Good

Northumberland, Tyne and Wear NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX4E6	Campus for Ageing and Vitality	**Collingwood Court** **Gainsborough Ward** **Lowry Ward**	NE4 6BE
RX4Z3	Hopewood Park	**Beckfield** **Longview** **Shoredrift** **Springrise**	SR2 0ND
RX442	Queen Elizabeth Hospital	**Fellside**	NE10 9RW

Summary of findings

		Lamesley	
RX4E2	St Georges Park	**Alnmouth Ward** **Embleton Ward** **Warkworth Ward**	NE61 2NU

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
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

We rated Acute and PICU services as good because:

- Staff knew and understood the vision and values of the trust and the recruitment of new staff was based on the vision and values. Ward managers and clinical leads on all the wards were identified as being supportive and effective leaders.
- Staff knew who the senior managers for the acute and psychiatric intensive care unit services were and told us they also visited the wards on a regular basis. Ward managers received positive support from their line managers and were able to manage their ward.
- Mandatory training was above the trust compliance target on all wards and staff received regular supervision and appraisals.
- Mental Health Act documentation for detained patients was in good order. Patients were regularly read their rights under the Mental Health Act. All detained patients received an automatic referral to an independent mental health advocate.
- Any member of staff, via a web form, could report incidents.
- Following incidents, we saw evidence that lessons were shared and learned. Staff understood the whistleblowing policy and knew whom to contact.
- Staff on all wards reviewed their practise when using restraint or seclusion to see if they could have managed anything differently
- There was a bed management team in place and wards had access to a discharge facilitator. Beds for patients who were on leave from the ward were rated either red, green or amber. New patients would not be admitted to a bed rated as red so that the patient on leave could come back at short notice.
- There was a wide range of activities available from the occupation therapy department, the exercise therapy team and activity organisers on each ward.
- Patients had keys to bedrooms. The trust was trialling a sensory room as a new approach with patients who could display challenging behaviour.
- Information and support was available to patients from minority groups. Patients had a good choice of hot and cold food, including healthy options. All of the wards provided access to spiritual support.
- Patients told us they knew how to make a complaint. Staff knew how to handle complaints in line with the trust policy. Patients told us that staff were kind, caring and respectful
- Training in the Mental Health Act and the Mental Capacity Act was mandatory and 94% of staff had completed the training. Staff received management and clinical supervision in line with trust policy.
- There was a good range of staff working within a multi-disciplinary team.
- Staff had a clear understanding of the definition of rapid tranquilisation and carried out the required physical checks and observations of patients. Seclusion rooms were being used in line with principles within the Mental Health Act code of practice.

However:

- The trust were using mechanical restraint as an intervention in the management of violence and aggression in Acute and psychiatric intensive care unit services.
- The trust uses prone restraint during episodes where patients' behaviour is challenging and to withdraw from the seclusion room, this is not in line with the Mental Health Act Code of Practice. The trust should review their use of prone restraint and look at how they can bring their practise in to line with the Mental Health Act Code of Practice.
- Care plans were not person centred the trust should ensure that all care plans are person centred.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Ligature points in all wards were detailed on the ward risk register and mitigated against. These were reviewed each month.
- There were sufficient staff on the wards to allow patients enough one to one time with their named nurse.
- Compliance with mandatory training was above the trust target of 85%.
- Staff had a clear understanding of the definition of rapid tranquilisation and carried out the required physical checks and observations of patients.
- Seclusion rooms were being used in line with principles within the Mental Health Act code of practice.
- Clinic areas were clean and well maintained.
- Staff had a clear understanding and knowledge of safeguarding policies and procedures.
- Staff know how to report and record incidents on the ward.

However

- The trust were using mechanical restraint as an intervention in the management of violence and aggression in Acute and psychiatric intensive care unit services.
- The trust uses prone restraint during episodes where patients' behaviour is challenging and to withdraw from the seclusion room, this is not in line with the MHA Code of Practice. The trust should review their use of prone restraint and look at how they can bring their practise in to line with the MHA Code of Practice.

Are services effective?

Good

We rated effective as good because:

- Physical health monitoring was in place for all patients.
- Training in the Mental Health Act was mandatory and 94% of staff had completed training.
- Training in the Mental Capacity Act was mandatory and 93% of staff had completed the training.
- Staff were involved in clinical audits.
- Staff received management and clinical supervision in line with trust policy.
- Risk assessments were undertaken prior to Section 17 leave being taken.

Summary of findings

- There was a good range of staff working within a multi-disciplinary team.
- Documentation for patients detained under the Mental Health Act was in place.
- Patients regularly received their rights under the Mental Health Act.
- All detained patients received an automatic referral to the independent mental health advocate

However:

- Care plans were not person centred, person centred care plans clearly show the involvement of the patient in the developing of the plan.

Are services caring? Good

We rated caring as good because:

- Patients were involved in weekly community meetings that happened on the ward.
- Patients told us that staff were kind, caring and respectful.
- We observed interactions between staff and patients that were respectful and caring.
- Staff on the wards had a good understanding of the needs of patients.

Are services responsive to people's needs? Good

We rated responsive good because:

- There was a bed management team in place and wards had access to a discharge facilitator.
- Beds for patients who were on leave from the ward were rated either red, green or amber. New patients would not be admitted to a bed rated as red so that the patient on leave could come back at short notice.
- There was a wide range of activities available from the occupational therapy department, the exercise therapy team and activity organisers on each ward.
- Patients had keys to bedrooms.
- The trust was trialling a sensory room as a new approach with patients who could display challenging behaviour.
- Information and support was available to patients from minority groups.
- Patients had a good choice of hot and cold food, including healthy options.
- All of the wards provided access to spiritual support.
- Patients told us they knew how to make a complaint.

Summary of findings

- Staff knew how to handle complaints in line with the trust policy.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and understood the vision and values of the trust.
- The recruitment of new staff was based on the vision and values.
- Ward managers and clinical leads on all the wards were identified as being supportive and effective leaders.
- Staff knew who the senior managers for the acute and PICU services were and told us they visited the wards on a regular basis.
- Mandatory training was above the trust compliance target on all wards.
- Staff received regular supervision and appraisals.
- Mental Health Act documentation was in order and staff knew that the central office for Mental Health Act reviewed these.
- Each ward had its own risk register and these items were escalated to the organisational risk register through the service managers.
- All incidents could be reported by any member of staff via a web form. We saw evidence that lessons were shared and learned following incidents.
- Staff understood the whistleblowing policy and knew who to contact.
- Ward managers received positive support from their line managers and were able to manage their ward.
- Staff on all wards reviewed their practice when using restraint or seclusion to see if they could have managed anything differently.
- A prevent management of violence and aggression reflection group had been implemented. The meetings allowed all staff to discuss specific cases, incidents, and care plans for new patients.

Summary of findings

Information about the service

Northumberland Tyne and Wear NHS Foundation Trust provides in patient and community mental health services for people across Gateshead, Newcastle, North Tyneside, South Tyneside, Sunderland and Northumberland. The trust covers 2200 square miles and services a population of approximately 1.4 million.

