Northamptonshire Healthcare NHS Foundation Trust

Quality Report

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St Mary's Hospital
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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICU)	St Mary's Hospital Berrywood Hospital	RP1A1 RP1V4
Long stay / rehabilitation mental health wards for working age adults	Berrywood Hospital	RP1V4
Forensic inpatient / secure wards	Berrywood Hospital	RP1V4
Child and adolescent mental health wards	The Sett The Burrows	RP1V6 RP1V4
Specialist community mental health services for children and young people	Isebrook Hospital Newland House Sudborough House	RP1F2 RP1X1 RP1A1
Wards for older people with mental health problems	St Mary's Hospital Berrywood hospital	RP1A1 RP1V4
Community-based mental health services for older people	Berrywood Hospital Danetre Hospital The Rushden Centre Stuart Road Clinic	RP1V4 RP1J6 RP1X1 RP1X1

Summary of findings

Community-based mental health services for adults of working age	Campbell House Danetre Hospital Isebrook Hospital St Mary's Hospital Stuart Road Clinic	RP1X1 RP1J6 RP1F2 RP1X1 RP1X1
Mental health crisis services and health-based places of safety	St Mary's Hospital Berrywood Hospital Trust Headquarters Kent Close	RP1A1 RP1V4 RP1X1 RP1X7
Community-based mental health services for people with learning disabilities and autism	Newland House St Mary's Hospital	RP1X1 RP1A1
Community health services for adults	Battle house Willowbrook Health Centre Kettering Diabetes Centre St Mary's Hospital Brackley Health Centre Weston Favell Health Centre Isebrook Hospital Danetre Hospital	RP1X2 RP1P1 RNQ51 RP1A1 RP1J5 RNSX1 RP1F2 RP1Y8
Community health services for children, young people and families	Trust Headquarters Danetre Hospital St Mary's Hospital John Greenwood Shipman Centre Short Breaks Unit, 82 Northampton Road Isebrook Health Campus	RP1X1 RP1Y8 RP1A1 RP1JG RP1NR RP1X3
Community health inpatient services	Corby Community Hospital Danetre Hospital Isebrook Hospital	RP1E1 RP1Y8 RP1F2
Community dental services	Isebrook Hospital St James's Clinic Willowbrook Health Centre	RP1F2 RP1G9 RP1P1
End of life care	Manfield Campus St Mary's Hospital Danetre Hospital	RP1A2 RP1A1 RP1Y8

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We rated the trust overall as good because:

- The trust responded in a very positive way to the improvements we asked them to make following our inspection in February 2015. At this inspection, we have seen improvements in most core services across the trust.The senior leadership team have been instrumental in delivering quality improvement within the trust.
- Throughout the trust, in both mental health and community health services, staff treated patients with kindness, dignity and respect.Consistently, staff attitudes were helpful, understanding and staff used kind and supportive language that patients would understand. The style and nature of communication was kind, respectful and compassionate.Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.
- Staff encouraged patients to give feedback about their care.Staff offered patients the chance to give feedback in a variety of ways. A feedback system had been introduced across the trust called I Want Great Care. This received feedback from carers, patients and staff about the care of patients and other issues. The trust received 61,000 reviews since the system began.
- Patients were involved in projects across the organisation and we saw evidence of this in the core services.This included reviewing documents, delivering training, and recruiting and interviewing staff.The trust had a patient involvement group that was well attended by patients from the mental health pathway.
- Information leaflets were available in easy read formats and we saw evidence of information available to patients on how to access interpreters should they need one.
- The trust had a robust governance structure in place to manage, review and give feedback from complaints. Staff consistently knew how to handle complaints, and managers investigated complaints promptly and gave feedback to patients, carers and staff about outcomes of complaints.
- The trust had a clear vision and set of values.The vision and values had been widely communicated across the trust through posters, presentations, and the intranet page called the staff room, screen savers and board members visits to wards. Staff in mental health services and community health services were, for the majority, aware of the trust's vision and values.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and described how they worked with partner agencies to protect vulnerable adults and children.
- An operational management tool was in place which recorded data for 40 areas of patient safety and areas of compliance for the trust.The trust board had oversight of this.
- The trust had developed and invested in an extensive range of well-being schemes for the staff.They told us about physical fitness classes, recruitment and retention rewards, counselling, and support groups available.
- The trust ensured staffing levels and skill mix across 15 core services was planned and reviewed so that people who used services received safe care and treatment. The majority of services across the trust increased staffing based on clinical need or made arrangements to cover leave, sickness and absence. Managers had authority to make these decisions.
- Physical environments across most services in mental health and community services were clean and well maintained. Across most services staff had completed environmental risk assessments. Where issues had been identified, staff mitigated these risks by carrying out additional checks or had taken other actions to resolve the issues.
- Emergency medicines and equipment were available in all of the inpatient clinical areas that we visited. All emergency equipment was in date and staff checked them daily. Antipsychotic medication was prescribed within the British National Formulary (BNF) limits and monitoring was in place.

Summary of findings

- The trust was meeting Department of Health guidance for eliminating mixed sex accommodation.
- Staff completed detailed and clear risk assessments at seven of the 10 mental health core services and at all community health services.Staff involved patients in their care plans and risk assessments and where possible, staff gave copies to patients.Staff across mental health services completed comprehensive assessments and person centred care plans in a timely manner, and in collaboration with the patients.
- The trust used an electronic system for reporting incidents. At all services staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents.The trust had robust systems for sharing lessons learned from incidents.
- The majority of mental health services and used best practice to influence treatment and care offered to patients. Staff used a wide range of outcome measures within their practice, across most mental health services. The trust monitored and audited outcomes using rating scales, best practice and a range of audit.
- All mental health services had access to psychological therapies. All teams within mental health services and described effective and collaborative team working and had effective working relationships external agencies.Core services reported effective handovers between teams.
- Physical healthcare needs had been addressed at inpatient mental health settings. Information needed to deliver care was stored securely on an electronic record system which the GP also had access to, this improved continuity of care.The trust was nominated for a health service award following their work to introduce this system.
- The trust made available and supported specialist training and induction. Staff felt this training helped them in delivering services to patients.Both registered and non-registered staff had access to further training.
- The trust average compliance for supervision was 93% but this varied across services.
- The trust provided information that overall MHA training compliance was 92%.Most services showed compliance in adhering to the MHA and MCA. In all services we visited, staff told us about how patients could access independent mental health advocacy services
- The BME group had reconvened and had made progress in highlighting their goals for the year ahead.The trust supported the agenda and provided opportunity for meetings, projects and feedback and had a Workforce Race Equality Standard (WRES) action plan in place.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and the majority of staff felt able to raise concerns without fear of victimisation.
- Senior managers told us frequently that there had been much organisational change and transformation of care within the trust. Staff told us they accepted change but they positively embraced the opportunity it provided. They felt supported by the board to work with change and felt able to provide feedback about their experiences.

However:

- Some environments were not clean and well maintained and furniture was not sufficiently weighted. On acute wards and in some CHS hospitals, there were environmental issues identified.These included heating problems, drainage issues, and observation blind spots, areas of disrepair and privacy issues.
- There were no ligature audit assessments in place for any of the locations inspected within community-based mental health services for adults. Managers on community-based mental health services for children and young people had not completed ligature audits for the sites we visited.
- Weston Favell Health Centre (CHS Adults) had out of date equipment in a treatment room used by phlebotomists. In CHS Adults at Weston Favell and CHS for Inpatients, infection prevention and control processes were not always being followed.
- Medication was not being managed safely at Danetre Hospital and Corby Community Hospital.
- The trust did not meet compliance target for non-medical staff supervision in all core services.Systems used to record supervision were inconsistent across the trust.Some services used 1:1 supervision, group supervision or team meetings as a way of carrying out this task.Clinical and managerial supervision data was not collected separately.The trust wide average appraisal compliance rate was 65% at September

Summary of findings

2016. During the inspection data showed there had been an increase in average compliance from 65% to 90%.The difference in this data suggested that data collection required a review by the trust.

- Staff compliance with MCA and MHA training was 67% for community-based mental health services for older people, below the trust compliance target of 90%. Staff did not consistently document mental capacity assessments and best interest decisions in care records where they were required. Some staff were not able to tell us how they would put the Mental Capacity Act into practice in their work.
- There was a high number of delayed discharges from CHS Inpatient hospitals. Data showed 46% of all patients across the service were medically fit to be discharged home but remained in hospital because there were no care packages available or the patients were waiting to be assessed.
- The trust did not meet its target for mandatory training compliance of 90%.At the time of inspection, mandatory training compliance was 89% with the lowest compliance for a core service at 62%.
- CHS for Adults had waiting lists and no way to monitor deteriorating patients.Some acute mental health services used beds for new admissions that were already allocated to patients on leave.Discharges from forensic inpatient services were affected by a reduced number of beds on the rehabilitation ward.
- CHS for Inpatients had high vacancy and sickness rates which put additional pressure on substantive staff. The strategy to move all stroke patients to one hospital site was delayed. Plans started in August 2016had not been completed. However, the trust provided evidence that they are now working on this strategy. Not all risks had been identified on the risk register and some risks had not been recognised or responded to.
- The trust did not assess or monitor the phlebotomy service in CHS for Adults. There was a lack of oversight of the service and it had not been delivered in line with the service level agreement with commissioners.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated Northamptonshire Healthcare NHS Foundation Trust as requires improvement for safe because:

- Environments at four core services were not well maintained. On acute wards, there were heating problems, drainage issues, and observation blind spots, areas of disrepair and privacy issues in garden areas. Wheatfield unit had blind spots and mirrors did not cover the blind spots. Furniture at the HBPoS at St Mary's Hospital and Berrywood Hospital was not sufficiently weighted and could be thrown. Rooms in acute mental health liaison services at NGH and KGH did not meet the psychiatric liaison accreditation network standards. The trust had an action plan in place for rooms which did not meet PLAN standards. At Campbell House, in community-based mental health services for adults, the entrance did not have reception staff to monitor the arrival of patients for their appointments. Staff had identified fire-risks at a team base for community-based services for older people in a fire audit in 2013, but had still not taken action at the time of our inspection.
- Wards at community inpatient hospitals were in a poor state of repair and provided health and safety hazards including trips, leaking roofs and heating failures. At Corby Community Hospital the floor was uneven in the corridors in some areas. Three sets of fire doors were continually alarming. Staff told us several attempts to repair the alarms had failed or only worked for a short period.
- Some community-based mental health services had no alarms fitted in interview rooms.
- There were no ligature audit assessments in place for any of the locations inspected within community-based mental health services for adults. Managers on community-based mental health services for children and young people had not completed ligature audits for the sites we visited.
- We found out of date equipment in a treatment room used by phlebotomists at Weston Favell Health Centre (CHS Adults) during several separate visits made to this location. At the same site, staff did not always follow infection prevention and control processes.
- Medication was not being managed safely at Danetre Hospital and Corby Community Hospital. Medication had been prescribed but not signed for, staff had not reported all medication omissions, and doctors had not signed medication

Requires improvement

charts for discretionary medication. Controlled drugs were found for patients who had been discharged, staff did not regularly review patients receiving blood thinning medication and staff did not record an opening date on some medication. There were no guidelines for anticipatory medicines at Danetre Hospital.

- Caseloads for community-based mental health services for children, learning disability and older people were high. Staff at the Northampton Memory Assessment Service reported that they had a caseload of 1000 patients, split between three nursing staff, one psychologist, a CSW and a part time OT.
- The trust did not meet compliance targets for mandatory training in some core services; this included, safeguarding training, intermediate life support, manual handling, and infection, prevention and control.
- Staff in children, young people and families, were unable to show us the flow chart process or the trust's standard operating procedure (SOP) for child abuse medical examinations and it was not documented in the trust safeguarding policy. This meant that concerns may not have been evaluated in a consistent and effective manner.
- Staffing shortages existed in CHS inpatient, which related to 23 incidents reported. However, one moderate harm incident was not attributable to the trust.
- The trust did not have a long term segregation policy and the seclusion policy did not reference long term segregation. The trust information about long term segregation was unclear and contradictory. The seclusion policy referred to the Department of Health Mental Health Act 1983: Code of Practice 2008, rather than the current code of practice. We also found the trust's over-arching Mental Health Policy referenced the previous code of practice. The trust used the Code of Practice as policy for areas including long-term segregation and reading patients their rights (section 132 MHA).

However:

- Physical environments across 12 of the 15 core services in mental health and community health services were clean and well maintained. Across most sites within the trust, staff adhered to infection control principles including handwashing techniques. Across these services staff had completed environmental risk assessments and where issues had been identified; staff mitigated these risks by carrying out additional checks, or had taken other actions to resolve the issues.

Summary of findings

- Emergency medicines and equipment were available in all the inpatient clinical areas that we visited. All emergency equipment was in date and staff checked them daily.
- The trust was meeting Department of Health guidance for eliminating same sex accommodation.
- Staff completed detailed and clear risk assessments in seven of the 10 mental health core services and all CHS services.
- The trust used an electronic system for reporting incidents. Staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents and gave feedback to staff on lessons learned.

Are services effective?

Good

We rated Northamptonshire Healthcare NHS Foundation Trust as good for effective because:

- Staff in most services completed comprehensive assessments and person centred care plans in a timely manner, and in collaboration with the patients.
- The majority of mental health services and CHS used best practice to influence treatment and care offered to patients.
- Antipsychotic medication was prescribed within the BNF limits and monitoring was in place.
- All mental health services had access to psychological therapies.Professions delivered a range of services to mental health wards using guidance from best practice.The teams across mental health services included a full range of mental health disciplines.
- Physical healthcare needs had been addressed by inpatient mental health settings. Information needed to deliver care was stored securely on an electronic record system which the GP also had access to, this improved continuity of care.
- Staff used a wide range of outcome measures within their practice, across most mental health services. The trust monitored and audited outcomes using rating scales, best practice and a range of audit.
- The trust made available and supported specialist training and induction for staff and staff felt this training helped them in delivering services to patients.Both registered and non-registered staff had access to further training.
- The trust average compliance for supervision was 93% but was variable across services.Supervision data was a total of combined figures for clinical supervision and managerial supervision, and consisted of a range of one to one meetings and group meetings (which also included team meetings).

Summary of findings

- All teams within mental health services and CHS described effective and collaborative team working. All mental health teams and CHS teams across the trust reported effective working relationships external agencies. Core services reported effective handovers between teams.
- The trust's overall MHA training compliance was 92%. Most services showed compliance in adhering to the MHA and MCA. In all services we visited, staff were able to tell us about how patients could access independent mental health advocacy services

However:

- In community mental health services for older people, a shared protocol was in place that showed the GP was responsible for monitoring the patient's overall health and well-being.However, staff did not check whether annual health checks, including blood tests, had been carried out.
- Medical staff from forensic inpatient and rehabilitation wards felt service provision could be improved by accessing specialist training in personality disorder.
- The trust wide average appraisal compliance rate was 65% as of September 2016. During the inspection data showed there had been an increase in average compliance with appraisal from 65% to 90%.The difference in data suggested that data collection required a review by the trust.
- The provider did not set a compliance target for MCA training. Staff compliance with MCA and MHA training was 67% for community-based mental health services for older people, below the trust compliance target of 90%. Staff did not consistently document mental capacity assessments and best interest decisions in care records where they were required. Some staff were not able to tell us how they would put the Mental Capacity Act into practice in their work.
- The community inpatient service did not participate in any national audits, for example the Sentinel Stroke National Audit Programme. There was a lack of benchmarking with national standards to outcomes for patients undergoing rehabilitation programmes.

Are services caring?

Outstanding ☆

We rated Northamptonshire Healthcare NHS Foundation Trust as outstanding for caring because:

- Throughout the trust, in both mental health and community health services, staff treated patients with kindness, dignity and respect. Consistently staff attitudes were helpful,

understanding and staff used appropriate language patients would understand. The style and nature of communication was kind, respectful and compassionate.Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.

- Patients told us that staff were exceptionally caring and compassionate.During our inspection, patients across the trust confirmed our observations of positive and caring staff attitudes and behaviours.Patients told us that staff were kind and caring and were consistently positive about staff and the support they had received from services.
- Staff encouraged patients to give feedback about their care.Staff offered patients the chance to give feedback in a variety of ways.
- Senior managers told us that patients were involved in projects across the organisation.This included reviewing documents, delivering training, working as bank staff and recruiting and interviewing staff.The trust had a patient involvement group that was well attended by patients from the mental health pathway.
- A feedback system had been introduced across the trust called I Want Great Care.This received feedback from carers, patients and staff about the care of patients and other issues.The trust received 61,000 reviews since the system began.
- During our visit we saw numerous examples of patient involvement in care plans, in risk assessments and patient participation in meetings. Staff encouraged patients, where ever possible, to maximise their independence during their care.

However:

- The friends and family test was launched in April 2013. The trust achieved a significantly higher response rate than the national average in the time period March 2016 to August 2016. In all of the reported quarters the percentage of respondents who were 'extremely likely' to recommend the trust as a place to receive care was below the England average.
- Staff did not always document patient involvement in care plans or offer copies of care plans in some mental health services. However, in almost every service we visited we saw and heard staff engaging with people who used services about their care and how they could be involved.

Summary of findings

Are services responsive to people's needs?

