients continued to co-produce successful projects. Staff placed patients at the centre of everything they did. Co-production was very important to the trust.
- Leaders actively sought feedback on the quality of the care provided across the trust. Staff empowered patients who used the service to have a voice, consistently and strongly encouraged feedback, which was acted upon. Each ward held regular patient meetings. Carers meetings were established and well attended.
- Staff showed creativity to overcome obstacles to delivering care. They used a range of methods of communication, including easy read leaflets, information in different languages, and had access to interpreters and signers. Staff did not hesitate in seeking support from families and carers where appropriate.
- There was a strong, visible person-centred culture. Staff were highly motivated and proud to work for the trust. Relationships between people who used the services, those close to them, and between staff were caring and supportive. These relationships were highly valued by staff and promoted by leaders.

Are services responsive?

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

- Patients could access the right care at the right time. Oversight of bed management was effective, and teams managed admissions and discharges well and in a co-ordinated way with others. Patients were not moved between wards or services unless this was for their benefit. Staff assessed and treated patients who required urgent care promptly. Patients who did not require urgent care did not wait too long to start treatment. Access to treatment for psychological therapies within the learning disabilities team had been improved.

Summary of findings

- Staff across all services planned and managed discharge well. They liaised well with services and agencies that would provide aftercare. Staff were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The trust had taken steps to reduce out of area placements significantly in the last year. 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. This equated to a reduction of 968 over a three-month period, which was a 76% reduction.
- Services were easy to access. Referral criteria were clear and did not exclude patients who would have benefitted from care. The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line. There was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act.
- The design, layout, and furnishings of the wards and services supported patients' treatment, privacy and dignity. Each inpatient had their own bedroom with an en-suite bathroom. Patients had somewhere secure to keep their personal belongings. There were quiet areas for privacy, and areas for young people to visit safely, where appropriate. Patients could make hot drinks and snacks freely and at any time. When clinically appropriate, staff supported patients to self-cater.
- Staff encouraged and supported patients to engage with the wider community. For example, patients attended local gyms, shops, places of worship, and different cafes. The trust supported patients access education, training, as well as paid work opportunities. Staff encouraged, and facilitated where possible, contact with family members and those close to them. Patients on all wards had access to outside space.
- The service met the needs of all patients, including those with a protected characteristic. Reasonable adjustments were made to remove barriers if people found it hard to use or access the services. Staff had the skills, or access to people with the skills, to communicate in the way that suited each patient. Staff supported patients to access advocacy services, cultural and spiritual support. The importance of flexibility, choice and continuity of care was reflected across all services.
- The trust was proactive with treating concerns and complaints seriously. Senior staff investigated them and learned lessons from the results. Lessons learnt were shared with the immediate teams and the wider service. Staff completed investigations in a comprehensive and timely way. We saw numerous changes that had been implemented as a result of learning from complaints.

However:

- The attention deficit hyperactivity (ADHD) and Asperger's service had not met the trust target for referral to assessment and referral to treatment for both adults or children. The average (median) waiting time for both targets at this service was 244 days (34 weeks) against a trust target of 126 days. In the children's pathway, 102 children waited longer than 18 weeks with 95 waiting more than 20 weeks. In the adult's pathway, 484 patients waited longer than 18 weeks, with 262 waiting longer than 20 weeks. The trust had plans in place to reduce waiting lists by early 2020.
- Patients and staff at the Wheatfield unit, told us that the quality and variety of food was poor.

Are services well-led?

Our rating of well-led stayed the same. However, the overall rating in mental health services improved at this inspection due to an aggregation of core service ratings.

We rated it as outstanding because:

Summary of findings

- The absolute clarity of culture and leadership made it easy for staff, patients and stakeholders to understand what the trust did. The trust had a firmly embedded vision, values and strategy 'road map' which strongly underpinned the eight domains of the well-led key question.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was compassionate, inclusive and effective leadership. Leaders had an in-depth understanding of services they managed, including the issues, challenges and priority of their services. They explained clearly how each team worked to provide high quality, safe care. Leaders were visible and approachable for staff, patients and carers.
- Staff knew and understood the provider's vision and values and how these applied in the work of their teams. All staff were passionate, caring, focused on putting patients first, and viewed patient recovery as a priority. Staff consistently displayed the values in their interactions with colleagues, patients and carers.
- We heard many examples of quality improvement and innovation that had a wide-reaching impact for staff and patients. Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Improvement methods and skills were available and used across the trust. Staff were empowered to lead and deliver change. The trust had an ethos of sharing work and learning from others
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level. Staff managed performance and risk well. Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- There was a strong focus on patient and staff safety as a priority agenda. The trust had made improvements to how they learnt from investigations into serious incidents and engaged and supported families and relatives throughout the process.
- The organisational wide approach, culture and practice of co-production continued to grow from strength to strength. The opportunities for staff, patients, carers and stakeholders to be part of service delivery and innovation were extensive.
- We saw numerous examples of very effective use of information that steered decision making and priority setting across the trust.
- The trusts' approach to Freedom to Speak Up, equality, diversity, inclusion and cultural expectations of how staff behaved was well advanced. This underpinned how the trust operated internally and in the wider system.
- We were aware of how extensive the board involvement and influence had in the wider system to direct and lead system discussion, planning and performance to the benefit of people in the county.
- We were impressed by how the trust continued to celebrate success, internally and externally, and saw how a conscious decision to do so, had a clear and positive impact on improving and sustaining staff morale.
- Staff across the trust felt respected, supported and valued in their teams. The trust promoted equality, diversity, inclusion and wellbeing within day to day work. Staff had ample opportunities for further development and career progression. Staff felt able to raise concerns or challenge senior staff without fear of retribution. The trust placed a strong emphasis on staff well-being and leaders saw this as a priority focus for those who worked at the trust. The board had invested in well-being events, changed policies, well-being conversations and promoted work-life balance as integral to 'teamNHFT'.
- We heard about the work the board had done with governors to develop relationships and embed their position with the board had been effective and valued by all those we spoke with.