We visited four hospital sites covering the 12 wards:

Campus for Ageing and Vitality

Gainsborough Ward is a 15 bed acute admission ward based at Hadrian Clinic, Newcastle General Hospital. The service is for men over the age of 18 years who are experiencing a relapse or crisis regarding their mental wellbeing and require inpatient admission.

Lowry Ward is a16-bed acute admission ward based at Hadrian Clinic, Campus for Ageing and Vitality. The service is for women over the age of 18 years who are experiencing a relapse or crisis regarding their mental wellbeing and require inpatient admission.

Collingwood at Hadrian is a 16 bed acute admission ward based at Hadrian Clinic, Campus for Ageing and Vitality, Newcastle. The service is for men over the age of 18 years who are experiencing a relapse or crisis regarding their mental wellbeing and require inpatient admission. The ward also accepts young men aged 16-17 in an emergency when there are no CAMHS beds available.

St Georges Park

Alnmouth is a 19 bed acute admission ward based at St George's Park, Morpeth. It provides services for up to thirteen female patients. The service is for women over the age of 18 years who require treatment in hospital.

Embleton is a 19 bed acute admission ward based at St George's Park, Morpeth. The service is for men over the age of 18 years who require treatment in hospital.

Warkworth is a 19 bed acute ward based at St George's Park, Morpeth. The service is for men over the age of 18 years who require treatment in hospital.

Queen Elizabeth Hospital

Fellside is a 18 bed acute admission ward for people with mental health problems based at the Tranwell Unit, Queen Elizabeth Hospital, Gateshead. The service is for men over the age of 18 years with a mental illness who require treatment in hospital.

Lamesley is a 18 bed acute admission ward for people with mental health problems based at the Tranwell Unit, Queen Elizabeth Hospital, Gateshead. The service is for women over the age of 18 years with a mental illness who require treatment in hospital.

Hopewood Park

Longview is a 18 bed acute admission ward based at Hopewood Park, Sunderland. The service is for females over the age of 18 years with a mental illness who require assessment and treatment in hospital. The ward also accepts young women aged 16 -17 years in an emergency when there are no children and young people's services beds available.

Shoredrift is a 18 bed acute admission ward based at Hopewood Park, Sunderland.The service is for men over the age of 18 years with a mental illness who require assessment and treatment in hospital. The ward also accepts young men aged 16 - 17 in an emergency when there are no children and young people's services beds available.

Springrise is a 18 bed acute assessment ward based at Hopewood Park, Sunderland.The service is for men over the age of 18 years with a mental illness who require assessment and treatment in hospital.

Beckfield is a 14 bed Psychiatric Intensive Care Unit (PICU) based at Hopewood Park, Sunderland. A Psychiatric Intensive Care Unit is a type of psychiatric inpatient ward. These wards are always locked, the entry, and exit is controlled by the nursing staff. The service is for men and women over the age of 18 years detained under The Mental Health Act (1983) who are experiencing a relapse or crisis and require a period of intensive secure care until they can return to an open inpatient unit.

This was the first inspection by the CQC under the current methodology.

Summary of findings

Our inspection team

Chair: Paul Lelliott, Deputy Chief Inspector (Mental Health), Care Quality Commission

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Jennifer Jones, Inspection Manager (Mental Health) Care Quality Commission

Sandra Sutton, Inspection Manager (Acute) Care Quality Commission

The team inspecting the acute and PICU inpatient services comprised one inspector, two consultant psychiatrists, four registered mental health nurses, and one occupational therapist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited 11 acute wards and one psychiatric intensive care unit and looked at the quality of the environment
- spoke with the managers for each of the services
- spoke with 36 patients and two carers whose relatives or friends were using the services
- spoke with 111 other staff members; including doctors, nurses, psychologists, occupational therapists, exercise therapists, activity workers, discharge facilitators, pharmacists and support workers
- attended and observed a 72 hour meeting, a discharge meeting, two breakfast clubs, five multidisciplinary meetings, and an occupational therapy group
- collected feedback from 11 patients, carers, and staff using comment cards.
- looked at 34 treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients were given the opportunity to provide feedback on the service they received prior to our inspection via comment cards left on the wards. We received 11 completed comments cards from patients. Eight of the comments were positive. Patients commented that staff were kind and helpful, and that they treated patients with

Summary of findings

respect. Negative comments related to there not being enough staff to run activities and enable patients to take leave. One comment referred to a member of staff who was rude. We looked at the complaints record and saw that staff performance had been raised through supervision.

We held focus groups and 11 patients attended those and told us they felt staff attitude was a problem, saying they can be rude / abrupt at times but one patient described staff as 'fantastic'. All but one patient felt they were listened to by staff and had regular 1:1s. A few patients commented on how some staff forget things, i.e. they forget that you requested something or forget to pass it on to the next shift. Other patients told us they saw their doctor regularly and could speak with them on request.

We spoke with 36 patients across all 12 acute and psychiatric intensive care wards about the care and treatment they received. Overall, patients spoke very positively about the staff on all of the wards.

We spoke to two patients who did not know if they had a care plan. Others could not tell us if they had been involved in the development of the care plan.

Good practice

On the wards at Hopewood Park the pharmacist, ward manager and consultant held a weekly meeting to look at prescriptions of the patients. The object of the meetings was to remove any 'as required medication' that had not been used in 14 days, to review the anti-psychotic medication and if possible change it or reduce the dose. They also used the opportunity to look at general health and mental health pharmacy issues to ensure medications did not react with one another.

The ward manager from the psychiatric intensive care unit had implemented a prevent management of violence and aggression reflection group. This was a weekly meeting open to all staff on site. The meetings were an opportunity to discuss specific cases, incidents, and care plans for new patients. It was also an opportunity to reflect on practice and share lessons learned.

Areas for improvement

Action the provider SHOULD take to improve

The trust should review the use of mechanical restraint as an intervention in the management of violence and aggression in acute and psychiatric intensive care unit services.

The trust should review the use of prone restraint within their services and look at how they can bring their practice in to line with the MHA Code of Practice.

The trust should ensure that care plans are person centred.

The trust should ensure that oxygen cylinders are checked regularly

Northumberland, Tyne and Wear NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Collingwood Court Gainsborough Ward Lowry Ward	Campus for Ageing and Vitality
Fellside Lamesley	Queen Elizabeth Hospital
Alnmouth Ward Embleton Ward Warkworth Ward	St Georges Park
Longview Ward Shoredrift Springrise Beckfield PICU	Hopewood Park

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.

Staff attended mandatory training in the Mental Health Act, with the overall compliance rate across the acute and

psychiatric intensive care unit services being 94% at the time of inspection. The trust had a Mental Health Act office and staff knew how to access them for support and guidance.

Some of the consultants within teams were approved under Section 12 of the Mental Health Act to undertake Mental Health Act assessments.

Staff knew how to access advocacy services for patients should they be required.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance with this was 93% at the time of inspection.