Good

We rated Northamptonshire Healthcare NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning service developments and delivering services. The trust had effective working relationships with commissioners and other stakeholders.
- The trust board supported and encouraged a Black and Minority Ethnic project called Moving Ahead. This project delivered training to healthcare professionals across Northamptonshire to work with Black and Minority Ethnic patients.
- The trust met the target of 95% of patients being followed up within seven days of discharge.There were a high number of delayed discharges from CHS inpatient hospitals. Data showed 46% of all patients across the service were medically fit to be discharged home but remained in hospital because there were no care packages available or the patients were waiting to be assessed.
- The majority of services had a range of rooms and equipment to support care and treatment. Patients had access to quiet areas on wards and access to outside space.
- Patients told us they had co-produced information leaflets with staff and carers in one of the services. There was a provision of accessible information on treatments, local services, patients' rights and how to complain across all services.We saw evidence of information available to patients on how to access interpreters should they need one.
- The PLACE assessment relating to food scores showed the trust scored slightly over the national average of 92% for food with 97%.
- The trust had a robust governance structure in place to manage, review and give feedback from complaints. The trust set a 72 hour time frame in which they responded to a complaint. If an investigation was required, a written response would be received by the complainant within 25 days. All complaints are reviewed by the CEO.
- Staff knew the process to support patients to make a complaint.Staff gave patients information on how to do this where appropriate, and information was readily available on ward notice boards and in welcome packs. Staff consistently knew how to handle complaints, and managers told us they investigated complaints promptly and gave feedback to patients, carers and staff about outcomes of complaints.

However:

Summary of findings

- The average bed occupancy rate was 102% across all wards. Five of the eight core services had average bed occupancy of 85% or more with acute and PICU wards with the highest occupancy at 116%.
- There were no patient phones within any of the older people's wards. However, patients could ask to use the ward phone to make private phone calls and patients could use their personal mobile phones.
- The HBPoS at St Mary's Hospital did offer patients access to fresh air within a safe setting, however this was on another ward and could only be used when patients from that ward were not using it.
- CHS had waiting lists and no way to monitor deteriorating patients.Some acute mental health services and forensic inpatient services used beds for new admissions that were already allocated to patient on leave.Discharges from forensic inpatient services were affected by a reduced number of beds on the rehabilitation ward.
- Community-based mental health services for older people did not have information leaflets readily available in other languages. Staff told us they had to request these from the trust communications team.
- Corby Community Hospital had bright blue flooring. This could be confusing for patients with a cognitive impairment or dementia because it looked like water. Staff told us some patients did not want to step on the blue floor because it looked like water.

Are services well-led?

Good

We rated Northamptonshire Healthcare NHS Foundation Trust as good for well-led because:

- The trust had a clear vision and set of values. The trust board had taken a number of actions to role model their values and vision. The board level leadership was outstanding. The senor leadership team were instrumental in delivering the quality improvement work across the trust.
- Staff in mental health services and community health services was, for the majority, aware of the trust's vision and values. Although some staff were not able to repeat the phrases of the values verbatim, they told us in their own words what the values meant to them in their work with patients, carers and colleagues.

Summary of findings

- The trust's strategy clearly articulated a vision for quality and improvement. It was based on five principles, and we saw that from board members to senior leaders and staff that they showed, through their actions, the principles of the strategy and values.
- Staff across services told us they knew how to give feedback to their managers or more senior staff on things that could improve services. A feedback system had been introduced across the trust called I Want Great Care.This received feedback from carers, patients and staff about the care of patients and other issues. Staff used the I want great care resource to offer feedback.
- The trust had systems in place to support and monitor staff performance and development.
- In mental health services and community health services, staff knew what incidents needed to be reported and how to report them. Managers ensured they monitored the reporting and recording on incidents.
- The trust collected data to demonstrate that immediate post incident reviews were taking place and that learning was identified to inform future care.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to use de-escalation processes effectively.
- The trust had safeguarding policies and robust safeguarding reporting systems in place.We saw robust databases and dashboards of safeguarding data collated by the trust.
- Equality and Diversity training was a mandatory training course at the trust, which must be completed once every three years. Staff compliance was 90%.
- The trust board had oversight of patient safety and compliance. The trust used key performance indicators/dashboards to gauge the performance of the teams.
- The trust had developed and invested in an extensive range of well-being schemes for the staff.
- The Black and Minority Ethnic group had reconvened and had made progress in highlighting their goals for the year ahead.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and the majority of staff felt able to raise concerns without fear of victimisation.
- Staff felt supported by the board to work with change and felt able to provide feedback about their experiences.

However:

- The trust operational risk register, dated August 2016, had two risks related to safe staffing.

Summary of findings

- Managers in community-based services for older people did not have assurance systems in place to monitor and audit the quality and performance of the service.
- CHS for Inpatients had high vacancy and sickness rates which put additional pressure on substantive staff.
- The strategy to move all stroke patients to one hospital site was delayed. Plans started in August 2016 had not been completed. However, the trust provided evidence that they are now working on this strategy.
- Not all risks had been identified on the risk register and some risks had not been recognised or responded to.
- The trust did not assess or monitor the phlebotomy service in CHS for Adults. There was a lack of oversight of the service and it had not been delivered in line with the service level agreement with commissioners.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Merseycare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Tracy Newton, Inspection Manager, mental health hospitals, CQC

Inspection Manager: Charlotte Rudge, Inspection Manager, acute hospitals, CQC

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacy inspectors, support staff a variety of specialist advisors and experts by experience. An expert by experience is someone who had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health and community health inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about Northamptonshire Healthcare NHS Foundation Trust and asked other organisations to share what they knew. We spoke with commissioners, local Healthwatch, Northamptonshire Police, East Midlands Ambulance Service, and local service user groups. We reviewed information received from service users and carers and members of the public who had contacted the CQC about the trust.

Prior to and during the visit the team:

- held focus groups with 19 different staff groups
- spoke with 229 patients and 98 carers and family members
- collected feedback from 124 comment cards
- attended 40 meetings which included multidisciplinary meetings, handover meetings and ward community meetings
- observed 104 episodes of care which included community treatment appointments, home visits and clinics
- reviewed the personal care or treatment records of 407 patients and service users, and 216 medication cards
- looked at patients' legal documentation including the records of people subject to a community treatment order
- observed how staff were caring for people
- interviewed 484 staff members
- interviewed 109 senior managers
- looked at 24 staff personnel records

Summary of findings

- reviewed information we asked the trust to provide.

We inspected all wards across the trust including adult acute services, the psychiatric intensive care unit, rehabilitation wards, forensic, children and young people wards and older peoples' wards. We inspected community-based mental health services for people with learning disability, for children and young people, for adults of working age and for older people. We also inspected mental health crisis services and health-based places of safety.

We visited a sample of community health services provided by the trust including community adult inpatient services, community adult services, end of life care, services for children, young people and families and community dentistry services.

Information about the provider

Northamptonshire Healthcare NHS Foundation Trust provides services across the area of Northamptonshire to a population of 700,000. 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 21 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
- forensic inpatient/secure wards
- long stay/rehabilitation mental health wards for working age adults
- wards for older people with mental health problems
- child and adolescent mental health wards
- community-based mental health services for adults of working age
- community-based mental health services for older people
- community mental health services for people with learning disabilities or autism
- specialist community mental health services for children and young people
- mental health crisis services and health-based places of safety.

In addition, the trust provides the following community health services:

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

Other services provided by the trust, but not inspected are:

- eating disorder services
- veterans liaison service
- sexual assault referral centre
- criminal justice team.

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. In 2016 it has an income of £189.06 million, and employs 2951 substantive staff.

NHFT has been inspected once under the comprehensive mental health and community health inspection programme, in February 2015. 17 core services were inspected and the trust received an overall rating of requires improvement. All domains, including safe, effective, responsive and well-led were rated as requires improvement. The domain of caring was rated as good.

We issued 34 requirement notices across the trust, 30 of which were against nine core services. These core services were acute wards for adults of working age and psychiatric

Summary of findings

intensive care, child and adolescent mental health wards, community-based mental health services for adults of working age, community health services – dental, community health inpatient service, community health service – end of life care, forensic inpatient/secure wards, long stay/ rehabilitation mental health wards for working age adults, and mental health crisis services and health based paces of safety.

We issued four requirement notices at the provider level for breaches of the following regulations:

- Regulation 13(2) - safeguarding service users from abuse and improper treatment – systems and processes must be established and operated effectively to prevent abuse of service users
- Regulation 17(2)(c) – good governance – maintain securely an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.
- Regulation 18(1) – staffing – suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements.
- Regulation 18(2) (a) – staffing - persons employed must receive appropriate, training, professional development, supervision and appraisal.

There had been 14 Mental Health Act monitoring visits between June 2015 and October 2016, all unannounced. In total, over the 14 visits, there were 20 issues found at locations across the trust.

What people who use the provider's services say

We spoke with 229 patients and 98 carers. We received 124 comment cards from patients. We held nine focus groups prior to the inspection for patients and carers, where 43 patients attended and their views were heard.

- Overall, patients were consistently and extremely positive about their care and treatment and said staff were always caring, very understanding and respectful. Patients told us that that staff listened and supported them in their care. Patients reported that they felt very safe on the wards and were always treated with respect and dignity.
- Overall across services, patients told us that they knew how to complain if they needed to and that staff supported them when this happened. There was clear and detailed information across the trust available for patients who wanted to raise concerns. Advocacy and the patient advocacy and liaison service were also available to provide information and receive feedback about the trusts' services.
- Carers spoke extremely positively about the service their relatives received, and confirmed that they had been offered carers assessments and signposted to extra support if required. They felt fully involved in care and were always able to give feedback to the trust.
- The latest patient led assessment of the care environment audit for privacy, dignity and wellbeing for wards across the trust showed 89% satisfaction. This was the same as the national average of 89.7%.
- Patients told us that signposting to other services was helpful and there were waiting times to access counselling services.
- Patients told us that they felt involved in their care plans and had been involved in service developments across the trust. However, they also told us they felt there were high levels of bank and agency staff used, particularly at night.
- Patients told us the food was of good quality and they were happy with the quantity of food provided.

Good practice

- The safe care leads were involved with a national working party to improve the acuity and dependency tools for mental health. Ward matrons supported by the safe care leads had utilised the most appropriate tools available (such as the Keith Hurst Acuity and Dependency Tool) to help plan the current staffing levels.

Summary of findings

- The trust delivered bespoke safeguarding training for staff. Managers had undertaken training to be able to deliver safeguarding training to their teams.Safeguarding training was delivered in a variety of ways and bespoke training was available to community staff working in remote areas.
- The trust board supported and encouraged a Black and Minority Ethnic community (BME) project called 'Moving Ahead'.The BME network engaged with local stakeholders, including police, external BME community groups, Healthwatch, Public Health England and advocacy services to develop a community engagement project.The trust board, non-executive directors and local universities had supported the BME network to carry out this work.The trust was one of three trusts nationally to have developed the moving ahead project and they had been asked to support other trusts in doing the same.Patients had also been involved in the project.Moving Ahead, had also provided training for BME communities focused on empowering and enabling BME communities to access the services the trust provides.This project had also delivered training to healthcare professionals across Northamptonshire on improved engagement with BME patients.
- The 'Johns Campaign' had been adopted across wards for older people. This supported and encouraged family and carers to visit the wards 24 hours a day. We observed visitors support their relatives during a meal time and during a physiotherapy session.
- Children and adolescent mental health wards held a yearly 'rivers of experience' event. Young people and parents who had used the service during the preceding 12 months were invited to attend a meeting whereby they were encouraged to share their experience, contribute to developing the service and to look at where things could have been done differently.
- The 'opportunities for you' service was commissioned to provide personalised care packages for people in their own home who were unable to access community services. This meant that people who would not normally be able to access services were included and increased their independence.
- The children and young people's community health services had successfully bid for funding from the Health Education England's innovation fund. The grant was used to develop and implement initiatives to support the emotional well-being and mental health of young people and their parents/carers. These included an online live chat room, telephone support and a self-referral facility. Health visitors had developed a social media page for children's services at the trust, which provided advice and guidance to parents and service users. School nursing had implemented a confidential helpline texting service for young people in schools to enable them to raise issues and concerns which they did not want to discuss in person.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure capacity assessments and best interest decisions are completed and documented in the care records.
- The trust must ensure that appropriate arrangements are in place for accurate recording and monitoring of the administrations of medicines.
- The trust must ensure that the prescribing of medicine for rapid tranquilisation of patients is completed as detailed in the National Institute for Health and Care Excellence (NICE) guidelines and follow their own policy document.
- The trust must maintain medicines at correct temperatures in all areas and ensure action is taken if they are stored outside the correct range.
- The trust must ensure that medicines administered to patients are safe and effective.

Summary of findings

- The trust must ensure patients waiting for care and treatment are appropriately risk assessed for deterioration, action taken if required and waiting lists are routinely audited.
- The trust must ensure infection, prevention and control follows national guidance and their own policy document.
- The trust must ensure that all staff receive training in appropriate levels of safeguarding.
- The trust must ensure that environmental risks are assessed and premises and equipment are secure, clean and maintained to ensure patient safety.
- The trust must address the environmental concerns in the health-based places of safety (HBPoS).
- The trust must ensure there are systems in place to monitor quality and performance of services.

Action the provider SHOULD take to improve

- The trust should ensure environments offer confidentiality, privacy and dignity to patients.
- The trust should ensure seclusion records are completed accurately, reviewed and audited.
- The trust should ensure environmental risk assessments are completed.
- The trust should ensure that mandatory training meets trust compliance targets at all services.
- The trust should ensure staff receive training, supervision and appraisal necessary for them to carry out their roles and responsibilities.
- The trust should ensure emergency equipment is available in community mental health team bases.
- The trust should ensure bed occupancy and waiting lists are monitored and audited.

Northamptonshire Healthcare NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- We visited all of the wards at the trust where detained patients were being treated. We reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the MHA. We also looked at procedures for the assessment of people under the MHA.
- The trust provided information that MHA training compliance was 92%.Staff attended training every year. Staff had access to the Mental Health Act 1983: Code of Practice, (Department of Health, 2015).
- The trust's Mental Health Act Scrutiny Committee monitored all aspects of MHA performance and met quarterly.The Mental Health Act Scrutiny Committee received monthly MHA reports, which fed into the Quality Forum.The monthly report included information about the use of the MHA across the trust.
- The Quality Forum reported to the Quality and Governance Committee, which then reported to the trust's board of directors.The medical director was the clinical specialist for the MHA on the trust board.Issues and concerns were considered and reviewed at various levels.The board would then be presented with issues and solutions for sign off.
- We met with the hospital managers and were informed that they link with the MHA manager.We were told that the hospital managers met twice a year and received a rolling programme of training that ensured that they had the knowledge and skills to undertake the role effectively. This training programme covered policy and procedures, issues of clinical importance, and legal aspects including the MHA Code of Practice (CoP).
- The trust did not have a long term segregation policy and the seclusion policy did not reference long term segregation.The trust information about long term segregation was unclear and contradictory.The seclusion policy referred to the Department of Health Mental Health Act 1983: Code of Practice 2008, rather than the current code of practice.We also found the trust's over-arching Mental Health Policy referenced the previous code of practice. The trust used the Code of Practice as policy for areas including long-term segregation and reading patients their rights (section 132 MHA).
- We found section 132 rights were not always read to patients following admission or at key times.

- Seclusion was used at a number of services we visited.We found the number of patients secluded, the frequency and duration of seclusion was low across the trust.The seclusion facilities met the requirements of the current code of practice.
- We reviewed practice under Section 136 of the MHA in detail.Staff at the Section 136 units appeared to be knowledgeable about the Mental Health Act and the code of practice. They were aware of their responsibilities around the practical application of the Act and we found that the relevant legal documentation was completed appropriately in those records reviewed. We noted the Section 136 units visited had patient information readily available for and everyone was given a leaflet about the powers and responsibilities of Section 136 of the Act.
- Staff on the adolescent unit and in community teams had a good understanding of the Gillick competence and Fraser guidance and routinely sought consent to share information and consent to treatment from the young people in these services.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC had made a public commitment to reviewing provider adherence to MCA and DoLS.

- The MHA administration team managed the Deprivation of Liberty Safeguards (DoLS) applications countywide. This enabled the trust to track applications and authorisations. Between 01 October 2015 and 30 September the trust made 64 DoLS applications.Brookview ward at Berrywood Hospital and Orchard ward at St Marys Hospital had the highest number of applications which accounted for almost 90% of all applications made by the trust. This is likely due to the fact they are both dementia wards.
- The governance route for the Mental Capacity Act was the same as for the Mental Health Act except the information was also reported to the safeguarding board.
- The trust provided information that MHA training compliance was 92%. The trust told us the MHA training included training on MCA.Staff attended training every year. Staff had access to the “Mental Health Act 1983: Code of Practice” (Department of Health, 2015).This training was not mandatory but those eligible were required to attend an update once every three years. The provider did not set a compliance target for MCA training. 72% of eligible staff were up to date with their Mental Capacity Act / DoLS training for the period 01 October 2015 to 30 September 2016. Thirteen of the sixteen core services at the trust reported training rates below 90%.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated Northamptonshire Healthcare NHS Foundation Trust as requires improvement for safe because:

- Environments at four core services were not well maintained. On acute wards, there were heating problems, drainage issues, and observation blind spots, areas of disrepair and privacy issues in garden areas. Wheatfield unit had blind spots and mirrors did not cover the blind spots. Furniture at the HBPoS at St Mary's Hospital and Berrywood Hospital was not sufficiently weighted and could be thrown. Rooms in acute mental health liaison services at NGH and KGH did not meet the psychiatric liaison accreditation network standards.The trust had an action plan in place for rooms which did not meet PLAN standards. At Campbell House, in community-based mental health services for adults, the entrance did not have reception staff to monitor the arrival of patients for their appointments. Staff had identified fire-risks at a team base for community-based services for older people in a fire audit in 2013, but had still not taken action at the time of our inspection.
- Wards at community inpatient hospitals were in a poor state of repair and provided health and safety hazards including trips, leaking roofs and heating failures. At Corby Community Hospital the floor was uneven in the corridors in some areas. Three sets of fire doors were continually alarming. Staff told us several attempts to repair the alarms had failed or only worked for a short period.
- Some community-based mental health services had no alarms fitted in interview rooms.
- There were no ligature audit assessments in place for any of the locations inspected within community-based mental health services for adults. Managers on community-based mental health services for children and young people had not completed ligature audits for the sites we visited.
- We found out of date equipment in a treatment room used by phlebotomists at Weston Favell Health Centre (CHS Adults) during several separate visits made to this location. At the same site, staff did not always follow infection prevention and control processes.
- Medication was not being managed safely at Danetre Hospital and Corby Community Hospital. Medication had been prescribed but not signed for, staff had not reported all medication omissions, and doctors had not signed medication charts for discretionary medication. Controlled drugs were found for patients who had been discharged, staff did not regularly review patients receiving blood thinning medication and staff did not record an opening date on some medication. There were no guidelines for anticipatory medicines at Danetre Hospital.
- Caseloads for community-based mental health services for children, learning disability and older people were high. Staff at the Northampton Memory Assessment Service reported that they had a caseload of 1000 patients, split between three nursing staff, one psychologist, a CSW and a part time OT.
- The trust did not meet compliance targets for mandatory training in some core services; this included, safeguarding training, intermediate life support, manual handling, and infection, prevention and control.
- Staff in children, young people and families, were unable to show us the flow chart process or the trust's standard operating procedure (SOP) for child

Requires improvement

Are services safe?

abuse medical examinations and it was not documented in the trust safeguarding policy. This meant that concerns may not have been evaluated in a consistent and effective manner.