Summary of findings

- There was a strong culture of openness, honesty and learning. There was evidence of sharing practice with others, and an ethos for embracing constant opportunity for learning and improving. The trust had formed a strong relationship with a neighbouring trust and embraced a 'buddy' relationship. The trust board were clear that this was not only an opportunity to support another NHS organisation, but an opportunity to improve and learn for themselves.

However:

- Oversight of both safe management of medicines and levels of restraint and seclusion, required improved governance and targeted action.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in four of the five core services we inspected. For more information, see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right.

We found 12 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

We issue requirement notices and take enforcement action against the provider. Listing them as shown below will include action relating to all problems in the trust's services, whether they are trust-wide or at service type, location or core service level.

We issued two requirement notices to the trust. Our action related to breaches of two legal requirements in two core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

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

Outstanding practice

We found outstanding practice in four of the five core services at this inspection.

Summary of findings

In community services for people with a learning disability or autism, we saw that a staff member had developed an equality and diversity booklet, which identified all different religions, beliefs and what staff need to consider for patient care.

Staff followed current national practice to check patients had the correct medicines. 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 person-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.

In an acute ward for adults of working age, we saw an example where staff supported a patient to undertake their university exam in the hospital. Staff had liaised with the university in order to facilitate this.

In the crisis care pathway, we saw several examples of outstanding care. There were a number of innovative ways people could access support for crisis care. 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.

The mental health crisis care pathways were committed to improving crisis services for the public by ensuring current and future services were informed by the feedback of service users and carers. The trust had developed the crisis house and crisis cafés in collaboration with service users and families.

Staff were positive and passionate about their roles and the client group they were supporting. Staff felt valued by the leaders within the service. Staff felt proud about working for the trust and their teams. Patients told us staff listened to their choices, went the extra mile and the care they received exceeded their expectations.

We found examples of outstanding practice in the forensic core 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. Staff role modelled healthy lifestyles.

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 used 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.

Managers selected patients through an interview process to be a ward representative. This role involved representing patients on the ward, attending 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.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with two legal requirements. This action related to two core services.

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

- The trust must ensure that medicines are administered and recorded in line with local policy and national guidance and ensure that medicines being administered are within their expiry date.
- The trust must ensure they review timescales and take necessary action to reduce the numbers of restraint and seclusion in this service.

This was a breach of Regulation 12, safe care and treatment.

Mental health crisis services and health-based places of safety:

- The trust must ensure they take adequate steps to prevent the spread of infection at The Warren crisis house.
- The trust must ensure staff have received adequate training in infection control.

This was a breach of Regulation 12, safe care and treatment.

- The trust must ensure a review is completed of the environment of the Health-Based Place of Safety suites at Berrywood hospital and St Marys hospital to ensure environments meet the Mental Health Act Code of Practice.

This was a breach of Regulation 15, premises and equipment.

Community Mental Health services for people with a learning disability or autism:

- The trust must ensure patient waiting times for assessment and treatment in the adult and children's ADHD pathways meet targets.

This was a breach of Regulation 9, patient centred care.

Action the trust SHOULD take to improve

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

- The trust should ensure that care records accurately reflect the chosen name and preferred pronoun for transgender patients.

Forensic inpatient or secure wards:

- The trust should ensure that medical staff fully complete 'authorisation for leave of absence forms - section 17'.
- The trust should ensure all staff treat patients with kindness, dignity and respect.
- The trust should ensure that they provide patients with a variety of good quality food.

Long-stay or rehabilitation mental health wards for working age adults:

- The trust should ensure that there is an adequate number of experienced and trained staff to provide therapeutic interventions to patients.
- The trust should ensure that there is effective monitoring of the cleanliness of the patients self-catering kitchens on the ward.
- The trust should inject pace into its timescales for organisational change and provide support to staff during this time.

Summary of findings

- The trust should ensure that all mandatory is up to date.

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

- The trust should ensure that controlled drugs are always stored in line with national and local policy.
- The trust should ensure that staff attend Mental Capacity Act training
- The trust should ensure that staff are supported during organisational change.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of the well-led at the trust stayed the same. However, the overall rating in mental health services improved at this inspection due to an aggregation of core service ratings.

We rated well-led at the trust as outstanding because:

- The absolute clarity of culture and leadership made it easy for staff, patients and stakeholders to understand what the trust did. The trust had a firmly embedded vision, values and strategy 'road map' which strongly underpinned the eight domains of the well-led key question.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was compassionate, inclusive and effective leadership. Leaders had an in-depth understanding of services they managed, including the issues, challenges and priority of their services. They explained clearly how each team worked to provide high quality, safe care. Leaders were visible and approachable for staff, patients and carers.
- Staff knew and understood the provider's vision and values and how these applied in the work of their teams. All staff were passionate, caring, focused on putting patients first, and viewed patient recovery as a priority. Staff consistently displayed the values in their interactions with colleagues, patients and carers.
- We heard many examples of quality improvement and innovation that had a wide-reaching impact for staff and patients. Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Improvement methods and skills were available and used across the trust. Staff were empowered to lead and deliver change. The trust had an ethos of sharing work and learning from others
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level. Staff managed performance and risk well. Teams had access to the information they needed to provide safe and effective care and used that information to good effect. There was a strong focus on patient and staff safety as a priority agenda. The trust had made improvements to how they learnt from investigations into serious incidents and engaged and supported families and relatives throughout the process.
- The organisational wide approach, culture and practice of co-production continued to grow from strength to strength. The opportunities for staff, patients, carers and stakeholders to be part of service delivery and innovation were extensive.
- We saw numerous examples of very effective use of information that steered decision making and priority setting across the trust.