Staff had a good working knowledge of the Act and patient records showed that staff continually assessed patients' capacity. Staff felt they supported people to make their own decisions where possible by ensuring they involved the families and carers.

Staff worked with independent mental health advocates and independent mental capacity advocates to ensure patients had an independent person to discuss their wishes with.

Staff could give clear examples of when they had needed to assess a patients capacity and understood that an assessment of capacity was decision and time specific.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

All of the wards visited were clean and well maintained with the exception of Gainsborough Ward. Whilst Gainsborough was clean the décor was tired and looked unsightly. The trust had acknowledged that this ward was no longer fit for purpose. We noted on four wards the wall covering in the seclusion room had bubbled. We identified this issue to the ward managers and they took immediate action to ensure the wall covering could not be removed and used by patients to self harm. The company that provided the wall covering was in the process of repairing or replacing those walls identified as a problem. We were told it would take about two months to ensure all the walls had been examined and repaired All of the wards had a monthly cleaning audit and they all scored between 95-99%.

PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and included at least 50 per cent members of the public (known as patient assessors). They focused on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. The ancillary staff were employed by the trust and each ward had a dedicated team that were supervised by a housekeeper.

In relation to cleanliness, the 2015 PLACE score for Northumberland Tyne and Wear NHS Foundation Trust is at 99%. This is 2% above the England average of 97%.

Safe staffing

The trust provided data on the total number of substantive staff working on each of the wards:

Collingwood Court : 30 whole time equivalent

Alnmouth: 32 whole time equivalent

Gainsborough Ward: 29 whole time equivalent

Warkworth Ward: 32 whole time equivalent

Embleton Ward: 30 whole time equivalent

Beckfield PICU: 52 whole time equivalent

Lowry Ward: 26 whole time equivalent

Longview: 33 whole time equivalent

Shoredrift: 33 whole time equivalent

Springrise: 33 whole time equivalent

Fellside: 29 whole time equivalent

Lamesley: 32 whole time equivalent

Data showed that eight wards were above the trust average vacancy rate with Lowry Ward having the highest qualified nurse vacancy rate of 28.57% and is above the trust average of 13.95%. None of the wards were above the trust average of 9.21% for nursing assistant vacancy rate. Lamesley had zero vacancies for both qualified nurses and nursing assistants.

During the inspection ward managers confirmed they had vacancies but there had been several recruitment hub days and they had filled their vacancies. However, the majority of staff appointed were not starting until September or October and would be preceptorships. Preceptorship is 'a period of transition for the newly qualified registrant during which time he or she will be supported by a preceptor to develop their confidence. One ward had five preceptorships starting in October. The manager was aware of the difficulties and was working with their line manager to ensure they could manage both the work on the ward and the preceptorships.

All of the wards had a manager and they were supported by four clinical leads. They told us the staffing levels were determined by the acuity on the ward. Managers and band six nurses were able to increase the staffing levels if patients needs warranted it. This meant wards were not waiting for approval before staffing to meet need.

The acute wards worked the same shift pattern of a morning shift starting 07:30hrs,an evening shift which started at 12:30 and a night shift starting at 20:30hrs.

Minimum staffing numbers for each shift on these wards was:

Morning shift: two qualified staff and two support workers

Late shift: two qualified staff and two support workers

Good

Are services safe?

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

Night shift: one qualified staff and three support workers

On the psychiatric intensive care unit the qualified staffing levels were the same as the acute wards. They had between five and six support workers on each shift as a minimum requirement.

The trust provided data on the number of shifts covered by bank or agency staff in the three month period between February 2016 and April 2016. Embleton Ward had the highest use of bank or agency staff with 315 shifts covered by bank or agency staff. Longview had the most shifts at 49 that had not been covered with bank/agency staff.

The trust had a pool of staff that were working for the trust and were in a position to take on extra shifts. There was also a bank of people who could also be accessed to cover extra shifts and they had previously worked for the trust. All of the ward managers told us they would try to access staff from the pool and bank before going to agency. The ward managers told us they had the autonomy to organise extra cover on the ward if the acuity levels determined they needed extra staff.

Embleton Ward had the highest use of bank and agency staff due to having several members of staff on long term sick. Their absences were due to physical health issues and were not stress related.

All patients had a named nurse. Patients also had a named member of staff allocated each day from the available staff on duty. The rotas on all wards showed that there was protected 'patient engagement time' of one or two hours each day. Patients told us this meant they had definite time they could spend with their named nurse and they appreciated this. We observed staff interacting with patients at all points of the day during our visits.

Section 17 leave had not been cancelled in the last three months due to staffing shortages. When it had been cancelled, it was due to a change in the patient's presentation. Each morning at the multidisciplinary meeting, issues around leave for the day and other health and social appointments were discussed and organised for the patients.

Consultants and junior doctors worked a seven-day rota. This meant that patients who were admitted over night or on a weekend could access treatment and assessment in a timely way. One ward manager told us that if they had someone admitted on a Friday evening they were able to see the doctor and commence treatment on the day they were admitted and they may be suitable for discharge or moving to another ward on the Monday.

All staff were required to undertake a suite of mandatory training. The average mandatory training rate for staff across the acute wards and the psychiatric intensive care wards as of 23 May 2016 was 92%. This was above the trust compliance target of 85%. Embleton Ward and Fellside had the highest percentage of trained staff with an overall training rate of 95%. Collingwood Court and Lamesley had the lowest rate of training at 89%.

Records and record keeping training had the highest rate of completion with 100%. Care pathways had the lowest aggregate training score with Shoredrift scoring the lowest for this course with 63%. All of the ward managers told us that the care pathways course was no longer available to staff.

Assessing and managing risk to patients and staff

Staff used the Function Analysis of Care Environment to assess risks. This was in line with the Department of Health Best Practice in Managing Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Service Document 2009**.** Staff carried out risk assessments upon admission and updated them regularly. We reviewed 34 patient care records. We found completed risk assessments in all but one record we reviewed.

The trust had an observation policy and staff understood their responsibility when carrying out observations. There were four levels of observation; general where patients were observed on an hourly basis, intermittent so staff engaged with a patient every 30 minutes, within eyesight so a member of staff always had to be able to see the patient and within arm's length, this was the highest level of observation and staff had to be within touching distance of the patient. The level of observation was determined by staff from the presentation of the patient and their risk assessment. The trust policy outlines that observations should be used as a period of positive engagement where possible rather than an intrusive action. During the inspection we observed staff carrying out observations in a positive way. They were respectful of the patient at all times.

Good

Are services safe?

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

Whilst all of the adapted wards had been made as ligature free as possible and the new wards had been designed to be ligature free we found that all of the wards had identified ligature points. These were on the ward and trust risk register. Where a ligature point had been identified staff used a variety of tools to ensure patients remained as safe as possible. We saw records where their mood and presentation were recorded on a daily basis and if their presentation had deteriorated they were put on to the next level of observations that were appropriate to their care. This meant that staff were aware of where patients who were most vulnerable were. We had received no notifications of any incidents of attempted suicide by ligature in the period 1 November 2015 and the 30 April 2016.