- Staffing shortages existed in CHS inpatient, which related to 23 incidents reported. However, one moderate harm incident was not attributable to the trust.
- The trust did not have a long term segregation policy and the seclusion policy did not reference long term segregation. The trust information about long term segregation was unclear and contradictory. The seclusion policy referred to the Department of Health Mental Health Act 1983: Code of Practice 2008, rather than the current code of practice. We also found the trust's over-arching Mental Health Policy referenced the previous code of practice. The trust used the Code of Practice as policy for areas including long-term segregation and reading patients their rights (section 132 MHA).

However:

- Physical environments across 12 of the 15 core services in mental health and community health services were clean and well maintained. Across most sites within the trust, staff adhered to infection control principles including handwashing techniques. Across these services staff had completed environmental risk assessments and where issues had been identified; staff mitigated these risks by carrying out additional checks, or had taken other actions to resolve the issues.
- Emergency medicines and equipment were available in all the inpatient clinical areas that we visited. All emergency equipment was in date and staff checked them daily.
- The trust was meeting Department of Health guidance for eliminating same sex accommodation.
- Staff completed detailed and clear risk assessments in seven of the 10 mental health core services and all CHS services.
- The trust used an electronic system for reporting incidents. Staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents and gave feedback to staff on lessons learned.

Our findings

Safe and clean care environments

- The trust recorded nine significant or high level risks on the central directorate risk register relating to safe and clean areas. These were within community Adults, children, young people and families, community inpatient services, end of life care, child and adolescent mental health wards, acute wards for adults and the PICU.
- PLACE assessments are self-assessments undertaken by teams of NHS staff and members of the public (known as patient assessors). They focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services. In relation to cleanliness, the trust scored above the national average of 97.8% with 99.4% in 2016.
- The trust had a risk register relating to estates risks. It contained nine Items which ranged from fire safety, health and safety, lone working, environment (including car parking) to property management. We were told that the trust had undergone a recent audit from an independent auditor. Senior staff told us that one major area of concern highlighted was that of managing property in the trust's estate. This had been highlighted to the board so that had an understanding of the issues. The trust had a strategy to manage the issues.
- We observed that physical environments across eight services in mental health and four community health services were clean, well maintained and well furnished. Patients were positive about the ward environments and confirmed that they were always clean and tidy. Cleaning records were up to date.
- Across most services we saw staff had completed environmental risk assessments and where issues had been identified, staff mitigated these risks by carrying out additional checks, installed mirrors or had taken other actions to resolve the issues.

Requires improvement

Are services safe?

- We viewed building maintenance records in community-based services. These records included fire risk assessments, fire drills, portable appliance testing, health and safety audits and asbestos checks. Staff ensured that the issues identified, had action plans in place. Most of the required actions had been completed. However, at the Northampton site fire extinguishers were not fixed to the wall, they were sat on the floor. This had been identified as an issue in a fire audit in 2013, but had still not been actioned.
- The acute mental health liaison services (AMHLS) had two rooms to see patients at Northampton General Hospital. One room did not meet the psychiatric liaison accreditation network (PLAN) standards. The team at Kettering General Hospital had a designated room in the accident and emergency department. The trust had identified the room did not meet the PLAN accreditation standards. The trust had an action plan in place to address this.
- The HBPoS suites at St Mary's Hospital and Berrywood Hospital did not comply with Royal College of Psychiatrist's guidance. The HBPoS at St Mary's Hospital was not visibly clean and did not have access to a dedicated clinic room. There were no cleaning rotas available to show when the HBPoS was last cleaned. The ceiling and the floor were both visibly dirty.
- Environmental risks were identified in acute wards. These included heating problems and shower drainage issues on Harbour, blind spots on Cove, Bay and Sandpiper wards, where staff could not easily observe patients. Some measures were put in place to mitigate the blind spots. On Cove ward some aspects of the ward environment were in disrepair and not addressed. On Kingfisher, Avocet, Cove and Bay some parts of the wards and garden areas were over looked by nearby houses. On Avocet ward staples in notice boards presented a risk to patients.
- Environmental risks were identified on Wheatfield unit. Blind spots were not adequately covered by mirrors. Staff could not see some outside areas from inside the ward. There were cameras throughout the ward areas but these were not switched on. Two patients also reported that they were able to gain access to the ward when there were no staff available to admit them back onto the ward.
- Corby community hospital had some wards with poor visibility. Staff told us they risk assessed each patient to ensure only low risk patients stayed in areas of poor visibility. However, during our inspection, we spoke to two patients using these rooms who told us they were at risk of falling and would therefore only mobilise when staff came and provided assistance.
- There was insufficient provision of estates maintenance in community hospitals to keep the ward environments safe at all times. Beechwood ward, Hazelwood ward and Corby Community Hospital had all reported reoccurring heating failures and delays in carrying out repair work. Corby Community Hospital had several areas of damp and leaking roofs, fire alarm systems that did not work correctly and hospital floors that were uneven.
- At Campbell House, in community-based mental health services, the first floor waiting area was not monitored as there were no reception staff on that floor and patients did not sign in at the ground floor reception.
- At the last CQC inspection, the trust was informed that they must review their ligature risk assessment audits and address areas of concern. The trust told us that 226 ligature risks had been identified across mental health wards over the last year (to 30 September 2016). Ligature risks remained on the overall trust operational risk register.
- The trust completed ligature risk assessments across most services, detailing where risks were located and how these should be managed. Wards employed additional healthcare support workers to meet patient needs when needed. Staff maintained a presence in clinical areas to observe and support patients.
- The Sett and The Burrows had 30 risks identified, and staff told us the risks were mitigated using effective risk assessment and zonal nursing. Risks were discussed at each handover. They had a map of the wards which showed the risks and photographs aided staff to see the risks. Wards for older people had 102 ligature risks identified, but staff showed us they had assessed these risks and had mitigated against them.
- Other mental health wards for adults and forensic wards also mitigated against the risks with increased staffing levels and risk assessments.
- There was no ligature audit assessment in place for any of the locations inspected within community-based mental health services for adults and children. This was discussed with team managers, who advised that the

patients accessing these sites lived in the community, and were not at high risk of ligature. However, crisis services were co-located with the planned care, recovery and treatment teams (PCRT), and the inspection team observed a number of distressed patients using these premises to seek support and advice from staff.

- Emergency medicines and equipment were available in all the inpatient clinical areas that we visited. All emergency equipment was in date and staff checked them daily. We saw that pharmaceutical waste (including sharps) was handled appropriately throughout the trust. However, we found that anaphylaxis emergency medicine was not available within the community-based adult mental health teams, and no risk assessment or protocol was available for this.
- The clinic rooms on all wards for older people were spacious and fully equipped. We saw evidence of regular checks of equipment and medications.
- There were clinic rooms at Isebrook Hospital and Newland House in community-based mental health services for children and young people, which were equipped with necessary equipment to carry out physical examinations. Staff checked the blood pressure monitor and scales regularly to ensure they were in full working order. Cleaning records were up to date and demonstrated that the environment was regularly cleaned. Equipment was well maintained, clean and displayed visible in date testing stickers.
- The clinic room fridge at PCRT South, Daventry and South Northamptonshire, had a broken door lock. Staff had reported this to maintenance, but this issue remained outstanding at the time of the inspection. The fridge was located in a locked room only accessed by staff.
- On Sandpiper ward the clinic area was cluttered and untidy. A large portable air conditioning device was stored in the room and the medication trolley was untidy. We raised this with the ward matron on the day of our inspection. A remote temperature monitoring device linked to the pharmacy monitored the room and fridge temperatures. If the temperature was incorrect, an email and phone message alert was sent to staff. Staff recorded fridge temperatures regularly to ensure they were within the acceptable range in order to maintain the quality of medication. However, Harbour, Bay and Cove wards staff did not consistently record the clinic room temperatures.
- Staff at Weston Favell Health Centre used a fridge to store clinical specimens, such as blood and urine, as well as personal food items. Phlebotomy staff told us they did not store blood specimens in the fridge during their morning clinic but said they took responsibility for removing any blood specimens that were placed in the fridge by health centre staff at the start of each shift and ensured they were sent for testing. Managers were not aware of this arrangement. During our unannounced inspection, we were informed staff were no longer taking responsibility for blood specimens that had been taken by staff from a different organisation. Fridge temperatures were not monitored which meant that staff were not assured that the fridge was operating at the correct temperatures.
- Seclusion rooms across the trust were clean and met standards required by the Mental Health Act code of practice. There were a small number of blind spots but the service had placed mirrors to ensure that staff could observe patients at all times. The trust had built the new room in the de-escalation room in order to move it away from the main patient area. This had reduced the size of the quiet area where staff would try to calm distressed and disturbed patients.
- All wards within mental health services had clean, well-maintained equipment. In community services we found clearly displayed date testing stickers for all equipment. All services had arrangements for servicing equipment and all equipment was well maintained and fit for use. All.
- We found out of date equipment in a treatment room used by phlebotomists at Weston Favell Health Centre, such as vaginal speculums and sterile saline. We found there was no service level agreement in place with the owner of the health centre which meant the accountability and responsibilities were unclear of separate organisations using the building, the owner of the building and its occupiers. There was no system or process in place to ensure equipment used by the trust to provide care and treatment to patients was safe for use. This was escalated to the trust who took action to remove items. However, when we revisited, we found

further out of date medical consumables in treatment rooms and store cupboards used by trust phlebotomists. This was escalated to a service manager during our inspection who immediately took action to have the equipment removed. During our unannounced inspection, two weeks later, we found further out of date medical consumables. This meant that although the trust had assured us all out of date equipment had been removed, this was not the case.

- The trust was meeting Department of Health guidance for eliminating mixed sex accommodation. Kingfisher ward had addressed previous concerns related to breaches of mixed sex accommodation. On Kingfisher ward, the bedroom corridors were separated into male and female corridors. Prior to this inspection, the trust told us that there had been no breaches leading to mixed sex accommodation in their core services in the past twelve months from 01 October 2015 to 30 September 2016.
- Harbour ward continued to admit male and female patients but had taken all reasonable steps to meet the Department of Health and Mental Health Act (MHA) Code of Practice guidelines on eliminating mixed sex accommodation. The ward provided twelve beds, seven female and five male all with ensuite facilities and a female lounge. The bed management team considered the needs of each patient to determine whether the admission to the ward was more appropriate than sourcing a bed out of area. Staff implemented high-level observations when this occurred to ensure patient safety and protect the privacy and dignity of patients.
- Across all mental health core services within the trust, staff adhered to infection control principles including handwashing techniques. On wards for older people there were handwashing facilities across all wards and good hand hygiene by staff was observed. We saw handwashing posters in bathrooms and around the acute and PICU wards for adults. Staff had access to protective personal equipment, such as gloves and aprons in accordance with infection control practice. Staff in community-based mental health services for adults used alcohol gel in both clinical areas and when working out in the community.
- In most community services and end of life services, there were reliable systems in place to prevent and protect patients from healthcare associated infections. Staff cleaned their hands by using hand sanitiser between contacts with different patients. All areas we visited appeared visibly clean. Cleaning schedules were up to date and clearly documented. Arrangements were in place for the handling, storage and disposal of clinical waste including sharp items. Personal protective equipment was available for staff such as aprons and gloves as required. There were safe systems for the disposal of waste such as nappies.
- In September 2016, infection control training compliance for clinical staff was 87% or above for all community inpatient locations except for Danetre Hospital, where compliance was 79%. At Corby Community Hospital there was one hand hygiene sink in each bay of four patients. This sink was located inside a patient bed space. The dirty utility room at Corby Community Hospital did not have a dedicated hand hygiene sink which was compliant with Health Building Note 00-09. Personal protective equipment (PPE), such as gloves and aprons, was readily available in the wards but we saw staff did not always comply with the trust's PPE policy. Some staff wore the same gloves and aprons to carry out multiple tasks.
- Staff at Weston Favell Health Centre did not follow Department of Health best practice guidance. A treatment room used for phlebotomy had two sinks. However, one sink was inaccessible and was obstructed by a broken bed which was not in use. The sink that was in use contained dirty personal items, such as mugs and spoons. Staff used the same sink for both personal use, to clean personal items, and clinical use, to wash their hands. During our unannounced inspection, the second sink was still obstructed by the bed and action had not been taken to remove it. A senior manager told us the bed was in the process of being removed. Staff had left a pair of shoes on the clean trolley used for phlebotomy, which meant there was a risk that items on the phlebotomy trolley could become contaminated.
- Most mental health services had alarms for staff, or alarmed rooms where staff could alert others for assistance.
- At the premises of the children, young people and families core service, alarms were activated and tailored

for each service user's bedroom and were linked to the doors in one of the respite units we visited. This was put in place in order to manage risks at night-time and to keep service users safe.

- Wards for older people had no call bells in bedrooms or communal areas however staff wore personal alarms that they could use to summon assistance. Personal call alarms were provided to individual patients who required them. We saw staff respond quickly when patients used their alarm to call for support. Bed sensors could be activated when required for additional monitoring at night or if patients were resting during the day.
- Each location we visited in community-based mental health services for children and young people had an interview room. However, there were no alarms fitted in any of the rooms. Staff mitigated this by always telling colleagues where they were and who they were with. Other staff confirmed they would look for their colleagues if they were longer with patients than intended.
- The interview rooms in community-based mental health services for older people were not all fitted with alarms. Only one out of four of the sites visited had alarms fitted. The manager said this had never been an issue.
- Staff working within the crisis resolution and home treatment team (CRHTT) south had access to personal alarms and when activated the alarms sounded and were visible on a board located in reception. No staff we spoke with had needed to activate the alarm so did not know how fast response time would be. Staff working within CRHTT north had access to two alarmed rooms on site or were able to use rooms within hubs across the county.
- Staff working at the crisis house did not have access to room alarms or personal alarms. Managers told us the risk was mitigated by carrying mobile phones and staff that had contact with patients had received breakaway training (breakaway training supports staff in developing the skills and techniques to and protect themselves in aggressive situations where they have been threatened or physically assaulted).

Safe staffing

- Data received from the trust in September 2016 showed:
  - Total number of substantive staff was 2951
  - Total number of substantive staff leavers in the last 12 month was 427
  - Total turnover of all substantive leavers in the last 12 months was 14.5%
  - Total vacancies overall (excluding seconded staff) was 19.6%
  - Total permanent staff sickness overall was 4.4%
  - Establishment levels qualified nurses (WTE) in post was 1069.5
  - Qualified nurse vacancy rate was 23.4%
  - Establishment levels nursing assistants (WTE) in post was 676.5
  - Nursing assistant vacancy rate was 12%
  - Number of WTE vacancies qualified nurses was 250
  - Number of WTE vacancies nursing assistants was 81.4
  - Shifts filled by qualified bank staff to cover sickness, absence or vacancies was 15,168
  - Shifts filled by qualified agency staff to cover sickness, absence or vacancies was 17,840
  - Shifts NOT filled by qualified bank or agency staff where there is sickness, absence or vacancies totalled 2833.
- The trust reported vacancy rates had significantly increased from 11.7% to 19.6%. Mental health forensic wards had higher than the trust average turnover, vacancy and sickness rates. The trust wide vacancy rate for qualified nurses was 23.4%, as of September 2016. forensic and secure wards (52.8%) and crisis services reported the highest vacancy rates for qualified nurses (51.24%).
- The trust operational risk register, dated August 2016, had two risks related to safe staffing. The first related to the trusts' risk of being unable to maintain the right workforce capability and capacity to deliver its' strategic plan. The second related to insufficient medical staffing levels. The central directorate risk register held thirteen significant or high level risks relating to inadequate staffing levels, skill mix and high use of temporary staff. These risks related to CHS adults, CYPF, and mental health learning disability services. The trust used regular bank or agency staff to achieve the required amount of staff to ensure safer staffing levels and to meet the needs of the patients.
- In January 2017, 99% of the planned working hours for daytime nursing staff were filled. Safer staffing data showed staffing levels were between 90% and 125%. Sandpiper Ward night time nursing staff fill rates

reported were greater than 119.6% between March and September 2016, and staffing was increased if patients required enhanced observations. Spinney Ward reported daytime nursing staffing levels at less than 90% in five out of seven months and night time care assistant staffing levels at greater than 125% between March and September 2016. The John Greenwood Shipman Centre reported daytime care assistant staffing levels at less than 90% between March and September 2016. However this is compensated with increased registered nursing staff or low bed occupancy.