Summary of findings

- The trusts' approach to Freedom to Speak Up, equality, diversity, inclusion and cultural expectations of how staff behaved was well advanced. This underpinned how the trust operated internally and in the wider system.
- We were aware of how extensive the board involvement and influence had in the wider system to direct and lead system discussion, planning and performance to the benefit of people in the county.
- We were impressed by how the trust continued to celebrate success, internally and externally, and saw how a conscious decision to do so, had a clear and positive impact on improving and sustaining staff morale.
- Staff across the trust felt respected, supported and valued in their teams. The trust promoted equality, diversity, inclusion and wellbeing within day to day work. Staff had ample opportunities for further development and career progression. Staff felt able to raise concerns or challenge senior staff without fear of retribution. The trust placed a strong emphasis on staff well-being and leaders saw this as a priority focus for those who worked at the trust. The board had invested in well-being events, changed policies, well-being conversations and promoted work-life balance as integral to 'teamNHFT'.
- We heard about the work the board had done with governors to develop relationships and embed their position with the board had been effective and valued by all those we spoke with.
- There was a strong culture of openness, honesty and learning. There was evidence of sharing practice with others, and an ethos for embracing constant opportunity for learning and improving. The trust had formed a strong relationship with a neighbouring trust and embraced a 'buddy' relationship. The trust board were clear that this was not only an opportunity to support another NHS organisation, but an opportunity to improve and learn for themselves.

However:

- Oversight of both safe management of medicines and levels of restraint and seclusion, required improved governance and targeted action.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Dec 2019	Good →← Dec 2019	Outstanding →← Dec 2019	Good →← Dec 2019	Outstanding →← Dec 2019	Outstanding →← Dec 2019

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Aug 2018	Good Aug 2018	Outstanding Aug 2018	Good Aug 2018	Outstanding Aug 2018	Outstanding Aug 2018
Mental health	Good →← Dec 2019	Good →← Dec 2019	Outstanding →← Dec 2019	Good →← Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Community health services for children and young people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community health inpatient services	Good Aug 2018	Good Aug 2018	Outstanding Aug 2018	Good Aug 2018	Outstanding Aug 2018	Outstanding Aug 2018
Community end of life care	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community dental services	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019
Forensic inpatient or secure wards	Good ➔➔ Dec 2019	Outstanding ↑ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019
Child and adolescent mental health wards	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017
Wards for older people with mental health problems	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community-based mental health services for adults of working age	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Mental health crisis services and health-based places of safety	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Outstanding ↑ Dec 2019	Outstanding ➔➔ Dec 2019	Outstanding ↑ Dec 2019	Good ➔➔ Dec 2019
Specialist community mental health services for children and young people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community-based mental health services for older people	Good Aug 2018	Good Aug 2018	Outstanding Aug 2018	Outstanding Aug 2018	Outstanding Aug 2018	Outstanding Aug 2018
Community mental health services for people with a learning disability or autism	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019	Outstanding ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Good ➔➔ Dec 2019

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

Mental health crisis services and health-based places of safety

Good ➔➔

Key facts and figures

The mental health crisis services and Health-Based Places of Safety are part of the mental health services delivered by Northamptonshire Healthcare NHS Foundation Trust.

The crisis resolution and home treatment teams provide emergency, urgent assessment and home treatment for adults who present with a mental health need that requires a specialist mental health service. Their primary function is to undertake an assessment of needs, whilst providing a range of short-term treatment as an alternative to hospital admission. The team are also gatekeepers and can admit patients to an inpatient unit if required. This service is available 24 hours a day, 365 days a year and covers Northamptonshire. The service is separated in to South and North teams and are based at Campbell House in Northampton and St Mary's Hospital in Kettering.

The psychiatric liaison mental health service is provided for people who present to Kettering General Hospital or Northampton General Hospital with a mental health need. These teams aim to provide prompt assessment of a service user's needs and signpost care appropriately.

A Health-Based Place of Safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, to be assessed by a team of mental health professionals. There are two Health-Based Places of Safety in Northamptonshire, one in the South of the county at Berrywood Hospital in Northampton and one in the North of the county at St. Mary's Hospital in Kettering.

The crisis telephone support service (CATSS) provides a daily 24-hour 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.

The Warren crisis house offers an alternative to hospital admission for people who need support for their mental health problem. This service offers help to those who need support in managing their crisis, and supports patients in developing skills, abilities and coping strategies in a supportive environment. The crisis house has seven beds and is open for referrals 24 hours a day.

The crisis cafés are based at six locations across Northamptonshire and run 15 times a week at evenings and weekends in collaboration with a partner agency. Crisis cafés are available for anyone 18 years old or over who are finding themselves in a crisis or need support with their mental health.

The established Police Street Triage car provides a dedicated frontline police officer alongside a mental health professional, collaboratively working to ensure that all service users with mental health issues are effectively supported during a crisis period, we did not inspect this service on this occasion.

The Northamptonshire Healthcare NHS Foundation Trust crisis services and Health-Based Places of Safety were last inspected in June 2018, where the overall rating for the service was Good. Safe was rated as requires improvement, effective, caring and well-led domains were rated as good and the responsive domain was rated as outstanding.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- spoke with 14 patients who were using the service and two carers
- spoke with eight managers

Mental health crisis services and health-based places of safety

- spoke with 25 other staff members including doctors, nurses, psychologists, occupational therapists and support workers
- observed a multi-disciplinary team meeting and a handover
- reviewed 44 patient care records
- Reviewed 18 medication records
- observed 15 episodes of care.

Summary of this service

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

- There were a number of innovative ways people could access support for crisis care across the county. The crisis cafés had become overwhelmingly popular and alongside the crisis house, had reduced the number of admissions to acute wards, and attendances at local accident and emergency departments. The treatment pathway and access to crisis services in the county was exemplary and had been recognised for national awards.
- The mental health crisis service was available 24-hours a day and was easy to access, which included a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients thoroughly and promptly. Staff consistently followed up with patients who missed appointments.
- The mental health crisis care pathways were committed to improving crisis services for the public by ensuring current and future services were informed by the feedback of service users and carers.
- Staff were overwhelmingly positive and passionate about their roles and the client group they supported. Staff felt highly valued by the leaders within the service, who themselves were dynamic. Staff felt very proud about working for the trust and within their teams. Patients told us staff listened to their choices and went “the extra mile”. Patients told us heartfelt stories about the care they had received had exceeded their expectations.
- Leaders within the service had an in-depth understanding of the service. They had the skills, knowledge and experience to perform their roles effectively. They explained clearly how the teams worked to provide high quality care. Leaders had an inspiring shared purpose, strived to deliver high quality and safe care, and motivated staff to succeed.
- Staff thoroughly assessed and managed risks to patients and themselves. They responded promptly to any sudden deterioration in a patient’s health. When necessary, staff in the mental health crisis teams and the psychiatric liaison mental health services, worked in collaboration with patients, families and carers to develop crisis plans.
- Staff assessed the mental health needs of all patients. Staff routinely worked with patients, families and carers to develop individual care plans and updated them when needed.
- The crisis pathway at the trust had been awarded national recognition for the services provided and develop in collaboration with patients.