There was a trust searching policy. This document outlined what items were not allowed on the wards and items that may be used but were restricted in use so staff would hold these. Searches would be carried out only if staff were concerned about a risk to the patient or to the therapeutic environment. Staff would first speak to the patient and ask about any items they may have brought onto the ward. If this was unsuccessful the patient would be asked for their consent for staff to carry out a search. If the patient did not want to be searched and they were on a section of the Mental Health Act then a search would only be carried out following a multi disciplinary team meeting. All searches had to be reported on RIO. We saw evidence that staff followed the trusts policy when carrying out a search. The trust had its own drugs dog; this was a retired police dog and also visited as a patient therapy dog. The dog visited wards where staff had concerns that drugs had been smuggled on to the ward. One manager told us how they had discovered a patients drugs hidden in the grounds and another one where the patient had secreted drugs behind the covering of the bathroom wall. All of the managers told us that the drugs dog could not find new illegal highs and this was beginning to be an issue on the wards.

Prior to our visit the trust provided data on the use of restraint and seclusion. Between 1 November 2015 and 30 April 2016, there were 491 uses of restraint on 207 different patients. The highest number of restraints occurred on Beckfield, the psychiatric intensive care unit, (107 restraints). The trust told us “There were five patients who required frequent restraint totalling 51 of the 107 restraints. The number of restraints recorded had varied between the assessed need for a full restraint to a restraint requiring more of a de-escalation and distraction approach rather than a full restraint being required”. When we spoke to the manager of Beckfield they told us that the unit had been open for twenty months and that many of the patients had found the move initially to be stressful. Of these incidents of restraints, prone restraint had been used 44 times with 19 incidents of rapid tranquilisation. The use of prone restraint does not comply with the guidance in the Mental Health Act code of practice which states: “Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor”.

We did not see any advance directives from patients about how they wished to be treated when they were ill. Care plans did not appear to be person centred and we saw minimal patient involvement in the development of these plans.

Beckfield was followed by Longview having 51 episodes where restraint was used. On Springrise, they had used restraint only nine times in the same period.

Mechanical restraints were used in the trust. We saw evidence that mechanical restraints had been used eight times in the period 1 November 2015 and the 30 April 2016. We saw that the plans in place followed the trust policy ‘Safe Use of Mechanical Equipment’. The policy provided staff with a clear rationale of when mechanical restraint could be used. The policy stated:

“Mechanical restraint devices must only be used where the patient has a known history of absconding, combative and resistive behaviour and is presenting a threat of harm to self or others or if there is an immediate risk of significant harm if the equipment is not deployed”.

And

“Mechanical restraint devices must only be used where continued application of physical intervention techniques would place the patient and/or staff at increased risk of physical distress and/or injury due to evidence based documented risks associated with prolonged physical restraint”.

Care plans and records made by staff following the use of mechanical restraint showed that patients were being combative and resisting interventions by head butting the walls, spitting and punching staff and attempting serious

self harm. The application of the mechanical restraint equipment approved for use in the trust was handcuffs, soft-cuffs, and emergency response belts. The use of mechanical restraint was outlined in individual plans of care in response to a multi disciplinary risk assessment. Staff had to get approval to use mechanical restraint from their director and must provide evidence of the multidisciplinary discussions that reached the decision for use of mechanical restraint. We saw that the mechanical restraint equipment was used for the least possible time and that patients had a debrief following any incidents.

However, the national institute for health and clinical excellence guidance states that health and social care provider organisations should ensure that mechanical restraint is used only in high-secure settings. The trust should review the use of mechanical restraint as an intervention in the management of violence and aggression in acute and psychiatric intensive care unit services.

There was a trust policy on the use of rapid tranquillisation, this policy had been updated in February 2016 to take in to account NICE management of violence and aggression guidance NG10 (May 2015). Records contained evidence that staff were following the guidance when they used rapid tranquilisation. The policy stated that staff must be trained in immediate life support and that emergency medications should be available. Trust data showed that 83% of staff working in the acute and psychiatric intensive care units had received training in prevent management of violence and aggression, this training included immediate lifesaving skills. During our inspection ward managers were able to provide us with evidence that all staff at work had completed this training. All of the wards had an emergency bag and this contained oxygen and adrenaline for immediate emergencies. On several wards we found bottles of oxygen to be empty, half full or out of date. These bottles were replaced before we had finished the inspection.

We looked at 24 seclusion records. Patients were observed every 15 minutes and received two hourly checks. Many of the seclusion records covered times of less than eight hours but we did see evidence that an independent multi disciplinary team reviewed the seclusion where it was over eight hours. As soon as the patient was settled seclusion was ended. All of the seclusion rooms had ensuite facilities and in the seclusion room at Hopewood Park staff could use CCTV to monitor patients discreetly. During the inspection we witnessed a situation where, in order to care for a patient safely, staff needed to restrain a patient. The patient was restrained in the prone position twice, once to administer rapid tranquilisation medication and the second time to withdraw from the seclusion room. Our specialist professional advisor commented that staff had handled the incident in a professional manner and they treated the patient with dignity at all times. They told us the prone restraint lasted for 30 seconds each time, they said it had been used appropriately.

Staff held monthly 'positive and safe' meetings where they reviewed all incidents that had happened and reviewed them to see if they could improve their practice. These meetings included the ward managers and clinical leads from each ward. All wards held a review of any restraint, rapid tranquilisation or seclusion used with the staff who had been involved. The monthly meeting looked at instances from different wards as an overview.

All of the wards had a list of banned items these included aerosols, butane fuel canisters, mobile phones, plastic bags, sharps of any kind, cigarettes and e-cigarettes. Staff told us that patient were allowed their mobile phones as they improved and we saw patients with phones.

Most patients were detained under the Mental Health Act. We spoke to patients who were in hospital on an informal basis and they told us they could leave the ward as long as they told staff they were going out. We noted on several wards that the information board in the office indicated that informal patients had escorted leave. We explored these examples with staff and they were able to show us that each patient had been risked assessed and they had escorted leave because of physical health problems or they were vulnerable in the community without support.

We looked at the systems in place for medicines management. We reviewed 48 prescription records and spoke with nursing staff who were responsible for medicines.

Medicines were stored securely and were only accessible to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were stored appropriately and temperatures

Good

Are services safe?

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

were monitored daily in line with national guidance. We saw an example of appropriate action taken in response to the fridge temperature falling outside of the recommended range.

Prescription records were completed fully and accurately, and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act. 'When required' prescriptions contained relevant information to enable staff to administer them safely. On the wards at Hopewood the pharmacist, ward manager and consultant held a weekly meeting to look at prescriptions of the patients. The object of the meetings was to remove any 'as required medication' that had not been used in 14 days, to review the anti psychotic medication and if possible change it or reduce the dose. They also used the opportunity to look at poly pharmacy issues to ensure medications did not react with one another.