- The trust established a safe staffing escalation process. The implementation of health roster enabled the effective and efficient use of the available staffing resource across each area. Safe care leads monitored and investigated short staffing incidents reported via the trust's reporting system.
- Ward Matrons and shift leaders had the authority to increase staffing in response to increased acuity and dependency. Safe care leads completed a staffing review every six months which included meeting with ward and senior matrons, use of most appropriate acuity and dependency tools, triangulation data, workforce measures, feedback from "I want great care" (IWGC) and use of the Professional Judgement Tool.
- Specialist community mental health services for children and young people reported the highest vacancy rate for nursing assistants (82.3%). However this core service had an establishment level of fewer than ten.
- The trust provided details of actions they took to ensure use of bank or agency staff did not compromise care. Teams requested preferred temporary staff, and used overtime payments for staff in critical areas. Teams block booked preferred bank or agency staff and moved staff between units and teams to ensure there was no over dependency on agency staff. The trust used quality metrics to monitor agency and bank usage.
- The trust reported sickness rates had fallen slightly from 4.9% to 4.42% over the period from September 2015 to September 2016.Community-based mental health services for people with learning disability and autism had the highest total permanent sickness at 9.6% which was higher than the trust average of 4.4%. Mental health crisis and HBPoS had the lowest rate at 1.5%. Six core services exceeded the trust average.
- The trust reported staff turnover was down from 14.7% in September 2015 to 14.5% in September 2016. Forensic inpatient wards had a higher than trust average turnover, vacancy and sickness rates at 16%, 20% and 5%.
- Senior managers had a recruitment strategy in place, but found recruitment to nurse positions difficult. Patients were involved in interviewing for staff positions. The trust had put in place various strategies for retaining staff, such as wellbeing schemes, recruitment and retention payments, counselling services and support groups available.
- Core service managers across mental health services effectively monitored their staffing levels and skill mix within teams. Staffing levels across the trust were sufficient to meet patient need, and managers had the necessary authority to arrange additional staffing, cover shifts with regular bank staff or agency where required. Staff in many core services reported they had sufficient time to carry out their duties to support patients, and activities were rarely cancelled or they rearranged activities in the event of staff shortages. Patients confirmed that staff were visible and that they felt safe.
- The HBPoS suites were staffed from the acute wards. A designated qualified professional and support worker were on the staff rota to undertake duties.
- Teams in mental health services had a range of professionals working within them, such as psychiatrists, nurses, psychologists, occupational therapists, physiotherapists, social workers and speech and language therapists.
- The trust employed a registered general nurse to assist with assessment and management of physical healthcare needs for patients on Marina PICU. Staff on acute mental health wards confirmed input from the specialist nurse had been a valuable resource for staff and patients.
- The response team in community-based mental health services for children and young people had recently recruited new staff but maintained their staffing as an issue on the trust risk register due to the appointments being made so recently, allowing the staff time to develop into their roles.
- Across community-based mental health services for children and young people, within the specialist

intervention teams, the average caseload was 30 per full time clinician. The children's response team had a team caseload of 30 when we visited. The number of patients waiting for an allocation of a care coordinator was 110 across the service. Two senior clinicians monitored the list on a weekly basis and maintained contact with patients.

- Managers from community-based mental health services for older people reported that caseloads varied across the teams and ranged from 17 to 59 cases per care coordinator. However, staff at the Northampton Memory Assessment Service reported that they had a caseload of 1000 patients, split between three nursing staff, one psychologist, a CSW and a part time OT. Caseloads varied depending on the level of support that patients required.
- In community-based mental health services for people with learning disability and autism, the trust expectation was that staff would hold caseloads of up to 20; however caseloads for some nursing staff were 30 or more.
- At the time of inspection CRHTT south had a caseload of 25 patients. CRHTT north had a caseload of 40 patients. Caseloads were discussed and managed during handovers, team meetings and individual supervision.
- A consultant psychiatrist and a speciality doctor provided medical cover to the Wheatfield unit. The consultant psychiatrist also worked with trainee doctors. They also provided out of hours cover to the unit, supplemented by the hospital response team, which included junior doctors and an on-call consultant. This enabled them to arrive at the unit in under an hour. The same doctors provided cover for physical healthcare.
- There was adequate medical cover across wards for older people during the day and night and a doctor was able to attend each ward quickly in an emergency. We saw evidence in care records of doctors seeing patients upon admission and reviewing their physical health. Managers reported adequate medical cover for their wards.
- The community-based mental health service for children and young people had rapid access to a psychiatrist when required although access had been limited recently when two full time psychiatrists were off sick at the same time in the south of the county.
- PCRT North and South teams (community-based mental health services for adults) both accessed five consultants and speciality doctors. PCRT North had one consultant on long term sick leave. N-Step countywide teams had access to one consultant and a staff grade doctor. NHFT Personality Disorder Hub did not have a consultant allocated to their team.
- Consultants moved with patients if under the PCRT team, but required support from the crisis team for consistency of approach.
- Junior doctors told us that they had high caseloads. They wrote discharge summaries for patients they had not met.
- The trust provided a breakdown of mandatory training for staff which included the following courses:
- Health, safety & welfare
- Safeguarding adult & child - Level 2
- Equality, diversity & human rights
- Infection prevention & control - Level 1 - non-clinical
- Manual handling level 1 - Theory
- Resuscitation - level 1
- Information governance
- Safeguarding adult & child - Level 1
- Conflict resolution
- Safeguarding adult & child level 3
- Infection prevention & control - level 2 - clinical
- Fire safety
- Resuscitation - level 2 - (basic life support)
- Resuscitation - level 3 (immediate life support)
- Manual handling level 2 - practical
- Safeguarding prevent health WRAP
- As of 30 September 2016, mandatory training compliance was 79% against the trust target of 90%.

Non mandatory training compliance was 65%.There is no trust target for non-mandatory staff training. At the time of submission (September 2016), nine of the 15 targeted training courses had not met the 90% trust compliance rate.

- At the time of inspection, overall mandatory training compliance had increased to 89%. The increase was due to implementation of a new IT system that allowed staff to book their own training. Also, the trust made available bespoke training sessions available for staff across all locations when needed and a combination of face to face training and e-learning training.
- The central directorate risk register had thirteen significant or high level risks relating to safe staffing. Training issues were identified as risks for staff working in community inpatient services, mental health acute wards, and older people mental health wards.
- Community-based mental health services for older people had a poor compliance with mandatory training for the service at 78%. Resuscitation level 2 training was 73%.
- In community services we found some staff were not compliant with appropriate training in life support. At Corby Community Hospital, 79% of eligible staff had the appropriate level of immediate life support. At Hazelwood ward, this figure was 67% and at Danetre Hospital, 33% of staff had the appropriate level of life support training.
- The trust did not meet compliance with mandatory training in community adults, with some training at 71% (manual handling) and 77% (resuscitation) and 86% (infection, prevention and control).

Assessing and managing risk to patients and staff

- The trust identified two significant risks on the operational risk register relating to assessing and managing risk to patients and staff. The central directorate risk register identified two high level risks relating to assessing and managing risk to patients. One of these risks is not within a service covered by this inspection.
- There was inconsistency in the seclusion data received from the trust. The trust reported a total of 84 incidents of seclusion across the trust from 01 October 2015 to 30 September 2016. However, the total number of incidents of seclusion reported for each core service amounted to 681. Following inspection the trust submitted data and accepted a miscalculation of data originally submitted. The total number of seclusions was 187 (October 2015 to September 2016).
- The incidents of seclusion increased significantly since the last inspection when 105 incidents were reported across a six month period. Child and adolescent mental health wards reported 16 incidents of seclusion on The Burrows between April and December 2016, and acute wards and PICU reported 158 incidents of seclusion.
- No incidents of mechanical restraint were reported.
- The trust did not have a long term segregation policy and the seclusion policy did not reference long term segregation. The trust information about long term segregation was unclear and contradictory. The seclusion policy referred to the Department of Health Mental Health Act 1983: Code of Practice 2008, rather than the current code of practice. We also found the trust's over-arching Mental Health Policy referenced the previous code of practice. The trust used the Code of Practice as policy for areas including long-term segregation and reading patients their rights (section 132 MHA).
- Seven incidents of long term segregation were reported across the 12 month period, comparable to three incidents reported in a six month period at the last inspection.
- Acute wards and PICU reported the highest number of incidents of restraint from 01 October 2015 to 30 September 2016 at 219.
- The trust reported 146 restraints carried out in the prone position over 12 months. This increased since the previous inspection where 37 incidents were reported over six months.
- The trust provided data to show post incident reviews took place and learning was identified to shape future care and was shared with teams.
- A monitoring group scrutinised all matters relating to restraint and seclusion on a monthly basis and reported into the trust's governance committee. An operational management tool recorded data for 40 areas of patient safety. Monthly governance meetings reviewed this and data was triangulated against patient and staff

feedback, compliments, complaints, feedback from the hospital wide feedback tool "I want great care" (IWGC) and serious incident recordings. At the time of inspection, the operational management tool was seen, and gave figures for seclusion, restraint and prone restraint incidents. The figures for December 2016 showed children's services had 18 restraints, five prone restraints and five seclusions. Mental health services recorded 16 restraints, five prone restraints, and four seclusions.

- Data showed from 01 November 2015 to 31 October 2016 the trust made 63 notifications to the CQC. 90% of the notifications were Deprivation of Liberty Safeguards (DOLS) applications. From January 2016 and April 2016, data showed an increase in notifications received in a month with around 40% of the total received in those 2 months.
- 235 adult safeguarding referrals and 406 child safeguarding referrals were made at the trust between 01 October 2015 and 30 September 2016. Adult services, acute and PICU wards made 42 referrals and forensic inpatient and secure wards made the lowest referrals at eight. In children's services, community-based mental health services for children and young people referred the highest number at 22.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and described how they worked with partner agencies to protect vulnerable adults and children. This included local commissioning groups, safeguarding teams, multiagency safeguarding hub, Northamptonshire County Council and the police. We saw robust databases and dashboards of safeguarding data collated by the trust. We sampled eight safeguarding case records, and we saw thorough, timely referral documentation and responses from agencies. However, the records sampled did not consistently match with the records on the trust incident reporting system and patient case notes. Only two records sampled matched with the incident report numbers. Safeguarding was not on the trust annual audit plan for 2015/16.
- The trust delivered bespoke safeguarding training for staff. Managers within the trust had undertaken training to be able to deliver safeguarding training to their teams. Safeguarding training was delivered face to face, or by e-learning. Also, during a 'STAR' staff training day, staff may complete extra safeguarding training. Bespoke safeguarding training was available to community staff working in remote areas. Other forums for training included lunchtime seminars, webinars, safeguarding awareness week, walk the wards, where the safeguarding team visit wards to discuss issues and the communications department had used screen savers on computers to deliver safeguarding messages.
- Staff across services knew how to raise a safeguarding report, and staff described the procedure for reporting safeguarding concerns. Some teams had safeguarding as a set agenda item at their team meetings. Staff contacted the trust safeguarding lead for advice or information if and when they needed to.
- Compliance with safeguarding training (level 1 and 3) fell below the trust target of 90%.Level one safeguarding training was 89%; safeguarding level three was 86%.However, level two safeguarding training was above target at 91%.Bank staff completed safeguarding training as part of mandatory training, but agency staff did not. In addition to training, the trust intranet site known as the staff room, had a specific safeguarding icon for staff to access the process to follow to raise a safeguarding.
- Staff at the physiotherapy service and TB service in community health services adult, did not have the appropriate level of safeguarding training. Staff were unaware they required level 3 safeguarding training for children.
- Community paediatricians in CHS CYPF, undertook child protection medical assessments in the local acute trust between the hours of 9am to 5pm from Monday to Friday. Out of hours, this was undertaken by the paediatricians employed by the acute trust. Staff were unable to show us the flow chart for this process or the trust's standard operating procedure (SOP) for child abuse medical examinations and it was not documented in the trust safeguarding policy. This meant that concerns may not have been evaluated in a consistent and effective manner.
- Staff completed detailed and clear risk assessments in seven of the 10 mental health core services. Staff used historical information to identify risks and staff updated

them regularly. They contained information about the patient's goals and considered positive risk taking where possible. Risks identified were individualised and reviewed regularly after incidents.

- In wards for children and young people, staff discussed and recorded updates of potential risks to young people in handover meetings, so all staff on duty were updated.
- In community-based mental health services for children and young people, staff used recognised risk assessment tools.
- Staff within community-based mental health services for adults' staff discussed risks collaboratively as a professional group at weekly team meetings, and this information was added to their minutes.
- Whilst thorough risk assessments were completed by staff in community-based services for people with learning disability, these were not always recorded on the electronic system.
- Records in community-based services for older people showed staff had undertaken a risk assessment at the initial assessment for 39 out of 42 care records reviewed. Staff had updated most of these regularly. Three of these records had no risk assessment and a further three risk assessments had not been updated. Staff had not completed crisis plans or advance decision documents in any of the care records reviewed.
- The trust had a 'Restraint Reduction Strategy' which included a training model for all clinical staff endorsed by The National Institute for Health and Care Excellence (NICE). Across mental health inpatient wards the implementation of the evidenced based 'Safe Wards' model was ongoing. Within learning disability services, the 'Positive Behavioural Support' model was used to reduce conflict and containment. The trust had also been working with 'Implementing Recovery through Organisational Change' (IMROC) to implement personalised recovery planning with patients across the inpatient mental health wards.
- The trusts' restraint training course was the only one in the country to have been accredited by NICE and was delivered in conjunction with experts by experience. Also, patients had worked with IMROC to develop better restraint practices. Patients on Harbour ward, Bay ward and Cove ward confirmed experiencing more positive restraint practice since their involvement.
- An up to date policy covering rapid tranquilisation (RT), based on the current NICE guidance NG10 dated May 2015, was available. However, staff did not always follow this guidance. A medicine not appropriate and not approved by the trust for RT was prescribed and twice administered to a patient on Marina ward.
- We saw across the trust, when patients were given injectable medicines for RT, post dose physical health monitoring was seen to be completed as recommended by NICE guidelines NG10, and the trust's own policy document.
- Across mental health services, no issues of concern were raised in connection with patients experiencing blanket restrictions.Certain items were restricted on the acute adult wards but this was in line with the list of trust restricted items for this setting. Information about these was given to patients in a welcome pack or via posters on the entrance to the ward.
- We found that medicines, including controlled drugs and IV fluids, were stored securely in most services.
- We identified that in a community health inpatient hospital ward, the fridge temperature that was out of range was not actioned as per trust policy. This did not demonstrate a consistent temperature had been maintained to assure the safety and efficacy of the medicines. At Danetre Hospital there was confusion over the use of an external system to monitor fridge temperatures.
- There was not a consistent approach to the monitoring of room temperatures across the trust. Only five out of 11 wards were monitoring room temperatures, although there were air conditioning units with regulated temperature panels that could be set.
- Arrangements for storing some medicines in CHS CYPF, such as vaccines, were always appropriate. We found boxes of vaccines stored in a cool box with cool packs and no thermometer was in the box. Staff said vaccines were stored for up to four to five hours. According to the Green Book 2013, temperatures of cool boxes should be monitored when in use, using maximum and minimum thermometers.
- Open medicines with a limited shelf life were not always clearly labelled with a date of their opening. Across the trust there was a risk that the medicine could be used

passed its expiry date and meant the medicine may not have been as effective in providing treatment. In addition, we found at Danetre Hospital, had used a single use vial, of a medicine to administer multiple doses. It had been used daily from 16 January 2017 until 24 January 2017 to provide "when required" doses of ketamine. This did not follow the trust policy and it was raised with staff during our inspection. We also found an out of date bag of glucose intravenous fluid at Danetre Hospital. This was removed during our inspection.

- Doctors undertook medicines reconciliation for each patient admitted to the trust. The pharmacists took responsibility for conducting a more in depth medicines reconciliation at the next available opportunity. All prescriptions charts included information about allergies, admission date, and date of birth. Appropriate codes were, used to note medicines refusals and medicines for physical health were, prescribed and monitored appropriately.
- We saw appropriate arrangements were in place for recording the administration of medicines. However, these records were not always fully completed and we saw on Marina ward and Riverside ward, that medicine was not always recorded as being administered on the prescription chart. This included critical medicines such as insulin and those prescribed to prevent deep-vein thrombosis.
- There was no record available of blank prescriptions held in the clinic at the CRHTT south team. Staff did not carry out any audits with regard to unopened boxes held in the storage area, meaning that they would not know if any prescriptions went missing.
- The trust completed medicine audits to assess quality and to assist in the identification of areas for improvement. Pharmacists delivered training to junior doctors and nurses. There was a risk register specific to medicines optimisation and a strategy document.
- We saw issues with safe management of medication within the community inpatient services. This included medication prescribed but not signed for and related to a time critical Parkinson's disease medication, insulin, an antibiotic and a drug used to help reduce blood clots. Staff were unsure if some of the medications had been given but not signed for, or if the medication had not been given.
- At Corby Community Hospital, not all medication omissions were reported as incidents. Two incident reports were raised at our request following unsigned doses of critical medication.
- Medication charts for drugs which could be administered without a specific prescription (such as paracetamol) required a signature from a doctor before a nurse can administer against it. None of the medication charts we reviewed had been signed by a doctor, even though nurses had administered medications against the chart. This was brought to the attention of doctors and the lead pharmacist during our inspection. We revisited Danetre Hospital and reviewed 15 extra prescription charts; five had discretionary medications which were not signed by a doctor.
- On two wards at Danetre Hospital and Corby Community Hospital, we found patients' own controlled drugs (CD) available in the CD cupboard after the patient had been discharged.
- At Danetre Hospital, four out of 15 patients did not have a review of blood thinning medication whilst in hospital. Patients prescribed this medication were required to have a review every seven days.
- All staff had access to procedures and guidelines for the prescribing of palliative medicine and for the use of anticipatory medication at the end of life and this was in line with national guidance. Anticipatory medicine refers to medication prescribed in anticipation of managing symptoms, such as pain, agitation and nausea. However, staff prescribed and administered two medications without the policy and advice of what to do if side effects occurred at Danetre Hospital as there were no guidelines for these medicines.