However:

Mental health crisis services and health-based places of safety

- The physical environment of the Health-Based Place of Safety at Northampton did not meet the requirements of the Royal College of Psychiatrists standards on the use of Section 136 of the Mental Health Act 1983. The room could not be observed externally and required staff to enter the room to observe patients effectively. At times, staff observed patients with the door ajar and some attempts by patients to abscond from the room when aggressive, led to episodes of restraint.
- The Health-Based Place of Safety at St Mary's hospital did not have an observational panel or CCTV, in line with the Mental Health Act Code of Practice. Access to the room in an emergency, could not be gained via a second door.
- The Warren crisis house did not adhere fully to infection control principles. Patients' personal bathing items were stored together in a shared bathroom. Infection Prevention and Control training was low across this core service at 70% which was below the trust target of 90%.

Is the service safe?

Requires improvement 

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

- The physical environment of the Health-Based Place of Safety at Northampton did not meet the requirements of the Royal College of Psychiatrists standards on the use of Section 136 of the Mental Health Act 1983.
- The Health-Based Place of Safety at St Mary's hospital did not have an observational panel or CCTV, in line with the Mental Health Act Code of Practice. Access to the room in an emergency, could not be gained via a second door.
- The Warren crisis house did not adhere to infection control principles. Staff compliance with Infection Prevention and Control training was low across this core service at 70%, below the trusts' target.

However:

- All other clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The services had enough staff, who received training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff thoroughly assessed and managed risks to patients and themselves. They responded promptly to any sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams and the psychiatric liaison mental health services worked with patients, families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff who worked for the mental health crisis teams and psychiatric liaison mental health services kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.

Mental health crisis services and health-based places of safety

- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good 

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

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis pathway worked with patients, families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The psychiatric liaison mental health service issued all patients with a personalised action plan.
- Staff working for the mental health crisis teams and the psychiatric liaison mental health services provided a range of care and treatment interventions. Patient's care and treatment was planned and delivered in line with evidence-based guidance and best practice. Staff ensured that all clinical needs were given consideration, including physical health and wellbeing.
- Staff working for the mental health crisis teams and psychiatric liaison mental health services used recognised rating scales to assess and record severity and outcomes. All teams participated in clinical audit, benchmarking and quality improvement initiatives.
- The mental health crisis pathway included or had access to the full range of specialists required to meet the needs of patients under their care. Managers supported staff to maintain and further develop their professional skills and experience. Staff received meaningful and timely supervision and appraisals. Managers provided a robust induction programme for new staff.
- Staff from different disciplines and services worked together in a co-ordinated way to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff obtained consent to care and treatment in line with legislation and guidance. Staff supported patients to make decisions on their care for themselves. Staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded individual capacity clearly for patients as appropriate.

However:

- 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%.

Is the service caring?

Outstanding 

Our rating of caring improved. We rated it as outstanding because:

Mental health crisis services and health-based places of safety

- We saw significant improvement over the last 12 months in the way staff interacted with patients and carers and held them at the centre of all care and treatment in the service.
- Staff truly respected and valued patients in their care. Staff provided patients with exceptional practical and emotional support through their journey and were empowered to collaborate in their care.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients said staff were caring, respectful, supportive and sensitive to their needs. Patients told us staff listened to their choices and went the extra mile. Patients told us heartfelt stories about the care they received and how staff exceeded their expectations along their recovery.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff recognised and respected the totality of people's needs. Individuals personal, cultural, social and religious needs were understood.
- There was a strong commitment by staff to include and collaborate with patients. Staff in the mental health crisis pathway involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff involved patients in discussions and decisions around treatment. Patients were active partners in their care. Staff ensured that patients had access to advocates and support networks in the community and supported them with this when needed.
- Staff informed and involved families and carers consistently. Feedback from people who used the service and those who were close to them was continually positive about the way staff treated people.

Is the service responsive?

Outstanding ☆ ➔➔

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

- Services were tailored to meet individual needs of patients. The pathway provided many options for people to access care and support and staff delivered this in a flexible way with patients' choice in mind. The pathways used innovative ways to deliver care, which had been recognised nationally.
- The mental health crisis service was available 24-hours a day and was easy to access, which included a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- The trust had clear criteria and a range of ways for patients to access the pathway. Any team could refer patients to the crisis house. The crisis house had no waiting list and admitted patients without delay when a bed was available so that people avoided unnecessary inpatient admissions.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services meet people's needs. The service was designed in co-production at all stages with service users. Involving service users at all stages meant that people could access services in a way and at a time that suited them.
- The Health-Based Places of Safety were available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who used the service – including those with a protected characteristic.

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff and other services. Investigations were comprehensive and undertaken in a timely way.

Is the service well-led?

Outstanding ☆ ↑

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

- Over the last 12 months, the trust had developed crisis services significantly which offered a robust and wide-reaching range of services for people in the county experiencing mental health crisis. The crisis pathway had been recognised nationally for innovation, leadership and quality of service.
- The crisis care pathway strategy was stretching, challenging and innovative. We saw a demonstrated commitment to system wide collaboration and leadership.
- Leaders within the service had an in-depth understanding of the service. Staff had the skills, knowledge and experience to effectively perform their roles. They explained clearly how the teams worked to provide high quality care. Leaders had an inspiring shared purpose, strived to continue to deliver high quality and safe care, and motivated staff to succeed.
- Staff we spoke with told us that leaders were visible in the service and approachable for patients and staff. They felt supported by managers and senior managers, if required staff felt happy to raise concerns with them. Staff were overwhelmingly proud of the trust as a place to work. Staff spoke highly of the culture, strong team working and a common focus in their teams.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. All staff were passionate, caring, focused on putting patients first and viewed patient recovery as a priority. During the inspection staff displayed the values in their interactions with colleagues and patients.
- Staff could explain how they worked to deliver high quality care within the budgets available; by linking in with other agencies in the local community, providing mutual aid and support groups. Staff understood arrangements for working with other teams, both within the trust and external organisations, to meet the needs of the patients. Staff had the opportunity to contribute to 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.
- Leadership development opportunities were available, including opportunities for staff below team manager level.
- Managers proactively engaged patients and carers at various forums and with service developments. The crisis house was designed jointly with service users and their views were given equal weight.
- 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.