People with physical health problems received appropriate monitoring, for example physical observations and blood tests, in accordance with national guidance. We saw an example of a comprehensive care plan for a patient with diabetes, which contained detailed and personalised information about their management. Ward staff told us about the comprehensive support provided by the pharmacy team, which included a visit by a clinical pharmacist at least three times per week and attendance at multidisciplinary team meetings. An electronic medicines storage and management system was in use; this enabled the ward pharmacist to spend more time in patient-facing activities rather than being involved in medicines supply.

There were adequate supplies of emergency equipment, oxygen and defibrillators. Stocks of emergency medicines were kept as per the trust resuscitation policy, and a system was in place to ensure they were fit for use.

Staff had a good understanding and knowledge of safeguarding policies and procedures. Safeguarding training compliance on all wards was above the trust target of 85% at 95%. Staff were able to describe situations that would lead to a safeguarding referral. Staff knew the internal lead for safeguarding as well as the local authority safeguarding hub.

Track record on safety

There had been six recorded serious incidents on the acute wards and psychiatric intensive care unit between 1 January 2015 and 31 December 2015. Four of incidents relating to criteria set by the Commissioners. Another one related to a medication incident and one to an incident of self harm.

Reporting incidents and learning from when things go wrong

Staff on all the wards visited knew how to report an incident. There was a trust web form that could be completed by any member of staff.

During the period 1 April 2015 to 30 April 2016 4802 patient incidents were reported to the trust. Of these five were deaths, 16 involved major harm to a patient, 233 moderate harm, 1571 minor harm and 2977 no harm. The moderate and minor harm categories included 630 attempts at self harm by patients. Staff told us that after every incident there was an immediate debrief and in the case of a serious incident a further debrief after a few days to ensure staff did not feel overwhelmed. Patients told us that staff spent time with them after an incident and talked to them about what had caused the incident.

Ward managers had oversight of the incidents and determined what, if any, further action was required. We saw evidence that in several incidents disciplinary procedures had commenced. We saw a break down of incidents reported on the Beckfield psychiatric intensive care unit and these showed an increase in reporting but a decrease in the use of restraint or seclusion. The manager thought this was down to the way incidents were reported and that staff were comfortable reporting them.

Staff had a good understanding of the duty of candour and when they would use it.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Staff carried out comprehensive assessments of patients' needs upon admission. Assessment included a review of clinical needs as well as mental and physical health needs. A 72-hour formulation meeting took place after every admission. People involved included a consultant, a nurse, the discharge facilitator and the patient. The planning meeting started the discharge process and the community mental health team were invited to each meeting. We observed a 72-hour meeting and found that the patient was fully involved. Risks and the care and treatment were discussed and actions were minuted. The patient was included in the meeting and staff listened to what they wanted. Staff on other wards confirmed that 72-hour meetings took place for all patients.

We looked at 34 patient records. All patients had a care plan. However, we found the quality of the care plans varied. At the St Georges Hospital we saw that staff were reviewing the care planning process and were using a system called the 5P's which looked at purpose, patients, professionals, process and patterns of care planning. We found little evidence of patient involvement in 12 of the care plans we reviewed, however, we did find information about patient involvement in care planning contained in their progress notes. Ten of the patients we spoke to said they had discussed their care plans with their named nurse and were involved in the development of their plan. The care plans did not reflect this, however, the information was contained in the progress notes.

A multi-disciplinary meeting happened on each ward every day. We observed four meetings and found they were well structured and included individual risks. Members of the multi-disciplinary team included a consultant, an occupational therapist, nurses, a psychologist and a discharge liaison coordinator. They all contributed to the discussion. We saw that positive risk taking was taking place, for several patients whose acuity was high staff determined that the environment was affecting them. They were given escorted leave following the meeting and their agitation decreased. All staff demonstrated a good knowledge of individual patients and capacity was discussed and reflected on. Actions were created from the meetings and people were specifically appointed to those actions. The actions were checked each morning to ensure they were being implemented. All of the meetings were supported by an administrator.

Patients care records were electronic, although paper files still existed for detention paper work and letters. All patients had a functional analysis of care environments risk assessment.

We found that all of the 34 records seen contained a physical health examination and there was evidence that where necessary ongoing physical support was provided. Patients were escorted to appointments at the general hospital and staff organised dental care for patients who needed it.

The progress notes for each care plan we saw contained detailed information about activities, physical health checks, incidents and progress identified in the daily meeting.

Best practice in treatment and care

We reviewed 48 prescription records in detail and spoke to nursing staff who were responsible for medicines. We found that staff were adhering to national guidance from the national institute for health and clinical excellence when prescribing and administering medication.

Staff used a variety of evidence-based tools to assess and record severity and outcomes, which were undertaken on admission and then at regular intervals. Tools included the recovery star, the model of human occupation screening tool, the international personality disorder examination and the Wechsler adult intelligence scale.

Patients on all wards could access one-to-one psychology support. Psychology also delivered group sessions including a 'managing emotions group'. Staff told us that psychology was not provided long term as patients were only on the wards a short time. Strategies were provided to help patients manage their situations and if necessary further psychology support would be provided when they had been discharged.

Patients were assessed using the mental health-clustering tool on admission. This was developed in partnership between the Department of Health, the Royal College of Psychiatrists Centre for Advanced Learning and Conferences and the Care Pathways and Packages Project as a means of allocating clients to care clusters, which in

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turn supports care. The mental health-clustering tool incorporates the Health of the Nation Outcome Scales. These scales are the most widely used routine clinical outcome measure used by mental health services in England. Staff reviewed patients regularly in line with the mental health-clustering tool to provide ongoing monitoring of patient outcomes.

Skilled staff to deliver care

All wards had a manager who were responsible for the management of the ward. Clinical leads provided support for the manager. Registered mental health nurses and healthcare assistants worked on all wards. There was access to staff from a wide range of mental health disciplines. This included consultant psychiatrists, psychologists, dual diagnosis nurses, junior doctors, occupational therapists and activities coordinators. The trust pharmacy team visited every ward on at least a weekly basis. During our visit we noted that a pharmacist or pharmacy technician visited each ward daily.

The trust policy on rapid tranquilisation stated that 'all qualified registered mental health nurses working in areas who may be required to administer rapid tranquillisation must include as part of their mandatory training: immediate life support, including the use of oxygen, suction, defibrillation and anaphylaxis'. Immediate life support training was provided as part of the prevent management of violence and aggression training. Information provided by the trust showed that on Fellside only 74% of staff had completed the training. However, during our visit managers were able to evidence that most of their staff had completed the training and where staff had not completed the training they were either booked on to the course or were away from work due to sickness.

The trust policy on supervision stated that all qualified staff should receive supervision every four weeks. During our visit, managers were able to evidence why their supervision rates were not at 100% and this was due to staff being away from work due to illness or bereavement. Staff allowed us to see their personal supervision notes and they showed that supervision covered both managerial and clinical issues. Staff told us they found supervision valuable.