Track record on safety

- We analysed data about safety incidents from three sources:
- the National Reporting and Learning system (NRLS)
- to the Strategic Executive Information System (STEIS)
- serious incidents reported by staff to the trust's own incident reporting system (SIRI).
- These three sources are not directly comparable because they use different definitions of severity and

type, and not all incidents need to be reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The most recent patient safety incident report covering incidents from 1 October 2015 and 31 March 2016 stated, the trust submitted 50% of its incidents more than 35 days after the incident occurred.
- When benchmarked, the trust was in the middle 50% of reporters. The NRLS considers that trusts that report more incidents than average and had a higher proportion of reported incidents that are no or low harm had a maturing safety culture. The trust reported 3,937 incidents to the NRLS between 01 October 2015 and 30 September 2016. The trust reported 87.6% of incidents as low or no harm. Five incidents related to deaths, 1894 (48%) resulted in no harm, 1554 (39.5%) resulted in low harm, 229 (5.8%) resulted in moderate harm, 10 (0.2%) resulted in severe harm. There were nine (0.2%) community safeguarding abuse incidents and 236 (6%) were patient to patient abuse incidents.
- The most common incident type was self-harming behaviour with 1201 (30.5% of total incidents), followed by patient accident with 1025 (26%) and implementation of care and ongoing monitoring/review with 595 (15.1%). No consent, communication or confidentiality incidents were reported.
- Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). There were 44 serious incidents reported to STEIS between 01 October 2015 and 30 September 2016. This was significantly lower than the last inspection. Two of these were never events. One was wrong-site surgery in community dental services and one was a failure of a collapsible shower rails in child and adolescent mental health services. 54.5% were 'apparent, actual or suspected self-inflicted harm' incidents and 29 (65.9%) were 'unexpected / potentially avoidable deaths'. However, there is inconsistency in data reporting. The number of serious incidents recorded by the trust incident reporting system was 31 and this was not comparable with that reported to the 44 serious incidents reported on STEIS.
- Acute wards for adults and PICU reported most STEIS incidents 5 (11.4%) and mental health crisis services and health-based places of safety reported 4 (9.1%). One incident was incorrectly reported to STEIS on 31 August 2016. One pressure ulcer incident, and one slip, trip and fall incident was reported to STEIS which was significantly lower than at the previous inspection. Non-compliance with Venous Thromboembolism / National Early Warning System (VTE / NEWS) assessment levels was identified on the operational risk register.
- The trust considered pressure ulcers, accidental injury and violent incidents / assaults to be the most common types of incidents reported. The services with the highest rate of incidents were; learning disability respite services, acute inpatient and PICU and Cransley Hospice. The trust stated its most frequently occurring type of serious incidents between 01 October 2015 to 30 September 2016 were suicide, deliberate self-harm and assaults respectively. The type of incidents with the highest number was "Apparent/actual/suspected self-inflicted harm meeting SI criteria" with 19 (61.2%).
- The trust submitted two serious case reviews for which they developed action plans in the 12 months preceding the inspection. Identified actions included graded care profile training, implementation of a neglect toolkit, launch of a safe sleep campaign, training around use of a specific assessment tool and reflection on cases with staff groups.
- At the time of inspection, the trust was undergoing two domestic homicide reviews and one safeguarding adults review. These were yet to be completed.

Reporting incidents and learning from when things go wrong

- The trust used an electronic system for reporting incidents. In mental health services and community health services, staff knew what incidents needed to be reported and how to report them. Managers ensured they monitored the reporting and recording of incidents. All incidents highlighted at medium risk and above were

automatically sent to the Patient Safety Team and the Deputy Director of Nursing for review. There was a robust and clear trust wide reporting structure and governance arrangements for reviewing incidents.

- The trust thoroughly investigated serious incidents and outcomes and lessons learnt were discussed in a variety of clinical governance meetings. Learning from incidents was disseminated in a number of ways. The trust had a robust communication strategy to share lessons learnt using emails, CEO bulletins, safety alerts and webinars. The trust had a lessons learnt exchange which provided clear information. The trust intranet had a page called the staff room where staff could find information about lessons learned. The learning from incidents was embedded amongst the board, senior managers and staff.
- During the inspection, we sampled five serious incident records which had been escalated to the safety team. We saw they were recorded in a timely manner, reports were detailed and had been reviewed by the safety team. Concerns had been escalated where necessary. However, when checking the patients care records, only one care record had recorded the reference number of the serious incident.
- The Prevention and Management of Violence and Aggression (PMVA) group reviewed the use of physical interventions and seclusion on a monthly basis, so that lessons could be learnt and good practice shared.
- The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which contain a summary of Schedule 5 recommendations, made by the local coroners with the intention of learning lessons from the cause of death and preventing further deaths. The trust has submitted no Prevention of Future Death reports in the 12 month period up to 1 October 2016.
- The NHS safety thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. The trust reported 129 new pressure ulcers during the time specified above (average of 10.75 per month). This was an increase since the last inspection. The highest monthly prevalence rate was in July 2016 at 1.38%.
- The trust reported 108 falls with harm during the time specified. This was a reduction since the last inspection. The highest prevalence rate reported was 1.75% which occurred in March 2016.
- The trust reported 53 catheter and new urinary tract infection cases in the time specified. This was a slight decrease since the last inspection. The highest prevalence rate recorded was in October 2016 with 0.87%.
- For the same date range, the trust also recorded 14,333 cases of 'Harm Free' care, with a mean of 1,194 cases per month. The trust saw their best performance in September 2016 recording a prevalence rate for harm free care of 98.43%.
- The trust had appointed a Medicine Safety Officer (MSO) who had the responsibility to oversee medication error incident reporting. All staff we spoke with discussed the process for reporting and investigating medicine incidents and described awareness of recent incidents within the trust demonstrating that learning from incidents was shared.

Duty of Candour

- In November 2014, the CQC introduced a requirement for NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust's policy for Reporting and Management of Serious Incidents defined duty of candour and what is expected of staff regarding openness when involved in the management of incidents and the sharing of information with carers and relatives. The trust's Incident Policy also did this. We saw that both policies contained a checklist for staff to complete when duty of candour responsibilities had been completed. However, the two checklists were different. Whilst they both contained relevant information, staff may not be sure which the correct one to use was.

Requires improvement

Are services safe?

- The trust monitored duty of candour as part of the weekly incident reporting schedule, with duty of candour statistics being reported to the trust board bi-monthly. The trust had a duty of candour e-learning training package available to all qualified clinical staff and it was also covered in root cause analysis training for managers. The trust delivered training called Freedom to Speak Up, which was a mandatory requirement for all staff.
- Staff from eight mental health services and all five community health services were aware of the duty of candour. Staff explained they were open and transparent and explained to patients if something had gone wrong. Patients and carers confirmed this. However, senior staff in community services for inpatients had not received any training regarding duty of candour and had not been following the trust policy. This had been recognised and training was being provided.
- We reviewed seven records of complaints made to the trust. All seven complaints had apologies for the patient's poor experience and were open and honest about what went wrong and what action the trust would take to improve. All seven complaints had received acknowledgements and final outcome letters upon closure of the investigation.

Anticipation and planning of risk

- The trust had a major incident plan available, dated 2015 to 2018, to deal with any major incidents or breakdown in service provision. Potential risks taken into account ranged from loss of water supply, gas leak, major IT failure or catastrophic accident. Roles and responsibilities of senior staff were clear and communication systems were highlighted.

Good

Are services effective?

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

Summary of findings

We rated Northamptonshire Healthcare NHS Foundation Trust as good for effective because:

- Staff in most services completed comprehensive assessments and person centred care plans in a timely manner, and in collaboration with the patients.
- The majority of mental health services and CHS used best practice to influence treatment and care offered to patients.
- Antipsychotic medication was prescribed within the BNF limits and monitoring was in place.
- All mental health services had access to psychological therapies.Professions delivered a range of services to mental health wards using guidance from best practice.The teams across mental health services included a full range of mental health disciplines.
- Physical healthcare needs had been addressed by inpatient mental health settings. Information needed to deliver care was stored securely on an electronic record system which the GP also had access to, this improved continuity of care.
- Staff used a wide range of outcome measures within their practice, across most mental health services. The trust monitored and audited outcomes using rating scales, best practice and a range of audit.
- The trust made available and supported specialist training and induction for staff and staff felt this training helped them in delivering services to patients.Both registered and non-registered staff had access to further training.
- The trust average compliance for supervision was 93% but was variable across services.Supervision data was a total of combined figures for clinical supervision and managerial supervision, and consisted of a range of one to one meetings and group meetings (which also included team meetings).
- All teams within mental health services and CHS described effective and collaborative team working. All mental health teams and CHS teams across the trust reported effective working relationships external agencies. Core services reported effective handovers between teams.
- The trust's overall MHA training compliance was 92%. Most services showed compliance in adhering to the MHA and MCA. In all services we visited, staff were able to tell us about how patients could access independent mental health advocacy services

However:

- In community mental health services for older people, a shared protocol was in place that showed the GP was responsible for monitoring the patient's overall health and well-being.However, staff did not check whether annual health checks, including blood tests, had been carried out.
- Medical staff from forensic inpatient and rehabilitation wards felt service provision could be improved by accessing specialist training in personality disorder.
- The trust wide average appraisal compliance rate was 65% as of September 2016. During the inspection data showed there had been an increase in average compliance with appraisal from 65% to 90%.The difference in data suggested that data collection required a review by the trust.
- The provider did not set a compliance target for MCA training. Staff compliance with MCA and MHA training was 67% for community-based mental health services for older people, below the trust compliance target of 90%. Staff did not consistently document mental capacity assessments and best interest

decisions in care records where they were required. Some staff were not able to tell us how they would put the Mental Capacity Act into practice in their work.

- The community inpatient service did not participate in any national audits, for example the Sentinel Stroke National Audit Programme. There was a lack of benchmarking with national standards to outcomes for patients undergoing rehabilitation programmes.

Our findings

Assessment of needs and planning of care

- Staff across all ten mental health services, community inpatients, community adults and end of life care services completed comprehensive assessments and person centred care plans in a timely manner. Assessments for all mental health crisis and health-based places of safety teams were completed thoroughly and within required timescales. Staff in both mental health services for children and young people completed the care records in in a person centred, personalised and holistic way. Inpatient services for children and young people completed assessment of need in collaboration with the young person and their families where appropriate.
- Two patients from acute services told us they had been involved in the co-production of a new CPA document.
- Staff on wards for children and young people recorded detailed objectives and individualised goals on patient care plans which were signed by the young person and included their views. Staff and young people reviewed these care plans regularly.

Best practice in treatment and care

- The majority of mental health services and all community health services used best practice to influence treatment and care offered to patients. In eight mental health core services, staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication across the service. Antipsychotic medication was prescribed within the BNF limits and monitoring was in place.
- Staff in all children's services were fully aware of Gillick competency and Fraser Guidelines. These are guidelines used to consider the competency and consent of young people. Consent was recorded in all patient records.
- The health visiting service had achieved the UNICEF and WHO stage 1 and stage 2 baby friendly initiative breastfeeding accreditation and were planning to undertake stage 3. This is an evidence-based approach to support breastfeeding by improving standards of care and support.
- The integrated sexual health service had incorporated the Fraser Guidelines within the child sexual exploitation (CSE) best practice protocol when they spoke with young people. The national CSE risk assessment toolkit was used with all young people under 18 years. The purpose of the assessment toolkit was to enable professionals to assess a child or young person's level of risk of child sexual exploitation.
- The school nurses delivered the routine school immunisation programme as set out by Public Health England and the Department of Health. The service also delivered the National Child Measurement Programme, which consisted of measuring the weight and height of children in reception class (age four to five years) and year six (aged 10 to 11 years) to assess overweight and obesity levels. School nurses told us this provided them with an opportunity to engage with children and families about healthy lifestyles.
- Staff used the National Early Warning Score (NEWS) in accordance with National Institute for Health and Care Excellence (NICE) clinical guidance, where appropriate, to record routine physiological observations including blood pressure, temperature, and heart rate.
- Professions delivered a range of services to mental health wards using guidance from best practice.Occupational therapists used a range of recognised assessment tools including Pool Activity Levels (PALS), Model of Creative Ability (MoCA), and Domestic and Personal Activities of Daily Living (DADL, PADL).
- Physiotherapists used evidence based assessments including the elderly mobility scale (EMS). EMS assesses mobility in frail elderly patients and enables physiotherapists to plan patient care according to individual patient needs.

Good

Are services effective?

- Community speech and language therapy services for patients, who were undergoing rehabilitation following a stroke, were delivered in line with the NICE guidance
- In crisis and adult mental health services patients were able to access psychological therapies as recommended in NICE guidelines. Therapies included use of dialectical behaviour therapy, cognitive behavioural therapy, cognitive analytic therapy, eye movement desensitization and reprocessing and family therapy.
- Planned care in community dental services was consistent with best practice as recommended by national guidelines for special care dentistry including those set out by the British Society for Disability and Oral Health.
- Staff in end of life services used the National Early Warning Score (NEWS) system. This system would alert clinicians if a patient was deteriorating depending on their score.Staff also used the Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care' framework. End of life care was managed in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. The palliative care inpatient ward at Danetre Hospital took part in the Gold Standards Framework (GSF) and achieved this award for 2015/16.
- The multiple sclerosis (MS) team complied with guidance from NHS England and NICE.
- The tuberculosis (TB) service adhered to the NICE (NG33) 2016 and NHS England's strategy for 2015 to 2020 which looked at 10 key areas.
- The community services used the Malnutrition Universal Screening Tool (MUST) for screening patients who may be at risk of malnutrition.
- Physical healthcare needs had been addressed by inpatient mental health settings. The trust employed a registered nurse to assist with assessment and management of physical healthcare needs for patients in the PICU and acute inpatient services.
- Information needed to deliver care was stored securely on an electronic record system which the GP also had access to. This improved continuity of care. Patient records were available to staff when they needed them including when patients moved between teams.
- In community mental health services for older people, a shared protocol was in place that showed the GP was responsible for monitoring the patient's overall health and well-being. However, there was no system in place to ensure that required annual health checks, including blood tests, were being carried out. Staff did not know whether this was the responsibility of the service or of the GP.
- With the exception of crisis services staff in mental health services used a wide range of outcome measures within their practice. These included Dialog (structured discussion with patients), QPR (questionnaire patient recovery), post morbid adjustment scale, mental health clustering, HoNOS, and HCR20.
- The End of Life service used the Integrated Palliative Outcome Scale. This scale used a variety of tools to measure patients' physical symptoms, as well as their psychological, emotional, spiritual, and support needs. This was a validated instrument that was used in clinical care, audit, research and training.
- The trust monitored and audited outcomes for patients in acute mental health wards. Managers monitored key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.
- Community inpatients did not participate in the Sentinel Stroke National Audit Programme (SSNAP). SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Local acute hospitals started patients on the audit pathway but this was discontinued once patients were admitted to the community. This meant the effectiveness of the stroke treatment provided by the service was not measured. The trust told us it was currently unable to supply data to SSNAP due to logistical issues following the reconfiguration of local services. However, the service was working with the acute sector to resolve these issues and hoped to take part in the audit in the future.
- The trust provided details of 69 clinical audits undertaken in 12 months from September 2015 to September 2016, two of which were national audits. These were completed by a range of staff across the trust.

Good

Are services effective?

- Staff in community-based mental health services for adults, participated in some national research trials, and teams were part of clinical networks.

Skilled staff to deliver care

- The teams across mental health services included a full range of mental health disciplines including psychiatrists, clinical psychologists, mental health nurses, social workers, occupational therapists, specialist mental health practitioners, and a participation worker. Community health services also had a wide range of health professionals to deliver services.
- The trust provided a pharmacy service across the mental health inpatient sites and community inpatient hospitals. Pharmacy technicians visited to provide stock, assessed patients own medication or removed unwanted medication. A clinical pharmacist visited to check prescription charts and attended ward rounds. Ward staff were very positive about pharmacist visits to the ward for clinical meetings. We saw many examples of positive clinical input by pharmacists to improve medicines optimisation. A clinical service was in the process of being introduced to the community mental health teams.
- In wards for children and young people, there was a wide range of staff skilled in mental health and working with children. Young people had access to clinical psychologists, psychiatrists, occupational therapists, activity coordinators education staff and nursing staff including registered general nurses to promote physical healthcare and to develop staff skills in managing physical ill health. The Burrows had a nurse lead for sexual health that undertook chlamydia screening and gave sexual health advice to young people.
- All mental health services had access to psychological therapies.However, wards for older people had limited psychological therapies available to assess and provide treatment as there was no dedicated psychologist in post. Patients on Cove and Harbour wards did not have input from psychology services. There was active recruitment for full time posts across the services.
- Patients reported that they received therapies and activities they needed and were making progress in their treatment.
- The trust supported specialist training for staff. This included two members of staff undertaking master's degrees in working with young people with eating disorders and two support workers who were advanced apprentices. Staff felt supported to maintain their continuing professional development. In all ten mental health services, staff reported they had access to training. The trust supported healthcare assistants to complete the care certificate.
- Staff accessed monthly team meetings. Managers had also recently introduced 'STAR' days. These took place once a month and provided protected time for staff to complete training and supervisions.
- However, medical staff from forensic inpatient and rehabilitation wards felt service provision could be improved by attending specialist training in personality disorder.
- Newly qualified staff accessed preceptorships. Preceptorship is a structured period of transition and learning for registered nurses when they first start nursing. This ensured new staff were provided with adequate opportunities for support, supervision and training.
- The trust target for appraisal compliance was 90%. The trust wide average appraisal compliance rate was 65% from 01 October 2015 to 30 September 2016. Seven core services fell below the trust average target for compliance among permanent non-medical staff for this period. Child and adolescent mental health wards had the lowest compliance rate for non-medical staff (18%). Community-based mental health services for older people completed 100% of appraisals required for non-medical staff across the period. However, we found data comparisons were inconsistent as some units' appraisals were reported as a total for the year, and others reported on a month by month basis. There were some appraisals that were completed prior to 12 months and this created an overlap of data in a 12 month period.
- However, the trust provided updated data at the time of our inspection. It showed there had been an increase in average compliance with appraisal from 65% to 90%, with 141 teams submitting data. One of the lowest

compliance rates at 17% was estates services. 91 teams had compliance of 100%. The differences in this data suggest that data collection required a review by the trust.