Outstanding practice

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

Areas for improvement

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

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

Good ➔➔

Key facts and figures

Northamptonshire community-based mental health services for people with a learning disability or autism consists of:

- Two community teams covering the north and south of Northamptonshire. These are multi-disciplinary teams working with people who have learning disabilities and additional health or social needs. This included a team for children with learning disabilities.
- One intensive support team for people with a learning disability who have mental ill health or challenging behaviour.
- One 'opportunities for you' team which provides bespoke packages of care for people with a learning disability and complex needs.
- One six bedded respite ward.

CQC last inspected this core service in January 2017. We found it to be requires improvement in responsive, good in safe, effective, and well led and outstanding in caring. Following the January 2017 inspection, we told the trust it must make the following improvements to the service:

- The trust should ensure there are systems in place to monitor whether people are able to access the right care at the right time.

We found that this improvement had been made.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to speak to was available, as well as allowing us access to home visits where appropriate. We visited all areas.

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

During the inspection visit, the inspection team:

- spoke with four patients who were using the service and 15 carers
- spoke with six managers for each of the teams
- spoke with 45 other staff members including doctors, nurses, psychologists, physiotherapists, occupational therapists, speech and language therapist and support workers
- observed a multi-disciplinary meeting, observation meeting, safeguarding supervision meeting
- reviewed 32 patient care records
- observed seven episodes of care.

Summary of this service

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

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

- The service provided safe care. The clinical environments were generally safe and clean. The teams had enough nurses and doctors. Staff assessed and managed risk well. Staff managed most medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance and best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those external to the teams and trust who had a role in providing care. Staff planned and managed transitions and discharges well and liaised well with external agencies.
- Staff understood and discharged their roles and responsibilities the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment. Staff understood their roles and responsibilities under the Mental Health Act 1983, although there were no patients subject to any section of the Mental Health Act during inspection.
- Staff treated patients with high levels of compassion and kindness, truly respected their privacy and dignity, and fully understood the individual needs of patients. They actively involved and collaborated with patients, families and carers in care decisions. People who used services were always fully involved in writing their care plans and action plans. Staff consistently provided care plans and treatment information in easy read and visual formats. The service routinely encouraged involvement and feedback from people who used service and their carers including recruitment of staff.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

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.
- Only 53% of staff had attended Mental Capacity Act training. Therefore, the trust had not met its target of 90%.
- The attention deficit hyperactivity (ADHD) and Asperger's service had not met the trust target. The waiting time for this service was 244 days (34 weeks) against a trust target of 126 days.

Is the service safe?

Good

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

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

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

- Staff adopted a proactive approach to anticipating and managing risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff had received up to date training in all safety systems, processes and practices. Staff followed good personal safety protocols.
- There were comprehensive systems in place to keep people safe, which took account of best practice. The whole team were engaged in reviewing and improving safety and safeguarding systems. Staff ensured that people who used the services were at the centre of safeguarding and protection from discrimination. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The systems to manage and share essential information that was needed to deliver safe care, treatment and support, were coordinated, provided real time information across services and supported integrated care for patients. Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- In most cases, the service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. Medicine administration on the respite ward did not conform to strict times and was tailored specifically to patient's needs in a truly client centred way.
- The teams had a sustained track record on safety supported by accurate performance information. The service had a genuinely open culture in which all safety concerns raised by staff and people who used the services where highly valued as being integral to service improvement. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- However:
- Staff had not stored a controlled drug correctly, although this was rectified by staff immediately when identified. There was no impact to patient safety.

Is the service effective?

Good  

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

- Staff undertook comprehensive assessments of patient's needs, which included consideration of clinical needs, mental health, physical health and wellbeing. They worked with patients, families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff understood and applied NICE guidelines in relation to behaviours that challenged. This included support for families, early identification and assessment, psychological and environmental interventions, medications and interventions for co-existing health and sleep problems.

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

- Staff used a range of recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams and services inside and outside the trust.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff understood the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- The trust's target for Mental Capacity Act training was 90%. The trust submitted data which showed that 53% of staff had received training in the Mental Capacity Act.

Is the service caring?

Outstanding ☆ ➔➔

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

- Staff truly respected and valued patients as individuals. Staff empowered patients as partners in their care. Staff were highly motivated and regularly went the extra mile to support people who used services.
- Feedback from patients, carers and stakeholders were continually positive about the way staff treated patients. Staff always treated patients with dignity, compassion and kindness. Staff fully recognised and respected the totality of the patient's needs including patient's emotional, social, personal and religious needs. Patients and carers stated that staff go the extra mile and that their care and treatment exceeded expectations.
- There was a very strong person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. Staff fully understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients and their carers were active partners in their care. Staff were fully committed to working in partnership with patients and carers and made this a reality. We saw many examples of co-production embedded into the service. Staff involved patients in care planning and risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients always had easy access to advocates when needed. Staff regularly informed and involved families and carers fully in assessments and in the design of care and treatment interventions.
- Staff always empowered patients to have a voice and realise their potential. Patients individual preferences and needs were always reflected in how care was delivered.

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

Is the service responsive?