Data provided from the trust indicated that up to the 30 April 2016 appraisal rates were at 86% across all wards. We saw evidence to show staff being away from work due to illness or bereavement contributed to the low percentage of staff having had an appraisal.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings took place daily on all wards. This gave professionals involved in patient care the opportunity to discuss the treatment being provided and any possible changes. We observed five multi-disciplinary team meetings. A range of professionals attended the meetings. This included the consultant psychiatrist, clinical psychologist, doctor, occupational therapist, pharmacist, mental health nurse, the discharge liaison coordinator and charge nurse. We saw that the views of patients and in some cases, family members had been taken into account in the formulation of decisions about treatment. Patient care records contained a summary of the decisions made at the multi-disciplinary meeting.

We observed two staff handovers, which included everyone coming on duty for that shift. The staff member leading the handover provided an overview of all patients on the ward. This included a summary of the patient's general presentation, any leave or activities planned and issues with medication. New admissions onto the ward were also discussed. Each ward had three handover periods during the day one each morning and evening for day and on for night shifts. These were only 10 minutes long although staff did say that if the meeting took longer they did not leave the ward until this was finished. The main handover took place in the afternoon and took 30 minutes.

We observed a discharge meeting which was attended by the patients community psychiatric nurse, an advanced mental health practitioner, a consultant, the deputy ward manager, the occupational therapist and the patients relative. Plans for supporting the patient and their relative were made before the patient was brought in to the meeting. The community mental health nurse was going to discuss the discharge plan with the patient after the meeting to ensure they agreed to the plan.

Ward managers and other staff told us there were effective relationships in place with local safeguarding teams. Information was available to staff about who to contact and when to contact them. There was also information about police liaison offices who were known to the ward.

Are services effective?

Good

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

All patients were referred to the community mental health team at the 72-hour meeting and where there was no named worker a duty worker would sometimes attend this meeting. Not everyone had a care co-ordinator allocated. The community mental health or the crisis team carried out a seven-day follow up for discharged patients.

Patients were supported using the care Programme approach. 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. We observed a care programme approach meeting involving the patient, consultant psychiatrist, mental health nurse and social worker.

Adherence to the MHA and the MHA Code of Practice

Training in the Mental Health Act (MHA) was part of mandatory training for staff. Information provided by the trust indicated that 94% of staff on the acute and PICU wards had completed this training. This was above the trust average of 85%. Training had included the revised Mental Health Act code of practice. Staff told us there was a central office within the trust for advice on any issues relating to the Act.

Mental Health Act monitoring visits had taken place on seven wards between March 2015 and October 2015. In total, 39 issues had been identified with Warkworth ward having the most issues on a single visit. Most issues were in the category of purpose, respect, participation and least restriction with 16 issues. During previous Mental Health Act monitoring visits the following issues had been highlighted:

- section 17 leave forms either incomplete or old forms not being cancelled
- seclusion room records reviews these were not being completed properly
- capacity assessments were not being completed
- advanced mental health practitioner reports were not available
- care plans did not address Mental Health Act detention and treatment – discharge planning
- patients were not being read their rights
- independent mental capacity advocates or independent mental health advocates were not being provided for patients
- emergency equipment checks and immediate lifesaving training was not up to date
- care plans did not indicate that patients had been involved with their development.

These issues had been addressed at the time of our inspection, although the care plans were still a work in progress.

We looked at 34 care records and reviewed six sets of detention paperwork in detail. We found in all cases that detention records were accurate and up to date. At the time of the inspection all detained patients appeared to be under the appropriate legal authority. We saw that patients had been given their rights under the Mental Health Act upon admission and at regular intervals thereafter. Ten patients told us they were regularly read their rights and staff asked patients to confirm their understanding of what they were being told.

Section 17 leave forms were generated on the RIO system and only the most current form was available to view immediately, the lapsed forms were retained in the history of the file. We saw that staff carried out an 'egress and leave' risk assessment before any patient went on leave. We observed staff asking patients if their leave had gone well.

Staff told us that all detained patients were offered a referral to the independent mental health advocate. Five patients we spoke to confirmed they were in contact with the independent mental health advocate. During our visit we spoke with an independent mental health advocate and they felt that the profile of the advocacy service was not as high as perhaps it could be. This meant staff did not automatically refer to the advocacy service in the multi disciplinary meetings and so patients could be without advocacy at important meetings.

We found that in the records we reviewed, consent to treatment had been given.

Staff told us that all original copies of Mental Health Act paperwork were held in the central Mental Health Act office, where documentation was reviewed. This was subject to audit by a scrutiny panel.

Are services effective?

Good

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

Good practice in applying the MCA

Mental Capacity Act training was part of t mandatory training. The trust target for this training was 85% and 93% of staff on acute and PICU wards had completed this training. Staff were aware of the trust's policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the principles of the Mental Capacity Act and assumed patients had capacity to make their own decisions unless there was a reason to challenge this. Staff told us they held best interest meetings for patients. We saw records of this in the daily progress notes.

The trust made six Deprivation of Liberty Safeguards applications between 1 November 2015 and 30 April 2016 No-one was on a deprivation of liberty safeguard during our inspection.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 36 patients receiving care and treatment. Observation of the interactions between staff and patients happened throughout our inspection. Staff spoke to patients in a kind and caring way. Patients told us that staff were kind, caring and respectful. Staff usually knocked before entering bedrooms for example.

Patients told us that staff had time during the day to speak with them. Most of the patients knew who their named nurse was. We observed staff speaking with patients whilst we were on the ward.

We observed one incident where a patient was becoming disruptive and trying to leave the ward. Staff responded to this situation very quickly, they initially used verbal de-escalation techniques but had to use physical restraint and eventually medication to help calm the patient down.

Throughout the incident, staff treated the patient in a calm and respectful manner. The patient was debriefed following the incident.

Patients told us about the community meetings that happened on the ward. They said this gave them the opportunity to contribute to what happened. We saw minutes to support this. We witnessed two breakfast groups where patients were supported to make their own breakfast.

Twelve of the patients we spoke with told us they thought the wards were understaffed as they couldn't access leave to have a cigarette. Records showed that where leave had been cancelled it was due to the acuity of the patient changing and staff had assessed they were not fit to go out.

The involvement of people in the care they receive

All of the wards had a clear admission process which included orientating new patients onto the ward. We saw copies of the welcome pack for new patients on all of the wards. This information was also available on the trust website. All patients were given an orientation tour of the ward either on admission or as soon as they were well enough to retain the information. On Embleton Ward the manager had put a written and pictorial admission process on the wall so patients who found it difficult to engage with staff could still access the information. The information was laid out from admission to discharge.

PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Northumberland, Tyne and Wear NHS Foundation Trust is 92, which was above the England average of 86.

We saw information boards on the wards, and each ward had a board with photographs of staff so patients could clearly see who worked on the ward and what their role was.

We reviewed 34 care records and found these varied in quality, 10 care plans did not appear to have any patient involvement. However, 24 of the patients we spoke to told us they had been involved in the development of their care plan. Other patients could not remember whether staff had spoken with them or not. The wording in the care plans did not indicate that patients had been involved but the records in the progress notes demonstrated they were.

All detained patients had access to an independent mental health advocate. An automatic referral to the independent mental health advocate was made by the central MHA administration office in the trust. Most of the detained patients we spoke to confirmed that they had seen and spoken to an independent mental health advocate.