- The trust wide average compliance rate for medical staff appraisal was 65%. One core service fell below the trust average for compliance rates among permanent medical staff; this was community other specialist services.
- The trust provided data for medical staff revalidation from 1 October 2015 to 30 September 2016. Nine of the thirteen medical staff had been revalidated in the last twelve months. Overall, community services had revalidated five out of the six doctors, with one deferred and mental health services had revalidated four out of the seven doctors with three deferred.
- The trust compliance target for supervision was 90%.Medical staff supervision ranged from 25% in community-based mental health service for learning disability to 275% in child and adolescent mental health wards.
- At September 2016, non-medical staff supervision ranged from 60% in community-based mental health services for adults to 100% for community dental services, community-based mental health services for older people, and mental health crisis and HBPoS.
- At the time of inspection, overall trust compliance with supervision was 93%. Data obtained from mental health core services during our inspection showed that the range of compliance for supervision ranged from 43% in community-based meant health services for older people, 63% on wards for older people to 100% in crisis services, and wards for children and young people.This differed from data submitted by the trust prior to inspection.Senior staff told us that supervision data was a total of combined figures for clinical supervision and managerial supervision, and consisted of a range of one to one meetings and group meetings (which also included team meetings). Senior staff told us they needed to think carefully about how to record clinical supervision more effectively in the future.
- Staff in community-based services for older people were not supervised and appraised in line with trust policy. The compliance rate for supervision was 43%. Out of 40 staff records reviewed 19 had no supervision records and a further five had not received supervision for over a year. Whilst supervision records were dated, we found that dates had been changed on two of the records and no explanation was given as to why this had been done. However, the trust submitted data after the inspection and it showed supervision had improved to 78% (CMHT Northampton 71% and CMHT Daventry 86%).
- Managers addressed poor performance when required and support was available from the human resources department. The trust policy supported managers to address poor performance.The trust used a postcard system sent to staff when they were off sick, which highlighted the importance of team work and the impact absence had on a team. Between January 2016 to December 2016 the trust had 44 disciplinaries and 17 grievances raised.The trust had introduced a new system that removed a first verbal warning if staff admitted to poor performance.The trust had worked with staff side members to agree staff received a first written warning without the need for a resource heavy investigation process.

Multi-disciplinary and inter-agency team work

- All teams within mental health services described effective and collaborative team working. Staff described supportive working relationships across the multidisciplinary team. Staff from wards for older people spoke very positively of the input from the occupational therapy and physiotherapy teams. Staff told us of strong working relationships between nursing and medical staff.
- All mental health teams across the trust reported effective working relationships with external agencies. All mental health crisis and health-based place of safety teams reported good working relationships with internal and external organisations. The community-based mental health service for older people had good working links with other agencies, including GP's, social services and voluntary organisations. Community-based mental health services for adults worked collaboratively with other agencies and professionals to support patients and their families. Staff discussed outcomes of joint visits with housing, social care, police and health visiting teams during team meetings.

Good

Are services effective?

- Nurse prescribers in PCRT South, Northampton worked alongside the consultants to reduce waiting lists, with the aim of enabling the consultants to be able to offer appointments to patients in crisis. Other teams were considering use of this model.
- The trust had developed a single point of access (SPOA) service in community health services for Adults. This was a new initiative and aimed to provide the right care, from the right practitioner at the right time. Staff from ICT, specialist nursing teams and district nurses worked in collaboration to achieve this to ensure referrals received were assessed by a clinician who identified the most appropriate care pathway, clinician and interventions.
- Every mental health core service reported effective handovers between teams. We observed 43 meetings during our inspection, some of which were handovers and team meetings. In children and adolescent mental health wards, staff were skilled in sharing key information about the young person's behaviours, goals and risks as well as plans for discharge which reflected the young person's circumstances and preferences. Frequent multidisciplinary team meetings took place to discuss care needs of patients in many services.

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

- The trust identified MHA training as a role specific mandatory course which had been included in the block training for mental health inpatient areas for the previous two years. However, MHA training did not appear on the list of mandatory training topics. In addition to block training, the MHA department offered regular MHA training sessions on a monthly basis at locations in both the north and south of the county, so all teams could access this opportunity. Bespoke MHA training was arranged at the request of individual teams and was tailored to the particular service area. The rust had an e-learning package in place for MHA to make training more accessible to all staff.
- The trust overall compliance with MHA training was 92%.Staff attended training every three years. Compliance ranged from 67% in community-based mental health services for older people to 100% in many services.
- Across most mental health core services, staff recorded that capacity and consent to treatment had been discussed in patient records.However, some CTO records in community-based mental health services for adults did not contain details of a discussion about consent to treatment.
- Where applicable, staff had correctly completed community treatment order (CTO) paperwork.In community-based mental health services for adults, we looked at 64 patient records during the inspection. We found 18 patients received care under a CTO. Most records contained copies of MHA paperwork relating to CTO or aftercare entitlement. Where applicable, CTO paperwork contained terms and conditions, for example where a patient was to reside, and under what terms the CTO could be recalled.
- Staff on forensic wards had recorded consent to treatment with medication. We looked at five medication charts all of which had the correct consent to treatment forms T2 (consent to treatment) and T3 (second opinion authorisations) in place and attached.However, acute wards for adults we found three people detained under the Mental Health Act (1983) on Bay and Cove wards whose legal documentation for treatment for mental disorder had not been completed accurately. The ward matron immediately arranged for the T2's to be reviewed with the responsible clinician.
- Staff across most services, apart from acute mental health wards and PICU services, documented that patients had been read their rights under the MHA.We found section 132 rights were not always read to patients at key times after admission.
- Almost all mental health core services had good support from MHA administrators who were available to offer support and legal advice to staff on the implementation of the MHA and its Code of Practice.
- The MHA department completed a large range of monthly or bi-monthly audits relating to the delivery, and recording of the MHA. Results of audits or issues of concern were highlighted with the appropriate nurse, responsible clinician and ward matron for action.We saw records of audits of MHA practice across most core services.

Good

Are services effective?

- In all services we visited, staff told us how patients could access independent mental health advocacy services. We saw information leaflets available to patients on how to access the IMHA service. In community-based services for adults, this information was provided with the welcome letter sent to patients when referred to the team. In child and adolescent mental health wards, the IMHA attended the patient experience meeting on a monthly basis. Managers of wards for older people reported regular advocacy visits to the ward. The welcome pack on forensic inpatient wards contained information about to use and access the IMHA service.

Good practice in applying the Mental Capacity Act

- Staff were aware of the Mental Capacity Act policy and how they could access it. They could access an electronic version of the policy as and when required and told us about the staff room intranet site where the policy was located.Staff across all ten of the mental health core services told us where to seek advice from if they were unsure about capacity issues.
- This training was not mandatory but those eligible were required to attend an update once every three years. The trust did not set a compliance target for this training. 72% of eligible staff were up to date with their Mental Capacity Act / DoLS training for the period 01 October 2015 to 30 September 2016. Thirteen of the sixteen core services at the trust reported training rates below 90%.
- Compliance with MCA training across the trust ranged from 41% (CAMHS community) to four core services at 100%.
- The MHA administration team managed the Deprivation of Liberty Safeguards (DoLS) applications countywide. This enabled the trust to track applications and authorisations.
- The MHA department completed MCA compliance audits including a yearly MCA training & knowledge audit. In most core services we visited, we did not find evidence to show that ward staff were involved in audit of MCA practice.
- An audit for compliance with DoLS showed that 20 randomly selected case files from across a range of high dependency care areas were sampled and reported quarterly. Record keeping audits were conducted quarterly via the Clinical Audit and Effectiveness Committee.
- Across most core services, patient MCA assessments were documented in their records, and were in date and question specific. Staff discussed MCA concerns with colleagues and in team meetings, and gave examples of where multi-disciplinary MCA assessments were completed. In mental health crisis services, staff working within psychiatric liaison reported good working links with the Kettering and Northampton General Hospital Mental Capacity Act leads. Two social workers had completed training as best interest assessors.
- Staff had completed Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms accurately in end of life services. We looked at seven DNACPR forms, all were in date and completed in accordance to the trust policy. There was evidence that either the patient had consented or mental capacity assessments had been completed in the decision making process. Relatives had been informed and were part of the decision making process.
- Staff in community-based mental health services for adults demonstrated clear understanding of how to implement assessment into practice and were aware of the five statutory principles.
- In community-based services for older people, staff did not consistently document mental capacity assessments and best interest decisions in care records where they were required. Where a patient was deemed to lack capacity, there was limited evidence that the best interest decision-making process was applied. We saw some evidence of family involvement in best interest decision making. There was little documentation of the person's wishes, feelings, culture, or history. Only 11 out of 42 records had evidence of capacity assessments. They were not detailed nor evidenced the consideration of the statutory principles. There was limited documentation of family or Independent Mental Capacity Act advocate involvement in the most mental capacity assessments. We did however, observe staff discussing capacity with patients

and in multi-disciplinary meetings, but some staff were not able to tell us how they would put the Mental Capacity Act into practice in their work. However, we did observe inclusive and least restrictive practice.

- Staff told us they could get support in following the Mental Capacity Act from the Mental Health Act administration office.
- Data provided by the trust showed the number of Deprivation of Liberty Safeguards (DoLS) applications made between 01 October 2015 and 30 September 2016. Sixty-four DoLS applications were made with the most made in January 2016 with 10 applications (14%). The trust data showed that older people mental health wards made the most applications with 57, which accounted for almost 90% of all DoLS applications made by the trust. None of the DoLS applications were granted.

Outstanding ☆

Are services caring?

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

Summary of findings

We rated Northamptonshire Healthcare NHS Foundation Trust as outstanding for caring because:

- Throughout the trust, in both mental health and community health services, staff treated patients with kindness, dignity and respect.Consistently staff attitudes were helpful, understanding and staff used appropriate language patients would understand. The style and nature of communication was kind, respectful and compassionate.Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.
- Patients told us that staff were exceptionally caring and compassionate.During our inspection, patients across the trust confirmed our observations of positive and caring staff attitudes and behaviours.Patients told us that staff were kind and caring and were consistently positive about staff and the support they had received from services.
- Staff encouraged patients to give feedback about their care.Staff offered patients the chance to give feedback in a variety of ways.
- Senior managers told us that patients were involved in projects across the organisation.This included reviewing documents, delivering training, working as bank staff and recruiting and interviewing staff.The trust had a patient involvement group that was well attended by patients from the mental health pathway.
- A feedback system had been introduced across the trust called I Want Great Care.This received feedback from carers, patients and staff about the care of patients and other issues.The trust received 61,000 reviews since the system began.
- During our visit we saw numerous examples of patient involvement in care plans, in risk assessments and patient participation in meetings. Staff encouraged patients, where ever possible, to maximise their independence during their care.

However:

- The friends and family test was launched in April 2013. The trust achieved a significantly higher response rate than the national average in the time period March 2016 to August 2016. In all of the reported quarters the percentage of respondents who were 'extremely likely' to recommend the trust as a place to receive care was below the England average.
- Staff did not always document patient involvement in care plans or offer copies of care plans in some mental health services. However, in almost every service we visited we saw and heard staff engaging with people who used services about their care and how they could be involved.

Our findings

Kindness, dignity, respect and support

- Throughout the trust, in both mental health and community health services, staff treated patients with kindness, dignity and respect. Staff attitudes were consistently helpful, understanding and staff used appropriate language patients would understand. The style and nature of communication was kind, respectful and compassionate. Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.

Outstanding ☆

Are services caring?

- Staff throughout the trust responded to patient requests in a timely and appropriate manner, and their interactions with patients were empathic, warm and respectful.Staff had meaningful interactions with patients and carer.
- In community dental services, staff helped several patients with a spectrum of learning disabilities to accept treatment in their best interests in a very sympathetic and caring way. Staff adopted a holistic approach to care concentrating fundamentally on the patients social, physical and medical needs.
- Nurses and health visitors in community services for young people children and families went out of their way to be child centred and we observed examples where trusting relationships had been developed with the child and their family. Receptionists, nurses, health care professionals and support staff interactions with children and young people were friendly and welcoming.
- We held focus groups for patients prior to the inspection.Patients told us that staff were exceptionally caring and compassionate.During our inspection, patients across the trust confirmed our observations of positive and caring staff attitudes and behaviours.Patients told us that staff were kind and caring and were consistently positive about staff and the support they had received from services. Patients told us staff were willing to help and treated them with consideration and dignity.They felt listened to and respected by staff.
- We spoke with four parents of young people who used the service. They were very positive about the way their loved one had been treated and felt that staff went the extra mile to keep them informed of their child's progress on the ward.
- However, some patients in forensic inpatient and rehabilitation wards told us staff spent too long in the nursing office and some staff were unfriendly and unhelpful.Two patients told us that while many of the staff were good, four staff members were unapproachable and unfriendly. This included staff commenting that opinions they expressed were indicators of their mental illness and a member of staff speaking to them rudely. Four other patients said that most of the staff were respectful but some were not. Three of the four patients said that some staff would knock on their door but enter without waiting for an answer.
- Staff encouraged patients to give feedback about their care.Staff offered patients the chance to give feedback in a variety of ways.They used the "I want great care" system, which allowed patients, staff and carers to give feedback about anything to do with patient care. Patients gave feedback in community meetings, through comment cards and by being able to make a complaint or compliment.
- Staff from all services across the trust, in both mental health and community services knew and understood the needs of their patients.Staff demonstrated understanding of need and spoke with compassion, in age and need appropriate ways so that patients would understand care being offered.Staff were highly motivated and regularly went the extra mile to support patients.
- Patients in community-based mental health services for adults reported that their allocated workers were responsive to their needs in times of crisis and that they could contact the team or out of hour's crisis services when needed for support.
- PLACE assessments are self-assessments undertaken by NHS staff and include at least 50% members of the public (known as patient assessors). In relation to privacy / dignity and wellbeing the trust overall score was similar to the national average of 89.7% at 89.3%.
- The following sites scored lower than the trust national average:
  - Isebrook Hospital (82.9%)
  - Corby Community Hospital (88.3%)
  - Danetre Hospital (88.2%)
- Staff in community dental services treated patients with dignity and respect.We observed a particular example where consent was gained form a patient and family in a gentle and caring manner.Privacy and confidentiality was maintained in the reception area. Receptionists spoke discreetly when necessary and moved to other areas of the desk if necessary.

Are services caring?

- However, on Kingfisher and Avocet wards privacy panels had recently been fitted in bedroom doors. Both staff and patients said they were noisy, difficult to use and some were broken.

The involvement of people in the care they receive

- Senior managers told us that patients were involved in projects across the organisation.This included reviewing documents, delivering training, working as bank staff and recruiting and interviewing staff.The trust had a patient involvement group that was well attended by patients from the mental health pathway.Five patient stories had been heard at the trust board, one of which brought about a pilot scheme for staff to trial body worn cameras, following a patient's experience of his admission to hospital.
- A feedback system had been introduced across the trust called I Want Great Care (IWGC).This received feedback from carers, patients and staff about the care of patients and other issues.Senior staff told us the feedback received helped to review data collection and trust dashboards and make changes to patient care.Changes to practice had taken place at The Squirrels, St Mary's Hospital, Cove ward and community hospitals and had included improved signage, provision of improved beds, response to call bell answering and more consistent use of bank or agency staff.The trust received 61,000 reviews since the system began.
- Senior staff told us that carers were offered the opportunity to be involved in care and give feedback about the care their relatives received.The trust had completed work with Northamptonshire Carers Association, carer ambassador roles had been created and monthly meetings took place for carers to share their experiences.
- During the inspection we received 124 comment cards from patients.They told us staff involved them in their care and staff were kind and compassionate.
- Child and adolescent mental health wards held a yearly "rivers of experience" event. Young people and parents who had used the service during the preceding 12 months were invited to attend a meeting whereby they were encouraged to share their experience, contribute to developing the service and to look at where things could have been done differently. Families and carers were involved in care where this was appropriate. Weekly meetings were held on the Burrows to review young people's progress. Following the meeting parents were either given a copy of the progress sheet or they were posted to their address. Parents we spoke with said the updates were invaluable.
- A participation worker in community-based mental health services for children and young people, involved patients in service development, including training patients to participate on interview panels for new staff.
- On Sandpiper ward we observed a patient and their family and carers were involved in care decisions in a multi-disciplinary meeting.
- Carers from community-based mental health service for older people told us that staff were supportive and involved them in their relatives care. Staff would also signpost carers to other services that could offer them support.
- Families and carers in community health services spoke highly of staff attitude, feeling involved in their loved ones care and were freely able to give feedback on the standard of care they received.
- Staff recorded patient involvement in care plans and risk assessments.During our visit we saw numerous examples of patient involvement in care plans, in risk assessments and patient participation in meetings. Staff encouraged patients, where ever possible, to maximise their independence during their care.Carers and patients were invited into wards rounds and clinical meetings to discuss their care.Staff provided easy read formats of care plans to patients when required, particularly in learning disability services. Patients told us they were involved in decisions, and given choices about treatments.
- Care and treatment plans demonstrated the involvement of young people in wards for children and adolescents. Young people signed their care plans to show their agreement. Young people said staff took into account their personal, cultural and social needs especially when planning activities.
- Patients in community-based services for older people told us that they were involved in decisions about their

care and given choices about treatments. However, patients reported that they had not been offered a copy of their care plan or been invited to care programme approach (CPA) reviews.