Requires improvement 

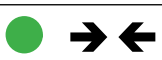
Our rating of responsive stayed the same. We rated it as requires improvement because:

- The attention deficit hyperactivity (ADHD) and Asperger's service had not met the trust target for referral to assessment and referral to treatment for both adults or children. The average (median) waiting time for both targets at this service was 244 days (34 weeks) against a trust target of 126 days. In the children's pathway, 102 children waited longer than 18 weeks with 95 waiting more than 20 weeks. In the adult's pathway, 484 patients waited longer than 18 weeks, with 262 waiting longer than 20 weeks. The trust had plans in place to reduce waiting lists by early 2020.

However:

- The service had made improvements to waiting times and access to treatment since our last inspection of this service.
- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and initiated care patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start receiving care. Staff followed up patients who missed appointments.
- Staff had developed transition pathways from children to adult services and had produced an easy read transition leaflet for patients and carers.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the day to day work of their team.
- Staff felt respected, supported and valued by each other, leaders and senior leaders of the trust. They reported that the provider promoted equality and diversity and well-being in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

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

- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

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.

Outstanding practice

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

Areas for improvement

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

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

Good 

Key facts and figures

Northampton Healthcare NHS Foundation Trust provides acute wards for adults of working age and psychiatric intensive care across eight wards at two locations which are:

Berrywood Hospital, Northampton had three acute wards for adults of working age and one psychiatric intensive care ward (PICU)

- Bay Ward (female acute)17 beds
- Harbour Ward (mixed gender acute)10 beds
- Cove Ward (male acute) 17 beds
- Marina Ward (male PICU) 7 beds

St Marys Hospital, Kettering had three acute wards for adults of working age and one psychiatric intensive care ward (PICU)

- Kingfisher Ward (mixed gender acute) 10 beds
- Avocet Ward (male acute) 16 beds
- Sandpiper Ward (female acute) 15 beds
- Shearwater Ward Female PICU (7 beds – four contracted by another trust)

The Care Quality Commission have registered the locations for the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act

We completed an inspection of this core service in June 2018 and inspected all eight wards. We found breaches of HSCA (RA) Regulations 2014 under Regulation 12: Safe care and treatment. We told the trust to take the following actions:

- The trust must ensure that seclusion documentation is in line with national guidance, and reflects the patients care needs, and how staff will meet these.
- The trust must ensure that it reviews the use of prone restraint in accordance with the Mental Health Act and Mental Health Act Code of Practice guidelines.

Our inspection of this core service was announced (staff knew we were coming) to ensure that everyone we needed to speak to was available. We looked at all key questions.

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

During the inspection visit, the inspection team:

- visited all wards, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 13 patients who were using the service and five carers

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

- spoke with nine managers or acting managers for each of the wards and other senior staff
- spoke with 29 staff; including doctors, nurses, nursing assistants; occupational therapists' psychologists, administration staff and the bed manager
- spoke with student nurses, bank and agency staff
- observed a multi-disciplinary team review meeting and clinical handovers
- reviewed 43 records relating to patient risk assessments and care plans
- checked medicines management processes and reviewed patient prescription charts on all wards
- reviewed in detail a range of policies, procedures and other documents relating to the running of the ward.

Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors to meet the needs of patients. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients which were in line with national guidance and best practice. Staff engaged in clinical audits to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, regular supervision and an annual appraisal. The ward staff worked well together as a multidisciplinary team, and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well. A bed was almost always available locally to a person who needed admission. Patients were discharged promptly once their condition warranted this.
- The service was well-led. Governance processes were established and ensured that ward procedures ran smoothly. Innovative ideas to reduce restrictive interventions had made a positive impact on patient care.

However:

- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.
- Incidents of restraint and seclusion had not reduced since our last inspection.

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

Is the service safe?

Requires improvement  

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

- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.
- Incidents of restraint and seclusion had not reduced since our last inspection.

However:

- All wards were safe, clean, well equipped, well-furnished and fit for purpose.
- The service had enough nursing and medical staff who knew the patients. Staff received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well, and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- 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 knew how to apply it.
- Staff had easy access to clinical information. It was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff regularly reviewed the effects of medications on each patient's physical health. Staff completed physical observations on patients during medication administration in the mornings.
- The wards had an improved track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. The trust promoted high levels of recording restraint incidents in a transparent way. 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 trust had a family liaison worker who worked with and supported family members during serious incident investigation, particularly after deaths. Family members and carers contributed to a group where views and feedback after incidents was considered to improve learning and change practice where needed.

Is the service effective?

Good  

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff ensured that all patients had access to appropriate physical healthcare.

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

- Staff participated in clinical audit, benchmarking and quality improvement initiatives. Staff used results of these to improve the care and treatment of patients.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for all new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had mostly effective working relationships with other relevant teams within the organisation, and with relevant services outside of the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust's policy on the Mental Capacity Act 2005. Staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- We identified that when a transgender patient was identifying as female, their preferred name and preferred pronoun was not always used in their care records.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. Staff 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 provided help and support to patients with their basic personal needs as and when required.
- Staff understood and met individual patients personal, cultural, social and religious needs. Staff encouraged patients to maintain and develop their relationships with those close to them, their social networks and the community. Staff informed and involved families and carers appropriately.
- Staff involved patients in care planning and risk assessments. Staff actively sought patient and carer feedback on the quality of care provided. Most wards ensured that patients had easy access to independent advocates. Carers we spoke with told us they were involved with all aspects of the patients care.

Is the service responsive?

Good 

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

- Staff managed admissions and discharges well. Beds were available for patients when needed. Patients were not moved between wards unless this was for their benefit. The bed manager was present at all discharge planning meetings. 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.

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

- The design, layout, and furnishings of the wards 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.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons. Managers shared these with the whole team and the wider service.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. Leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff demonstrated the trust values in their day to day work.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level, and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities, for example, safety pods. The service made effective use of internal and external reviews, and learning was shared effectively and used to make improvements.
- 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 trust had submitted a paper to board 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.

Outstanding practice

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

Areas for improvement

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

Long stay or rehabilitation mental health wards for working age adults

Good 

Key facts and figures

Meadowbank is a long stay rehabilitation ward for adults of working age. Part of Northamptonshire Healthcare NHS Foundation Trust, it is located at Berrywood Hospital Northampton. The ward provides services for those people identified with a need for further mental health rehabilitation including those people who are stepping down from the acute wards, and the forensic low secure unit.