Weekly community meetings took place on each ward. This provided patients with an opportunity to raise and discuss issues. We saw minutes of these meetings and the content included a reminder of the smoking policy, visiting hours and what patients were allowed to bring onto the ward. Patients were asked what activities they would like to do. Alnmouth ward had a 'comfort box' and this was brought into the meeting. This contained items that might be used by patients to help calm them when they were feeling anxious or agitated.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy rate between 1 November 2015 to 30 April 2016 was 90%. Bed occupancy rates varied between the wards. Lowry Ward and Longview had the highest occupancy level at 101% and Fellside had the lowest occupancy rate of 68%.

Ward managers told us they risk assessed the patients who went out on leave and alerted the bed managers that a bed rated as red could not be used. A leave bed for a patient who had been risk assessed as managing leave positively was rated as 'green' and the bed manager could use that bed. This meant that most of the patients who needed to return from leave early could do so and they returned to the ward they had left. They told us this allowed them to manage patients care in a positive way.

There was a bed management team in place and it was their job to coordinate admissions to the wards. They told us that patients only moved wards for reasons of acuity or safeguarding. Wards also had discharge coordinators who managed arrangements for patients who were being discharged.

Information provided by the trust showed that the average length of stay on an acute and /or PICU unit was 32.5 days. Gainsborough Ward had the longest average stay of 48 days and Beckfield PICU it was 23 days.

There were 158 readmissions, within 90 days of discharge, to the wards between the 1 November 2015 and 30 April 2016. Lamesley Ward had the highest number of readmissions at 23 whilst Gainsborough Ward had the lowest at four.

The trust provided data on delayed discharges. Between 1 November 2015 and 30 April 2016, there were 31 delayed discharges. Fellside had the highest rate of 16 delayed discharges and there were five wards with no delayed dischages.

Delays were due to limited access to appropriate services. There were six out of area placements at the time of our inspection. The bed manager told us these had been made because of the complexity of care needed and there were plans to bring them back in to trust accommodation.

The facilities promote recovery, comfort, dignity and confidentiality

The range of facilities varied significantly across the wards. All wards had a clinic room to examine patients. Most wards had a suitable range of rooms for patients to have one to one time with staff and meet with visitors. The faith room was used for visits, CPA meetings and other meetings.

Patients on all wards with the exception of PICU could use their own mobile phones. There was access to a telephone on the wards for those patients who did not have a mobile phone.

Patients had access to their bedrooms during the day. Patients could have a key to their own bedroom dependent on an assessment of risk. Some patients asked staff to lock their rooms, we saw that staff were able to unlock the doors quickly after a request from the patient. Patients on all wards were able to secure personal or valuable possessions in a lockable unit in their rooms.

All wards had outdoor space, which patients could access. Patients in seclusion on the psychiatric intensive care unit could also access secure separate outside space at the back of the ward. The wards had CCTV in all the communal areas, which meant staff could observe patients at a distance. The seclusion room on the psychiatric intensive care unit also had CCTV but it did not record the patients whilst they were in seclusion. This allowed staff to monitor patients whilst allowing them space.

We saw copies of weekly activity schedules on all the wards. The occupation therapy department organised a selection of activities including a closed art group off the ward, a brunch group, managing emotions, pool tournaments, quizzes, cooking, board games, tennis and access to a gym. At Hopewood park a garden area was being used for a group who wanted to grow their own vegetables. Occupational therapy staff were aware of the risks to each person, they kept up to date by either attending the morning meeting or checking RIO. We observed several craft groups and a woodwork session and we saw patients were positively engaged. It was noted that staff did not keep a log of scissors and knitting needles that were used in the sessions. The woodwork room was found to be untidy with tools left on the floor and not stored correctly. Each ward had an activities organiser and

Are services responsive to people's needs?

Good

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

patients also had access to the exercise therapy team. This team consisted of staff who had a sports science degree and were registered with the British Association of Sport and Exercise Science.

Warkworth Ward was trialling a sensory approach for inpatient psychiatric settings. They had a chill out room which was a space away from the ward. The room had bean bags, a radio, books, mindfulness books, art equipment and a chair that almost wrapped itself around the person sitting in it. Staff told us patients had responded positively to the room.

Several wards had a peer support worker and their role was to spend positive engagement time with the patients and worked a seven day rota. They were able to facilitate leave and helped with keeping in contact with family and friends.

All wards had locks on the main entrances with entry and exit controlled by staff. Staff provided informal patients with information about their rights to leave the ward. We spoke to one informal patient to confirm they were aware they could leave the ward at will.

Most of the patients we spoke to said there was a good choice of food and the quality was good. The only negative comment about food was that the portions were sometimes too small.

Patients could access drinks and snacks whenever they wanted, fruit was available in the communal areas of the wards.

Meeting the needs of all people who use the service

All of the wards provided some facilities for patients with physical disabilities.

We saw a wide range of information leaflets on the wards, printed in English. This included information on how patients could complain if they were not happy with the service. Staff told us they could access translation services and interpreters as and when required. Foreign language information leaflets would be printed when needed. At Hopewood Park, the wards had a touch screen for information in the front entrance. This provided information in a variety of languages including but not exclusive to; Polish, Urdu, German, Hindi, Greek and a video explaining things in sign language. We saw from care plans that interpreters had been used in multi-disciplinary meetings, 72-hour meetings and discharge meetings.

Patients had a good choice of hot and cold food. This included healthier options, gluten free and vegetarian choices. One patient told us that staff had organised a halal diet for them. If a newly admitted patient needed a special diet, staff arranged this. The assessment process included dietary requirements. We saw evidence that where patients had determined they would eat only certain foods staff supported them with this. Staff continued to work with patients and a dietician to ensure their diets were not detrimental to their health.

Patients could access a faith room on all sites, these were on the ward or in other places on the hospital site. Each ward had a faith box, this contained copies of the major religious books such as the bible and the Koran. There were also items that related to humanists, Buddhist, Jews and people of other faiths. A chaplain visited the wards on a regular basis and they worked with people of other faiths to ensure patients received the spiritual support that was important to them. We observed patients of different faiths celebrating their faith.

Patients who identified as lesbian, gay, bisexual or transgendered were treated with respect. We saw evidence that advice had been sought from the gender clinic, and networks supporting gay people. Staff were clear when asked that patients would be treated on the ward of their identified gender if they required hospital treatment. Although staff were not sure if there was a policy to support this.

Listening to and learning from concerns and complaints

There was information displayed on the ward, informing patients of the complaints process. Information on complaints was also contained in the ward welcome packs. Patients told us they knew how to make a complaint. However, some patients said that although they understood the process, they would not feel comfortable complaining about the ward. When patients did not feel they could complain they told us they would speak to their family or their advocate. Patients who had complained told us that staff had dealt with the complaint appropriately; several said they had received apologies following a complaint.

Staff knew how to handle complaints appropriately and in line with the trust policy.

Are services responsive to people's needs?