- Patient records in community-based services for adults demonstrated involvement in care programme approach reviews. However, some care plans were combined with the CPA record rather than being recorded as separate documents.Care plan checklists were inconsistently used to record patient involvement and it was unclear if the patient had been present at the CPA review due to the documents being merged.Some patient crisis plans reviewed were not personalised documents and did not contain patient's protective factors and plans to be implemented in the event of deterioration or relapse.
- Patient participation in care plans and risk assessments from wards for older people was varied with reduced input on the wards for patients with dementia.
- The friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they had used. The trust achieved a significantly higher response rate than the national average. However, in all of the reported quarters the percentage of respondents who were 'extremely likely' to recommend the trust as a place to receive care was below the England average. In quarter one, this figure was 76.6% for Northamptonshire below the England average.
- The trust provided four examples of audits or surveys relating to patient or carer involvement. One audit was carried out at the Welland Centre about the support group; a second audit evaluated the understanding mental health group in the forensic ward setting. A third audit was carried out to evaluate the N-Step service, and the fourth audit evaluated the experience of patents using cognitive stimulation therapy.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Northamptonshire Healthcare NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning service developments and delivering services. The trust had effective working relationships with commissioners and other stakeholders.
- The trust board supported and encouraged a Black and Minority Ethnic project called Moving Ahead. This project delivered training to healthcare professionals across Northamptonshire to work with Black and Minority Ethnic patients.
- The trust met the target of 95% of patients being followed up within seven days of discharge.There were a high number of delayed discharges from CHS inpatient hospitals. Data showed 46% of all patients across the service were medically fit to be discharged home but remained in hospital because there were no care packages available or the patients were waiting to be assessed.
- The majority of services had a range of rooms and equipment to support care and treatment. Patients had access to quiet areas on wards and access to outside space.
- Patients told us they had co-produced information leaflets with staff and carers in one of the services. There was a provision of accessible information on treatments, local services, patients' rights and how to complain across all services.We saw evidence of information available to patients on how to access interpreters should they need one.
- The PLACE assessment relating to food scores showed the trust scored slightly over the national average of 92% for food with 97%.
- The trust had a robust governance structure in place to manage, review and give feedback from complaints. The trust set a 72 hour time frame in which they responded to a complaint. If an investigation was required, a written response would be received by the complainant within 25 days. All complaints are reviewed by the CEO.
- Staff knew the process to support patients to make a complaint.Staff gave patients information on how to do this where appropriate, and information was readily available on ward notice boards and in welcome packs. Staff consistently knew how to handle complaints, and managers told us they investigated complaints promptly and gave feedback to patients, carers and staff about outcomes of complaints.

However:

- The average bed occupancy rate was 102% across all wards. Five of the eight core services had average bed occupancy of 85% or more with acute and PICU wards with the highest occupancy at 116%.
- There were no patient phones within any of the older people's wards. However, patients could ask to use the ward phone to make private phone calls and patients could use their personal mobile phones.
- The HBPoS at St Mary's Hospital did offer patients access to fresh air within a safe setting, however this was on another ward and could only be used when patients from that ward were not using it.
- CHS had waiting lists and no way to monitor deteriorating patients.Some acute mental health services and forensic inpatient services used beds for new admissions that were already allocated to patient on leave.Discharges from forensic inpatient services were affected by a reduced number of beds on the rehabilitation ward.
- Community-based mental health services for older people did not have information leaflets readily available in other languages. Staff told us they had to request these from the trust communications team.

Good

Are services responsive to people's needs?

- Corby Community Hospital had bright blue flooring. This could be confusing for patients with a cognitive impairment or dementia because it looked like water. Staff told us some patients did not want to step on the blue floor because it looked like water.

Our findings

Service planning

- The trust used information about the local population when planning service developments and delivering all services. The trust had effective working relationships with commissioners and other stakeholders. There were close links with the commissioners and ongoing discussions about developments to improve services.Feedback was received from stakeholders who felt the trust was open and transparent in its conversations, knew its challenges and was prepared to work with stakeholders to improve services.
- The CHS CYPF service reflected the needs of the local population and provided flexibility, choice and continuity of care to meet the needs of the local community. The trust was working with the clinical commissioning group and local partners across the NHS, local authority public health, children's services, education and the voluntary and community sectors to develop local transformation plans for children and young people over the next five years. Children, young people and family services were undergoing a radical service redesign to improve services for children and young people. This was being achieved through the implementation of the 0 to19 integrated pathway for children's services. The new approach had been a result of a large public engagement event led by the Clinical Commissioning Group.
- The trust used a mobile dental service to reach out to children with complex needs who attended specialist schools in the county.
- The trust board supported and encouraged a BME project called Moving Ahead.The BME network engaged with local stakeholders, including police, BME communities, Healthwatch, Public Health England and advocacy services to develop a community engagement project.The trust board, non-executive directors and local universities had supported the BME network to carry out this work.The trust was one of three trusts nationally to have developed the moving ahead project and they had been asked to support other trusts in doing the same. Patients had also been involved in the project. A further project to come from Moving Ahead, had been training for BME communities. It focused on empowering and enabling BME communities to access the services the trust provided. This project delivered training to healthcare professionals across Northamptonshire to work with BME patients.

Access and discharge

- The trust provided details of bed occupancy rates for 26 wards between 01 October 2015 and 30 September 2016. The average bed occupancy rate was 101.9% across all wards. Five of the eight core services had average bed occupancy of 85% or more with acute and PICU wards with the highest occupancy at 116%.
- The core service with the highest average length of stay between 01 October 2015 and 30 September 2016 was forensic inpatient wards with 318 days followed by child and adolescent mental health wards with 55 days. The average length of stay over all services, trust wide, was 32 days.
- The trust reported 133 out of area placements, all related to acute and PICU wards. The trust used 32 different locations to place patients.The trust reported no out of area placements for child and adolescent mental health services.
- Referral to assessment and treatment times were provided for 61 services across the period 01 October 2015 to 01 September 2016. No targets had been provided for days from initial assessment to onset of treatment for any of the services inspected. The following services had the longest waiting times; Children's Continence Service (29 weeks), Children's ADHD & Asperger's (20 weeks), and Adult ADHD & Asperger's service.
- The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The trust met the target of 95% of patients being followed up within seven days of discharge. However, in seven of the 12 months the trust fell below the England average.

Good

Are services responsive to people's needs?

- The trust provided information on 49 readmissions within 28 days during the period 01 November 2015 to 30 September 2016. 14 readmissions related to the community inpatient ward at Danetre Hospital. 35 readmissions related to end of life services; 15 to Cransley ward and 20 to Cynthia Spencer Hospice.
- Between 01 October 2015 and 30 September 2016 there were 720 delayed discharges across the trust. Eleven percent of all discharges at the trust were delayed. The ward with the highest numbers of delayed discharges was Hazelwood (CHS Inpatient) with 204 (86.8% of all discharges).
- The trust provided data to show that 438 patients had delayed transfers of care from September 2015 to August 2016.Overall, the most common reason for delay was completion of assessment, followed by a delay in awaiting a care package in their own home. These reasons accounted for 63.5% (278) of patients delayed discharges.
- The community-based mental health services for children and young people had a referral to treatment target time of 13 weeks. The majority of the patients received treatment within four to six weeks of initial assessment. Urgent cases were picked up within a week or passed to the children's response team who were able to see patients immediately.
- Mental health crisis teams (CRHTT) started discharge planning with patients during their first appointment and at each contact thereafter.
- Community-based mental health services for adults, (PCRT South) had a waiting list of 44 patients. Measures were in place to manage the risks associated, with designated staff that completed regular reviews and liaised with the crisis team and discussed patients at weekly team meetings to manage the list.
- All wards in community inpatients reported high numbers of delayed discharges. These had reduced over the previous 12 months. From September 2015 to September 2016, 68% (563) of all discharges across the service were delayed. Hazelwood had 87% delayed discharges which was the highest of all inpatient areas. This was due to patients waiting for packages of care at home or for placements in care homes. However, we found that 32% of delayed discharges in the service were due to delays in assessments and this compared with the England average of 18% delayed discharges due to assessments.We spoke to several patients across the service who were deemed fit for discharge. Some had been waiting for several weeks and expressed frustration that care in the community had not been found sooner.
- The trust did not provide data to show compliance with how long patients waited from their initial assessment to treatment in CHS for Adults. The trust did not provide any targets for days from initial assessment to onset of treatment for any of the community health services for adults.
- We noted that the acute inpatient wards had a relatively low proportion of detained patients. We wondered whether the thresholds for admission were low and whether this had an effect on their ability to admit patients in an emergency.

  In community adults, the average number of weeks from referral to treatment (RTT) varied between services. For example, from October 2015 to December 2016 the podiatric surgery service had the highest average RTT time (21 weeks) followed by the diabetic foot and high risk podiatry service (nine weeks). The average RTT for adult dietetics was seven weeks and four weeks for speech and language therapy services. The risk to patients waiting over 18 weeks for routine podiatry appointments was not being monitored. There were 1,400 patients county-wide waiting for routine treatment on the waiting list. We enquired how they assessed the risk to patients on the waiting list. Every patient referred to podiatry receives a letter which details how to recognise deterioration in their condition and how to contact the service. Staff confirmed they were dependent on the patient phoning to say their condition had deteriorated. This meant the service did not have systems or processes in place to manage the risk to patients on the waiting list.
- Community nursing teams within planned care were not using early warning scores in line with trust policy. Early warning scores are commonly used for the assessment of patients. These observations can detect when a patient's condition requires more intense observation and should be a trigger for further investigation and action, as early intervention can reduce morbidity and mortality in unwell patients.

Good

Are services responsive to people's needs?

- There were seven delayed discharges between October 2015 and September 2016 in child and adolescent mental health wards; these were all due a lack of availability of an appropriate community placement. In acute and PICU services, there were three out of area placements on Marina PICU. Bay ward had 17 beds, however three patients were on leave and they had been filled with three other patients. This meant that the ward had 20 patients allocated to the 17 bedded ward. If a patient needed to return early to the ward, there may not be a bed available. Seven patients on Avocet ward were ready for discharge, but placements were not available.
- There were insufficient rehabilitation beds between the forensic inpatient wards and rehabilitation wards, leading to delayed discharges from the Wheatfield unit. The trust had recently closed two rehabilitation facilities. A lack of rehabilitation beds meant that some patients who were ready to be discharged spent longer on the unit than they needed because there was no room on the rehabilitation ward.

The facilities promote recovery, comfort, dignity and confidentiality

- Most services had a range of rooms and equipment to support care and treatment. Patients had access to quiet areas on wards and access to outside space. Patients from Riverside ward told us that occupational therapy staff would come in on Saturday's and takes a day off during the week in order to provide weekend activities. Staff assisted patients to make food and encouraged patients to use therapy kitchens if appropriate. Staff facilitated 1:1 sessions and care co-ordinator sessions in private rooms to maintain confidentiality. Where appropriate, staff helped patients to personalise their bedrooms. Across most mental health inpatient settings, patients had access to outdoor space.
- The PLACE assessment relating to food scores showed the trust scored slightly over the national average of 91.9% for food with 96.6%. St Mary's Hospital scored 100% and Corby community hospital scored 98.7%. The Sett (88.2%) and Manfield Health Campus (90.5%) scored lower than the national average.
- Patient focus groups told us they could access halal, vegetarian, and gluten free food. Most patients told us the food was of good quality and they were happy with the quantity of food provided.
- The HBPoS at St Mary's Hospital did offer patients access to fresh air within a safe setting. However, we were informed that patients were able to enter the adjoining acute admission ward to use the garden area. This could only be facilitated when acute patients were not using the garden or lounge area of the ward.
- Staff and patients raised concerns in relation to room availability at Campbell House in community-based mental health services for adults. Staff reported that a review of the room booking systems was required.
- Interview rooms in community-based services for children and young people appeared to have adequate sound proofing for normal rate and volume speech, but if voices were raised this could be heard outside of the interview room, meaning that in those cases confidentiality may not be maintained.
- Patients told us they had co-produced information leaflets with staff and carers in one of the services.
- There was provision of accessible information on treatments, local services, patients' rights and how to complain across all services.One service had access to a language line and hearing loops were available in some of the team bases.
- The trust had a plan in place to achieve compliance with the Accessible Information Standard. All actions in the plan were due for completion by 29 July 2016 but up to the time of inspection we did not receive evidence of what the trust has done since that date. There were gaps in the provision of Makaton language materials, the availability of audio information / MP3 files and the provision of Access to Speech-to-text reporter (STTR) at the trust.

Meeting the needs of all people who use the service

- During the previous 12 months small cohorts of individuals with a learning disability had been admitted to mental health wards due to mental health being their main presentation. In these circumstances there was a patient- centred collaborative approach involving the Intensive Support Team provided in-reach working shifts alongside mental health practitioners; in addition to learning disability nurses were sourced via the staff

bank to support this. This means, people with learning disabilities were able to access appropriately skilled and knowledgeable professionals, meeting the requirements of the Greenlight Toolkit.

- There was access for wheelchairs and handrails in wards for older people to help those with restricted mobility and at risk of falling. Staff provided additional support to those who required it to walk around the wards. All wards were suitable for older age adults.
- End of life services met the needs of the local population. We observed services that had been planned to take into account the needs of patients and their family, for example on the grounds of age, disability, gender, religion or belief. Services were planned, delivered and coordinated to take into account patients with complex needs, for example those living with dementia or those with a learning disability.
- Information leaflets were available in easy read formats and in different languages for people whose first language was not English. We saw evidence of information available to patients on how to access interpreters should they need one. Staff told us they knew how to obtain this service. However, community-based mental health services for older people did not have information leaflets readily available in other languages. Staff told us they had to request these from the trust communications team.
- All mental health services had made adjustments for those who required disabled access.
- A prayer room was available and patients were supported to request a religious person of choice to attend their ward. Spiritual support was available to patients for a range of faiths. Information was displayed on notice boards. In end of life services, for patients who wished to take communion, the chaplain or an authorised member of the team brought communion to their bedside. We saw that a memorial evening was held. This provided an opportunity for relatives, friends and hospice staff to share a time to remember those that had died. It included music, readings lighting of candles and a chance to reflect and talk to other families and staff.

Listening to and learning from concerns and complaints

- The trust had a robust governance structure in place to manage, review and give feedback from complaints. The trust set a 72 hour time frame in which they responded to a complaint. On receipt of a complaint, contact was made immediately (by telephone or in person if they are on Trust premises, where feasible) to discuss their concerns.If an investigation was required, a written response would be received by the complainant within 25 days. All complaints are reviewed by the CEO who met with complainants if requested. The trust collated themes and trends from complaints and quarterly reports were presented to the complaints committee, the governors and deputy directors. The trust board had oversight of the process and detail of the complaints.
- We sampled seven complaints files. All were acknowledged within three days in accordance with trust policy. Six out of seven complaints were investigated and closed within the 25 day trust target. All six complaints had action plans to change practice as a result of the complaint.
- Between October 2015 and October 2016, 195 complaints were reported, of which 39% were partially or fully upheld and one complaint was referred to the Ombudsman which was still awaiting an outcome.
- Community-based mental health services for adults received most complaints with 34 (27%). Out of these complaints, 18 were either fully or partially upheld.
- Of the 57 complaints made which were either partially or fully upheld, 22 (39%) were in relation to 'all aspects of clinical treatment'. Most of these were with acute and PICU wards (seven) and community-based mental health services for adults (six).
- Eleven complaints (19% of all partially or fully upheld complaints) were received due to dissatisfaction with the attitude of staff. Five of these complaints were received for acute and PICU wards and three for community-based mental health services for adults.
- Nine complaints (15% of all partially or fully upheld complaints) were also in relation to appointments, delay / cancellation for outpatients. Three of these were within community-based services for adults, three within specialist community mental health services for children and young people, two within community health services for adults and one within community dental services.

Good

Are services responsive to people's needs?

- Two complaints were received in relation to restraint and seclusion and transport (ambulances and other), however neither complaint was upheld.
- Staff in all ten mental health services, and all CHS services knew the process to support patients to make a complaint.Staff gave patients information on how to do this where appropriate, and information was readily available on ward notice boards and in welcome packs. Staff consistently knew how to handle complaints, and managers told us they investigated complaints promptly and gave feedback to patients, carers and staff about outcomes of complaints.

Good

Are services well-led?

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

Summary of findings

We rated Northamptonshire Healthcare NHS Foundation Trust as good for well-led because:

- The trust had a clear vision and set of values. The trust board had taken a number of actions to role model their values and vision. The board level leadership was outstanding. The senor leadership team were instrumental in delivering the quality improvement work across the trust.
- Staff in mental health services and community health services was, for the majority, aware of the trust's vision and values. Although some staff were not able to repeat the phrases of the values verbatim, they told us in their own words what the values meant to them in their work with patients, carers and colleagues.
- The trust's strategy clearly articulated a vision for quality and improvement.It was based on five principles, and we saw that from board members to senior leaders and staff that they showed, through their actions, the principles of the strategy and values.
- Staff across services told us they knew how to give feedback to their managers or more senior staff on things that could improve services.A feedback system had been introduced across the trust called I Want Great Care.This received feedback from carers, patients and staff about the care of patients and other issues. Staff used the I want great care resource to offer feedback.
- The trust had systems in place to support and monitor staff performance and development.
- In mental health services and community health services, staff knew what incidents needed to be reported and how to report them. Managers ensured they monitored the reporting and recording on incidents.
- The trust collected data to demonstrate that immediate post incident reviews were taking place and that learning was identified to inform future care.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to use de-escalation processes effectively.
- The trust had safeguarding policies and robust safeguarding reporting systems in place.We saw robust databases and dashboards of safeguarding data collated by the trust.
- Equality and Diversity training was a mandatory training course at the trust, which must be completed once every three years. Staff compliance was 90%.
- The trust board had oversight of patient safety and compliance. The trust used key performance indicators/dashboards to gauge the performance of the teams.
- The trust had developed and invested in an extensive range of well-being schemes for the staff.
- The Black and Minority Ethnic group had reconvened and had made progress in highlighting their goals for the year ahead.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and the majority of staff felt able to raise concerns without fear of victimisation.
- Staff felt supported by the board to work with change and felt able to provide feedback about their experiences.