Meadowbank is a twelve bedded, all male, low secure rehabilitation ward, although staff risk assessed patients to allow them to access the building independently. The service aims to help individuals re-build their lives in a safe and caring environment; helping them to achieve their optimum potential with activities of daily living and meaningful occupation, and thereby enabling people move on to semi supported or independent living. Meadowbank accepts patients from all areas across Northamptonshire.

It is a purpose-built facility with up to-date amenities including a gym, sports area, library, multi-media room, arts studio, cafe and rooms for therapy sessions. The facilities are shared with The Wheatfield Unit, a low secure forensic mental health unit.

At the time of this inspection there were eleven patients on the ward. Six patients detained under the Mental Health Act, and five patients were informal admissions. The inspection included all key lines of enquiry in all domains and was announced.

CQC last inspected this service as a core service in January 2017, when it was rated as good in all key questions. Following that inspection CQC asked the Trust to:

- Ensure staff knew how to treat someone they had referred for a Deprivation of Liberty Safeguards (DoLS) authorisation whilst awaiting a decision from the local authority.

At our recent inspection we found managers had made sure that all staff had undertaken refresher training for safeguarding including Deprivation of Liberty Safeguards.

During our recent inspection the inspection team:

- visited Meadowbank ward at Berrywood hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients and three carers who were using the service
- attended and observed two episodes of care, one patient's community meeting, and three staff and patients' meetings
- spoke with two managers and eight other staff members, including doctors, nurses, healthcare assistants, occupational therapists, psychologists, and volunteers
- looked at six patients care records and six medication records
- carried out a specific check of the medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

Long stay or rehabilitation mental health wards for working age adults

Summary of this service

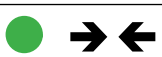
Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care in a safe and clean environment. The wards had enough nurses and doctors to operate safely. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Managers dealt with staff sickness in line with provider policy. There was enough staff to maintain patient safety on the ward, and managers were aware of the pressures on other staff members due to gaps in some roles. We saw quality improvement plans developed to address the issues.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff provided a range of treatments suitable to the needs of the patients, which were in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward staff had access to a range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions, and actively promoted co production whenever possible.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical or Ministry of Justice reason.
- The service worked to a recognised model of mental health rehabilitation. It was well-led and the governance processes ensured that ward procedures ran smoothly.

However:

- Managers had not ensured the multidisciplinary staffing establishment met the needs of patients. This followed an increase in patient numbers and the reassignment of a key post. There was significant long-term sickness on the ward, which resulted in high usage of bank staff.
- The patients self-catering kitchen was not clean, and there was no effective system for ensuring that this kitchen was cleaned after every use.
- Manual handling training compliance was 63%, which fell below the trust target.

Is the service safe?

Good 

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

- The service provided safe care in a safe environment. The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Long stay or rehabilitation mental health wards for working age adults

- The service had enough nursing and medical staff, who knew the patients. Staff received basic training to keep patients safe from avoidable harm.
- 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 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.
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records in electronic format.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The ward had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- 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.
- Managers used a variety of bank staff. In the month prior to inspection 27 bank shifts had been filled by 24 different people. This meant patients worked with many different staff on their treatment goals.
- Manual handling training compliance was 63%, which was below the trust target.

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. The model of practice adopted by the ward was the Life Skills Profile. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Long stay or rehabilitation mental health wards for working age adults

- The ward team had access to a range of specialists required to meet the needs of patients. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other staff from services that would provide aftercare following the patient's discharge. Staff engaged with appropriate teams early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers ensured that staff explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Managers had not reviewed the multidisciplinary staffing establishment since April 2017. Key staffing posts had not been recruited to. 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. However, work was underway to address this.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients reported that staff were kind and understanding, they listened to their requests and tried their best to address any concerns they had.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. We saw several examples of co-production between patients and staff such as when care planning, managing risk and being involved in the staff interview process. There were also ward representatives on governance groups and a co-production group to review changes in policy and procedure relating to the ward. Staff ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Carers were involved in their relatives care planning as required and where agreed with the patient as well as the carers groups and co-production groups.

However:

- Two of the five patients we spoke with told us that different bank staff who worked on the ward did not provide them with consistency in their care.

Long stay or rehabilitation mental health wards for working age adults

Is the service responsive?

Good ➔➔

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay. Discharge was rarely delayed for other than a clinical or Ministry of Justice reason. Managers used the ward as an effective step down for patients transitioning from the acute and forensic wards.
- Staff encouraged and supported patients to engage with the wider community. Patients accessed education and training opportunities, paid work opportunities, attended local gyms and other resources such as shops, places of worship, cafés and the library wherever possible. Patients could access outside areas within the hospital grounds. Staff used Section 17 leave, to facilitate patient's recovery and need for community access.
- The design, layout, and furnishings on 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.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The ward met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Managers treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good ➔➔

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

- Leaders had the skills, knowledge and experience to perform their roles, and had a good understanding of the services they managed. Leaders were visible in the service and approachable for patients and staff. Staff told us that leadership training within the trust was high quality and effective. Managers actively promoted the take up of leadership training opportunities at all levels of the organisation.
- Leaders had a clear vision of where the service was heading. Senior staff made attempts to involve all staff in sharing the vision and the development of the service plans through team building, and co-production.
- Most staff we spoke with felt respected, supported and valued by their managers, despite the organisational changes that had taken place. They reported the provider promoted equality and diversity in its day-to-day work and provided opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that managers managed performance and risk well. Managers dealt with poor staff performance and were managing their long-term sickness with support from their human resources and occupational health departments.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Long stay or rehabilitation mental health wards for working age adults

- Staff engaged actively in local and national quality improvement activities.
- The service had achieved Accreditation for Inpatient Mental Health Services in May 2017.

However:

- Organisational change had impacted on the delivery of patients' therapeutic intervention. 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. However, work was underway to address this.
- Some staff expressed that the change process had taken too long to develop a cohesive service. 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.