Good

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

The trust acute and psychiatric intensive care unit wards received 30 complaints between the period 1 November 2015 to 30 April 2016. Six complaints were fully upheld and seven partially upheld. One complaint had been referred to the parliamentary and health service ombudsman. The complaints covered topics such as: the smoking ban, assault by a patient, attitude of staff, medication, and all aspects of restraint. We saw that appropriate investigations had taken place. When a complaint had been upheld we saw the actions taken by staff to ensure it was not repeated.

The core service received eight compliments in the period 1 January 2015 and 30 April 2016. Springrise and Lamesley each received two and Alnmouth, Beckfield, Shoredrift and Embleton each received one.

Are services well-led?

Good

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

Our findings

Vision and values

The trust vision was to provide the best care, delivered by the best people, to achieve the best outcomes. The values were caring and compassionate, respectful and honest and transparent. All staff spoken with knew and understood the vision and values. Ward managers told us that the recruitment of new staff was based on the vision and values. Managers were invited to recruitment days, patients also attended and they assessed the behaviours and interactions against the vision and values. All ward managers felt that it had been a positive experience and they had been able to identify staff they wanted and didn't want. This meant they knew that people coming to work with them shared the trusts vision and values.

We observed staff working in a way that promoted good care and acted with professionalism. Staff interactions with patients were compassionate and kind. Staff spoke very strongly about good team working on the wards. Ward managers and clinical leads on all the wards were identified as being supportive and effective leaders.

The ward managers told us that they were supported by their clinical manager and service manager. All of the managers told us that these managers were accessible and visited the wards daily, not necessarily for anything other than to check out how staff on duty were. Staff confirmed what the managers told us and said they also worked hands on if they needed extra support. Staff also knew who the senior managers were for the acute and psychiatric intensive care unit services and told us they also visited the wards on a regular basis.

Good governance

Across all wards, we found that mandatory training was above the trust compliance target. Staff received regular supervision and appraisals. Recruitment days held meant that many of the vacancies had been filled, although many of the new starters due to their nursing course could not start until September. Basic cognitive behavioural therapy and dialectic behavioural therapy training had been provided to staff and staff were supported to further training. This included training a support worker in phlebotomy, providing nurse training for support workers, degree qualifications for nurses and providing secondment opportunities to work in different core services. Staff had protected engagement time each day so that they had space to spend time with the patients on each shift. Activities for patients on all of the wards were provided six days a week.

Mental Health Act documentation was in order and staff knew that the central office for MHA reviewed these. We saw evidence of risk assessments being undertaken prior to leave being granted.

Each ward had its own risk register and these items were escalated to the organisational risk register through the service managers. The risks were reviewed on a regular basis. We saw several risk registers and noted that one of the risks identified was ligature points. These were mitigated with clear actions to be taken by staff to mitigate the risk. When the risks were reviewed they were rated either low, medium or high and most of the risks were rated as low to medium.

Incidents, accidents and safeguarding issues were dealt with in line with trust policy. Staff knew who to contact when there was an issue around safeguarding and there were police liaison officers to call for advice when needed. All incidents could be reported by any member of staff via a web form on the staff intranet. We saw evidence that lessons were shared and learned following incidents.

Patients and staff knew how to make a complaint. Where a complaint had been upheld there was an action to follow, several patients told us they had received apologies and we were made aware of several disciplinary issues as a result of a complaint.

Leadership, morale and staff engagement

Staff understood the whistleblowing policy and knew who to contact, however each member of staff spoken with told us they felt able to speak to their manager if they were unhappy with anything.

Sickness rates varied between wards. Three wards had sickness rates higher than the trust average of 5.4%. These were Longview 8.52%, Fellside 9.27% and Embleton 8.52%. On the wards that had been identified as having high rates of sickness managers told us that staff had been away from work due to physical injuries and bereavements, none of which were work related. Patients who spoke to us told us that staff were available to spend time with them.

Prior to our inspection; the trust had been in the position of closing Gainsborough Ward but three weeks before the

Are services well-led?

Good

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

ward was due to close the trust implemented a staff engagement process and the ward remained open. Staff told us they had applied for and got different jobs within the trust and could identify where they were going to work. However, staff told us that the management had decided to carry out a consultation about the process to determine where the service they were going to close would be best provided. This meant that everything was put on hold. Staff did not feel as if they had been kept informed through this process and were finding it very stressful.

Ward staff spoke very positively about the support and leadership of ward managers. Ward managers were passionate about their jobs and the wards they managed. They told us that they received positive support from their line managers and were able to manage their ward with confidence.

All staff told us that they knew who their senior managers were and were confident that if they raised any concerns with them they would be dealt with appropriately. All staff that contributed to the care and support provided to patients on the wards told us they all worked together and the teams were supportive. This included the involvement of senior management.

Staff told us they did not feel part of the transformation programme that was happening throughout the service. Staff of all grades at the Hadrian clinic told us they felt like they were in limbo as one of the wards had expected to close in April 2016, this was delayed and a consultation started. Staff did not feel included in this process.

We saw minutes of team meetings, and 'snap chat' postcards that informed staff of any incidents and what lessons could be learnt from them. Staff on all wards told us they always reviewed their practice when using restraint or seclusion to see if they could have managed anything differently. We saw evidence of reflective groups happening for staff on a regular basis. These groups were not mandatory but something staff could attend if they felt they needed to discuss any incidents from their ward.

We saw records to show that staff received monthly supervision and this combined both clinical and managerial issues. Information provided by the trust showed that from the period February 2015 to April 2016 five staff were either suspended or on supervised practise as a result of a complaint by a patient or poor practice identified through supervision.

Clinical audits took place across the service. There were monthly case file reviews, the mental health documentation was audited weekly, the emergency equipment was audited weekly along with prescription charts. This was not an exhaustive list of audits.

Wards were monitored on a range of measures, including staffing levels, training, supervision and appraisals, bed occupancy, delayed discharges. Areas rated as requiring attention were added to the ward risk register and someone from the ward took responsibility to ensure identified actions took place.

Commitment to quality improvement and innovation

At the time of the inspection seven of the wards visited were fully accredited through the Royal College of Psychiatrists' accreditation for inpatient mental health services programme. The accreditation for inpatient mental health services is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards.

All of the wards were taking part in the 'Safe Wards' initiative. This is where staff look at areas of conflict on the ward and how they may be managed differently. They also look at how they approach patients.

Warkworth Ward were trialling a sensory approach for inpatient psychiatric settings. This approach was based on the Sensory Modulation Tool (Wilbarger, Williams, Shellenberger).

The ward manager from the psychiatric intensive care unit had implemented a prevent management of violence and aggression reflection group. This was a weekly meeting open to all staff on site. The meetings were an opportunity to discuss specific cases, incidents, and care plans for new patients. It was also an opportunity to reflect on practice and share lessons learned.

All of the wards had either been accredited by the The Accreditation for Inpatient Mental Health Services (AIMS) schemes or were awaiting results of the accreditation process. AIMS is a set of standards developed by the Royal College of Psychiatrists' to improve standards across mental health provision.