However:

- The trust operational risk register, dated August 2016, had two risks related to safe staffing.

Good

Are services well-led?

- Managers in community-based services for older people did not have assurance systems in place to monitor and audit the quality and performance of the service.
- CHS for Inpatients had high vacancy and sickness rates which put additional pressure on substantive staff.
- The strategy to move all stroke patients to one hospital site was delayed. Plans started in August 2016 had not been completed. However, the trust provided evidence that they are now working on this strategy.
- Not all risks had been identified on the risk register and some risks had not been recognised or responded to.
- The trust did not assess or monitor the phlebotomy service in CHS for Adults. There was a lack of oversight of the service and it had not been delivered in line with the service level agreement with commissioners.

Our findings

Vision, values and strategy

- The trust had a clear vision and set of values.Posters were seen on inspection around all sites within the trust.The vision and values had been widely communicated across the trust through posters, presentations, and the intranet page called the staff room, screen savers and board members visits to wards.The values had a direct relationship with the trust vision and strategy.The values were:
- People first, working together for patients in everything we do
- Respect, dignity and compassion by valuing each person as an individual
- Improving lives by improving health, wellbeing and people's experience of the NHS
- Dedication to quality of care and getting the basics right
- Everyone and equality count, using resources wisely for the whole community.
- We saw the trust board had taken a number of actions to role model the values and vision. They held events to formally introduce leadership behaviours for managers, a new staff intranet, and a celebration event of good practice and staff quality awards.
- Staff in mental health services and community health services were, for the majority, aware of the trust's vision and values. Although some staff were not able to repeat the phrases of the values verbatim, they told us in their own words what the values meant to them in their work with patients, carers and colleagues.This included making a difference, being person centred and ensuring what they did was of good quality.Some staff told us they were proud to work for their service. Staff from most services told us the values were embedded in their service culture. The district nursing service was an exception as they felt downbeat and not involved in the formation of the values.
- The trust's strategy clearly articulated a vision for quality and improvement.It was based on five principles, and we saw that from board members to senior leaders and staff that they showed, through their actions, the principles of the strategy and values.
- Staff across core services told us they knew how to give feedback to their managers or more senior staff on things that could improve services.Staff used the "I Want Great Care" (IWGC) resource to offer feedback.

Good governance

- An operational management tool was in place which recorded data for 40 measures of patient safety and areas of compliance for the trust.The trust board had oversight of this and a rating system was used to show compliance to KPIs, CQUINs, and trust targets.The trust had a variety of governance meetings in place at which the targets and KPIs were reviewed from ward team meetings to trust level quality forum and governance meetings.The leadership team also used IWGC as a means of monitoring service delivery.
- The trust board received detailed reports from the quality and governance subcommittee which included serious incidents, complaints and compliments.
- Some services did not have assurance systems in place to monitor and audit the quality and performance of the service. In the community service for older people

managers had access to reports generated by the trust but took no action to monitor compliance rates. Mandatory training, including Mental Capacity Act (MCA), supervision and appraisals were all below the trust compliance rates. The recording of supervisions and appraisals was poor. The community health service for adults did not identify risks such as inappropriate safeguarding training levels, service level agreements not being followed, equipment risk issues or infection prevention and control issues. Managers in community-based mental health service for older people did not ensure that staff were aware of the 'shared care' protocol between the service and GP's. This protocol set out responsibilities for physical health checks, including blood tests for patients on anti-psychotic medications. Due to this staff did not know who was responsible for these checks and therefore managers were not assured that patients had their annual physical health checks completed.

- The trust wide average appraisal compliance rate was 65% as of September 2016. During the inspection data showed there had been an increase in average compliance with appraisal from 65% to 90%. We found data comparisons were inconsistent as some units appraisals were reported as a total for the year, and others reported on a month by month basis.
- The trust compliance for supervision was variable across services. Average compliance for supervision was 93%, but the lowest compliance was 43%.
- The trust operational risk register, dated August 2016, had two risks related to safe staffing. The first related to the risk of being unable to maintain the right workforce capability and capacity to deliver the strategic plan. The second related to insufficient medical staffing levels. The central directorate risk register held thirteen significant or high level risks relating to inadequate staffing levels and skill mix and high use of temporary staff. These risks related to community adults, children, young people and families, and mental health learning disability services. The trust used regular bank or agency staff to achieve the required amount of staff to ensure safer staffing levels and to meet the needs of the patients.
- The trust used an electronic system for reporting incidents. In mental health services and community health services, staff knew what incidents needed to be reported and how to report them. Managers ensured they monitored the reporting and recording on incidents. All incidents highlighted at medium risk and above were automatically sent to the Patient Safety Team and the Deputy Director of Nursing for review. There was a robust and clear trust wide reporting structure and governance arrangements for reviewing incidents was embedded amongst the board, senior managers and staff.
- The trust collected data to demonstrate that immediate post incident reviews were taking place and that learning was identified to inform future care. This learning and incident detail was then reviewed by the multidisciplinary team.
- A monitoring group for restraint and seclusion scrutinised data monthly which also reported to the trust's governance committee. An operational management tool was in place which recorded data for 40 areas of patient safety. A governance meeting reviewed this and data triangulated against patient and staff feedback, compliments, complaints, feedback from the hospital wide feedback tool "I Want Great Care" (IWGC) and serious incident recordings.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to use de-escalation processes effectively.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and could describe how they worked with partner agencies to protect vulnerable adults and children. We saw robust databases and dashboards of safeguarding data collated by the trust.
- The trust's Mental Health Act Scrutiny Committee received monthly MHA reports, which fed into the Quality Forum. The monthly report included information about the use of the MHA across the trust. The Quality Forum reported to the Quality and Governance Committee, which then reported to the trust's board of directors.
- The MHA administration team also managed the Deprivation of Liberty Safeguards (DoLS) applications countywide. This enabled the trust to track applications and authorisations.
- The governance route for the Mental Capacity Act was the same as for the Mental Health Act except the information was also reported to the safeguarding board.

Good

Are services well-led?

- Equality and Diversity training was a mandatory training course at the trust, which must be completed once every three years. As of 02 November 2016, 90% of staff were up to date with this training.
- The trust data on equality and diversity in the Workforce Race Equality Standard (WRES) and in the NHS Staff Survey reported improved scores for Black and Minority Ethnic (BME) staff in comparison to the previous year. However, scores were still worse compared to white staff. There was no available data on hard to reach groups although the county health profile report indicated a higher percentage of emergency hospital admissions for Black and Chinese service users.
- The trust published an annual Equality Information Report and its equality objectives on the trust's website. The trust referenced the Human Rights Act (HRA) and the Equalities Act in its Inclusion and Equality Strategy and its Trust Equality Information Report. There had however, been less progress within other aspects of the diversity agenda in respect to the LGBT and Disability work streams.
- The trust published an Inclusion and Equality Strategy for 2016-19. The trust created this in partnership with the Equality and Inclusion Assurance Board, Patient Experience Group, Equality and Inclusion Champions Network, BME Staff Development Network, LGBT and Allies Staff Network, and a range of external parties, including Northamptonshire Rights Equality Council (NREC), Age UK (Northampton branch), Community Activists/Champions and the Trust Policy Board. The trust described how it would comply with the 2010 Equalities Act. Progress has been made with all the objectives, with only one part of an objective still not started.
- The Trust provided details of 69 audits undertaken in 12 months from September 2015 to September 2016. All of the audits were indicated as clinical audits with two national audits. These were completed by a range of staff across the trust. Staff across seven mental health core services and all five community health services gave details of audits they had been involved in.
- The trust used key performance indicators/dashboards to gauge the performance of the teams. These reports were presented in an accessible format.
- The trust has an overall operational risk register and below this a central directorate risk register. The overall operational risk register had 20 risks, five of which were rated as high risk at the end of August 2016. The higher rated risks relating to 'good governance' are summarised below:
- The trust is unable to maintain the right workforce capability and capacity to deliver its strategic plan
- Insufficient medical staffing levels
- The trust maintains an insufficient balance between CIPs and quality
- Regulatory non-compliance with CQC/Ofsted jeopardises the trust's ability to deliver its strategy
- The trust fails to safeguard children and adults appropriately
- The trust fails to identify and act on poor practice
- Clinical audit plan priorities may not match safety risks
- Compliance action of seclusion
- Compliance action for improving learning lessons
- Non-compliance with VTE/NEWS assessment levels
- The trust had a central directorate risk register with 53 risks identified across all trust locations. The trust rated five risks as significant, 29 as high, 12 as moderate and two as low. (Five risks were related to locations we did not inspect). There was a robust governance structure which included board review, update and progress against each risk. A quality forum meeting took place monthly that received feedback from directorate and management team meetings, operational management meetings (ward managers) and local team meetings. These meetings informed the overall trust quality schedule and quality priorities were decided. The trust had nine quality priorities.

Fit and proper persons test

- The trust provided documents which detailed their policy and procedures relating to fit and proper person's requirement checks. We reviewed the files for six directors and the trust had met these requirements and had ongoing monitoring for regular reviews of fit and proper person's requirement. However, two directors had only a standard Disclosure and Barring Service (DBS) check and not an enhanced DBS check. This was brought to the attention of the Chief Executive who said

that they had taken legal advice and had been assured that this was sufficient. Whilst this breaches no regulation this concern was taken account of and the trust will move to enhanced checks for all directors.

Leadership and culture

- The trust scored above the national average for mental health trusts in the 2015 NHS Staff Survey against 16 key findings.
- The following questions scored higher than the national average:
- 92% believing that their role makes a difference to service users/patients
- 37% of staff feel there is good communication between senior management and staff
- 37% of staff suffering work related stress in last 12 month
- 18% of staff experiencing harassment, bullying or abuse from staff in last 12 months
- 89% of staff believing that the organisation provides equal opportunities for career progression or promotion.
- The following questions were rated out of five and scored above the national average:
- staff rated motivation at work as four out of five
- staff rated the organisation and management had interest in and action on healthand wellbeing as 3.74 out of five
- staff rated the satisfaction with the quality of work and patient care they deliver as 3.92 out of five
- staff rated the organisation as a place to work a 3.78 out of five.
- Several board members were mentioned by staff as leading, inspiring and listening. The chief executive, new chair, director of nursing and chief operating officer all had strong visibility and were singled out by staff as exemplars as leaders.
- The board level leadership was outstanding. The senor leadership team were instrumental in delivering the quality improvement work across the trust and deserve specific mention for the improvements made since the last inspection.
- The trust had developed and invested in an extensive range of well-being schemes for the staff.They told us about physical fitness classes, recruitment and retention rewards, counselling, and support groups available.
- The staff Friends and Family Test (FFT) was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trust achieved a significantly higher response rate than the average for England across all of the quarters. The percentage of respondents who were 'extremely likely' to recommend the trust as a place to work was below the England average across each of the reported quarters. In quarter one for 2015/2016, the trust reported 64% of staff being 'extremely likely' or 'likely' to recommend the trust as a place to work.
- As of 31 March 2016, the trust's workforce was 2951 substantive staff, of which 10.9% came from a minority group. Black and Ethnic Minority (BME) representation on the board is aligned to the entire workforce.
- The NHS Staff Survey in 2015 showed the following results relating to BME workforce:
- 16% of BME staff at the trust experienced discrimination at work compared to 13% nationally.
- 74% of BME staff at the trust believed the organisation provided equal opportunities for career progression or promotion compared to 78% nationally.
- White staff scored better than the national average when asked about their experiences of harassment, bullying or abuse from service users or staff in the last year.
- We spoke with staff from the BME executive and senior staff who led on BME issues within the trust.The BME group had reconvened and had made progress in highlighting their goals for the year ahead.The trust supported the agenda and provided opportunity for meetings, projects and feedback and had a Workforce Race Equality Standard (WRES) action plan in place.However, BME staff told us they felt the trust needed to own the agenda as a whole, rather than allowing BME staff to lead it.Staff told us there was little

representation of BME staff at band seven or above, and the trust had some way to go with this issue.Data confirmed there were 37 posts in non-clinical areas at Band 8a, of which two were occupied by BME staff, and less than three posts in clinical areas. However, the board was more representative and showed good understanding and grip. We also heard from staff who said they had been supported by directors to progress in their careers, had had mentors and had been personally supported when something unpleasant had happened.

- The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and the majority of staff felt able to raise concerns without fear of victimisation. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families if things went wrong.
- Senior staff told us they felt supported to do their role by executive members of the board.They felt they were given opportunity to develop and had good role models in their managers. The trust provided a leadership training programme called leadership matters.This was a course designed for senior managers to develop skills needed for their roles.The trust had developed a set of leadership behaviours and senior staff told us they were embedded in their practice and were displayed around the trust.
- Managers addressed poor performance when required and support was available from the human resources department. The trust policy supported managers to address poor performance. Between January 2016 to December 2016 the trust had 44 disciplinaries and 17 grievances raised.
- Since 01 November 2015, 13 staff had been suspended, placed under supervised practice or both. 11 resulted in suspension, one in supervised practice and one in suspension and supervision. Four of the cases involved band five staff, four involved band six and above. Four were band three and below and one involved a member of staff on a spot salary.

Engagement with the public and with people who use services

- A feedback system had been introduced across the trust called I Want Great Care (IWGC). This received feedback from carers, patients and staff about the care of patients and other issues. Senior staff told us the feedback received help to review data collection, trust dashboards and make changes to patient care. The trust received 61,000 reviews since the system began.

Quality improvement, innovation and sustainability

- The trust gained accreditation to The Accreditation for Inpatient Mental health Service (AIMS) scheme for older people mental health inpatient wards. They were in the process of completing registration for AIMS for adult mental health wards, The Memory Services National Accreditation Programme and The Psychiatric Liaison Accreditation Network.
- The trust was a member of the Quality Newtork for Mental health Services.
- The trust used IWGC as a forum for feedback and evaluation, and embedded it into its governance framework as culture of challenge and change.
- The trust provided details of 69 audits undertaken in 12 months from September 2015 to September 2016. All of the audits were indicated as clinical audits with two national audits. These were completed by a range of staff across the trust.
- The trust employed three clinical researchers to the Research and Innovation (R and I) team. A strategy had been developed which promoted innovation. There were three main initiatives ongoing within the trust. The R and I team hosted a project ideas forum and invited staff, patients, carers and members of the public to offer ideas for clinical innovation. The trust employed an evolving innovation governance framework, and was guided by the R and I team.
- The trust board supported and encouraged a BME project called Moving Ahead.The trust BME network led on this project to improve access to diverse groups of people within the community.It focused on empowering and enabling BME communities to access the services the trust provided. This project delivered training to healthcare professionals across Northamptonshire to work with BME patients.
- The trust held recognition of achievement awards for staff and services. Staff at Corby Community Hospital won a recent Trust Ambassador Award for their implementation of the SAFER patient flow bundle.

Good

Are services well-led?

- Historically the trust has a strong financial position and has used this to support the values of the trust by championing a strong focus on quality whilst maintaining financial balance. This position was supported in conversations with managers and staff across the organisation who felt that quality and needs of patients was at the forefront of the trust's agenda.
- The provider has good working arrangements with commissioners, local authorities and other partners and third sector organisations. There were regular meetings with key stakeholders to make sure that strategic initiatives are joined up with the health and social care agenda within the area. Additionally the chief executive was bringing together chief executives across the sector and region to discuss and find joint solutions to common problems.
- The trust was a key player in the sustainability and transformation plan for the county and drove improvements within the local health and social care economy.
- The trust was using its foundation status to build a new landscape and has formulated a two year strategic plan that included business partnerships as well as the strategic direction internally. The trust used business opportunities to reinvest in clinical work.
- Senior managers told us frequently, there had been much organisational change and transformation of care within the trust. Staff told us they accepted change but they positively embraced the opportunity it provided. They felt supported by the board to work with change and felt able to provide feedback about their experiences.
- All wards in the acute and PICU service from December 2016 had taken part in a three month pilot scheme, to reduce violence and aggression. Some staff wore body worn cameras to monitor incidences when patients were violent or aggressive. This had been developed from direct feedback from a patient.
- A review of stroke services recommended all stroke patients should be cared for on the same ward to ensure they received the best care possible in line with national guidance. This had not been actioned however, following our inspection, the trust provided evidence that it is working with commissioners to move stroke services to one site only.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • **The trust had not ensured formal capacity assessments and best interest's decisions were fully recorded within the care records.** **This was in breach of regulation 11 (1)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensured that appropriate arrangements are in place for accurate recording and monitoring of the administration of medicines. • The trust had not ensured that the prescribing of medicine for rapid tranquilisation of patients is completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings, and follows their own policy document. • The trust had not ensured that medicines were consistently maintained at correct temperatures in all areas and ensured action taken was taken if outside the correct range. • The trust had not ensured that medicines administered to patients, and equipment used for patients was safe and effective.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured there was a process to assess staff competency following a medicine error.
- The trust did not ensure the risk of preventing infections was prevented, detected or controlled.
- The trust did not ensure environmental risks in the health-based places of safety had been addressed.

Regulation 12 (1) (2) (a) (b) (c) (d) (f) (g) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust did not ensure there were systems in place to monitor quality and performance of services. **Good governance 17 (1) (2) (a) (b) (c) (e) (f)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust did not ensure staff received the training, supervision and appraisals necessary for them to carry out their roles and responsibilities. **Regulation 18 (1) (2) (a)**

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

This section is primarily information for the provider

Requirement notices

- The trust did not ensure that environmental risks were assessed and premises and equipment was secure, clean and maintained to ensure patient safety.

Regulation15 (1) (a) (b) (c) (e)