Areas for improvement

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

Forensic inpatient or secure wards

Outstanding ☆ ↑

Key facts and figures

Northamptonshire Healthcare NHS Foundation Trust provides low secure forensic services for adults of working age on one ward.

The Wheatfield Unit is a low-secure facility for up to 12 male patients who require intensive multidisciplinary treatment in a secure environment. The unit provides a service to people over the age of 18 who are detained under the Mental Health Act. It is adjacent to Meadowbank, a step down rehabilitation unit to which patients can be referred when they are ready for further rehabilitation.

The Wheatfield Unit is part of Berrywood Hospital, Northampton. It is a purpose-built facility with up to-date amenities including a gym, sports area, library, multi-media room, arts studio, cafe and rooms for therapy sessions. The facilities are shared with Meadowbank rehabilitation unit. The trust states that it aims to help individuals on Wheatfield Unit re-build their lives in a safe and caring environment.

The service was last inspected in January 2017 and was rated good in all key questions. We identified areas for improvement and told the trust to take the following actions:

• The trust should review lines of sight throughout the ward to ensure effective observation of patients at all times.

• The trust should ensure that changes in medication are properly recorded in line with policy and protocol to minimise the chance of medication being administered after it has been discontinued.

• The trust should ensure staff receive formal clinical supervision.

The trust completed all of the actions from the January 2017 inspection.

Our inspection was comprehensive and announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about this core service and information we had requested from the Trust.

During the inspection visit, the inspection team:

- spoke with nine patients who were using the service
- spoke with the manager of the ward
- spoke with eight other staff members; including doctors, nurses, healthcare assistants, occupational therapists, nutritionists and psychologists
- observed two meetings and one episode of care
- reviewed seven patient records relating to physical health
- reviewed seven records relating to patient risk assessments and care plans, and seven patient prescription charts.

Summary of this service

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

Forensic inpatient or secure wards

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all people who used services. We saw safe use of innovative and pioneering approaches to care delivery. New evidence-based technologies were used to support the delivery of high quality 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.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used services. Staff from different disciplines worked together as a team to benefit patients.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders encouraged innovation and participation in research. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff.
- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Is the service safe?

Good 

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and 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.
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

Forensic inpatient or secure wards

- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Outstanding ☆ ↑

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

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all people who used services. This included addressing their medical needs, nutrition and hydration. 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, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements.
- We saw safe use of innovative and pioneering approaches to care delivery. New evidence-based technologies were used to support the delivery of high quality care, for example lifestyle apps. 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, including employing a nutritionist to support patients.
- Leaders ensured outcomes were consistently and regularly evaluated in line with national guidance and best practice. A variety of outcome measures was used, which promoted effective review of treatment programmes and promotion of healthier lives. Audit played an effective role in evaluating care in this service. They participated in the Quality Network for Forensic Mental Health Services and was last reviewed in April 2019.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used services. Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- All staff played an active role in promoting healthier lives and to improve outcomes for patients. A 'Better Body programme', healthy eating and meal preparation, gym membership and input from a nutritionist consistently promoted well-being.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Medical staff had not recorded an expiry or review date on nine patients' 'authorisation for leave of absence form - section 17'.

Is the service caring?

Good 

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

- Most 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 involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff regularly involved patients in decsions about the service. Regular community meetings allowed patients to give their views.
- Staff informed and involved families and carers appropriately. Carers attended monthly forums at which they chose topics for discussion. Staff offered to visit families at home if they preferred.
- Patients told us this was the best hospital they had stayed in, and staff treated them well and behaved kindly towards them.
- Staff directed and supported patients to access other services as part of their care. The ward manager sourced additional staffing resources to make this happen.

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.

Is the service responsive?

Good 

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward 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.
- Patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients and staff told us that the quality and variety of food was poor. Action was underway for patients to prepare their own meals more often.

Is the service well-led?

Outstanding ☆ ↑

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

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. There was compassionate, inclusive and effective leadership and staff felt highly valued by their leaders. Leaders had a deep understanding of issues, challenges and priorities in their service. Leaders were committed and passionate to provide a well led, innovative and cohesive service.
- Leaders had an inspiring shared purpose along with the team to deliver outstanding levels of care. They consistently strived to motivate their staff to succeed. Staff had opportunity to attend specilaised training, and delivered an ethos of 'rehabilitation starts here' in the treatment programme.
- There was a systematic and integrated approach to review progress of treatment interventions, and evidence outcomes. Outcome measures such as NEWS, HoNOS and HCR20 were used to review treatment goals in collaboration with patients. Leaders ensured robust audit reviewed practice outcomes and showed a commitment to continuous improvement for their service. 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.
- Leaders encouraged innovation and participation in research. The service used innovative methods to support patients achieve rehabilitation goals. Staff consistently promoted and encouraged patient participation to live healthier lifestyles with a 'Better Body Programme'. Healthy cooking and menu choices were reinforced with input from a nutritionist, and membership at community gyms. The service published a research paper on the use of body worn cameras as part of a pilot scheme co produced with patients and carers. An online physical health tool provided patients with a personalised physical health report and plan.
- Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. There was a strong record of sharing work. 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 from other providers visited the service to learn.
- Staff were extremely proud to work in this service and engaged with the reahbiltiation ethos. They spoke highly of the open culture, and the collaboration between other wards in the trusts and services within the local community. The staff were committed and engaged to deliver high standards of care and try new innovations and ideas to support patients in their recovery.
- Governance processes operated very effectively at ward level and that performance and risk were managed well. Leaders used results from audits, key performance indicators and essential information to review the service. Team meetings and at all levels were well attended and had effective reporting processes.

Forensic inpatient or secure wards

- Ward teams had access to the information they needed and were strongly committed to provide safe and effective care and used that information to good effect.

Outstanding practice

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

Areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

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

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

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

Our inspection team

Julie Meikle, head of hospital inspection, hospitals, mental health and Tracy Newton, inspection manager, hospitals, mental health, led this inspection. An executive reviewer, and a governance specialist advisor supported our inspection of well-led for the trust overall.

The team included two further inspection managers, 11 inspectors, one mental health act reviewer, one pharmacy inspector, eight specialist advisors and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.