Northumberland, Tyne and Wear NHS Foundation Trust

Inspection report

St Nicholas Hospital
Jubilee Road, Gosforth
Newcastle Upon Tyne
Tyne and Wear
NE3 3XT
Tel: 01912466800
www.ntw.nhs.uk

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

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

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

Ratings

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

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

Summary of findings

Background to the trust

Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing over 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totalling 2,200 square miles. Northumberland, Tyne and Wear NHS Foundation Trust have a total of 14 registered locations and became a foundation trust in December 2009. The trust had an annual income of over £316 million in 2016/17.

The trust operates from over 60 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. In addition, the trust provides a number of regional and national specialist services. The trust provides services commissioned by six clinical commissioning groups and specialist services commissioned by NHS England.

The trust provides 11 core mental health services:

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

• Child and adolescent mental health wards

• Forensic inpatient/secure wards

• Long stay/rehabilitation mental health wards for working age adults

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

• Wards for people with learning disabilities or autism

• Wards for older people with mental health problems

• Community based mental health services for older people

• Community mental health services for people with learning disabilities or autism

• Community based mental health services for adults of working age

• Specialist community mental health services for children and young people

The trust provides the following acute care services:

• Medical care and outpatient services

• Community health services

The trust also provides the following services:

• Substance misuse services

• Adult social care (Easterfield Court)

The trust delivers services from 14 registered locations:

•Easterfield Court:

•Elm House:

•Queen Elizabeth Hospital:

•Rose Lodge:

•Royal Victoria Infirmary:

Summary of findings

•St George's Park:

•Hopewood Park:

•Walkergate Park:

•Brooke House

•Monkwearmouth Hospital:

•Campus of Ageing and Vitality:

•Northgate Hospital:

•Ferndene

•St Nicholas Hospital:

We carried out our first comprehensive inspection of the trust in June 2016. The trust was rated as 'outstanding' overall and rated as 'outstanding' in the effective, caring, responsive and well-led domains and 'good' in the safe domain. The trust was issued with two requirement notices as we found the trust did not comply with regulation 9 (person centred care) and regulation 12 (safe care and treatment).

We carried out a focused inspection of acute and psychiatric intensive care wards and long stay rehabilitation wards in May 2017, inspecting against the safe and effective domains. There were no changes to ratings following this inspection.

Overall summary

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

What this trust does

Northumberland Tyne and Wear NHS Foundation Trust is a provider of inpatient and community mental health services, acute services, community health services and an adult social care service.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

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

The four core services we inspected as part of our continual checks on the safety and quality of healthcare services were:

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

Summary of findings

•Child and adolescent mental health wards

•Specialist community mental health services for children and young people

•Wards for older people with mental health problems

The trust provides the following core or additional services which we did not inspect:

•Forensic inpatient/secure wards

•Long stay/rehabilitation mental health wards for working age adults

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

•Wards for people with learning disabilities or autism

•Community based mental health services for older people

•Community mental health services for people with learning disabilities or autism

•Community based mental health services for adults of working age

•Medical care and outpatient services

•Substance misuse services

•Adult social care (Easterfield Court)

All these core services have previously been inspected and rated as part of our comprehensive inspection programme.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led?'

What we found

Overall trust

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

- We rated effective, caring, responsive and well-led as outstanding, and safe as good. We rated nine of the trust's 15 services as outstanding overall and six as good. In rating the trust, we took into account the previous ratings of the services we did not inspect this time.
- We rated well-led for the trust overall as outstanding. The leadership, governance structures and culture within the trust were used to effectively drive and improve the delivery of high quality person-centred care. Leaders had a comprehensive understanding of the challenges faced by the trust and worked collaboratively to develop solutions.
- Leaders strived to continually review and improve services. The collective leadership model and operational locality delivery structures meant that staff were empowered to drive improvement at all levels of the organisation. Innovation and new initiatives were celebrated both within the trust and externally.
- The quality of performance data was outstanding. Staff at all levels had access to a wide range of real time data which was used to actively inform and shape how services were delivered and how care was provided. Staff on child and adolescent mental health wards used data to change practice. This had resulted in reduced use of restrictive physical interventions for patients.
- Staff maintained high compliance rates for mandatory training.

Summary of findings

- There was an open incident reporting culture. Staff knew how to report incidents and there was evidence of learning from these. Staff received debriefing after serious incidents. There were comprehensive arrangements and procedures to safeguard children and young people. Staff in all services inspected demonstrated a good understanding of safeguarding and knew how to protect patients from abuse and report any concerns appropriately.
- Child and adolescent mental health wards and specialist community mental health services for children and young people had a truly holistic approach to assessing, planning and delivering care and treatment to patients. Patients had access to an extensive range of evidence based interventions. Staff worked consistently to ensure patients lived healthier lives and developed individualised approaches to meeting the physical and mental health needs of patients.
- The trust worked collaboratively with other organisations to ensure the highest provision of care for patients. This included facilitating training by specialists to enable staff on the wards to deliver the best care and treatment possible, particularly for patients with complex needs. Staff on inpatient mental health wards worked closely with community teams to facilitate effective discharge pathways for patients. The trust was working collaboratively with commissioners and staff to design specialist community based services for children and young people to prevent admission to hospital.
- Feedback from people who used the services, those who are close to them and stakeholders were continually positive about the way staff treat people. People said that staff go the extra mile and care exceeded expectations.
- There was a strong and visible person centred culture. Staff in all services we inspected were highly motivated to offer care that was kind and promoted people's dignity. Relationships between staff and people who used services and their carers were supportive and caring.

However:

- The trust acknowledged there was more work to do to review restrictive practices including blanket restrictions across all inpatient services. The trust identified this was an area of development. Whilst there was evidence of significant reduction in the use of mechanical restraint and every use was based on individual risk assessment and subject to director level authorisation, this intervention in the management of violence and aggression was still being used.
- Staff appraisal rates were slightly below the trust target. Whilst there was no trust target for clinical supervision rates, some services had lower levels of clinical supervision. There were delays in staff receiving formal written outcomes following disciplinary and grievance procedures.
- In acute wards for adults of working age and psychiatric intensive care units, staff were not always monitoring the physical health of patients after rapid tranquilisation. Seven of these wards did not have nurse call alarms.
- Waiting times for treatment in community specialist mental health services for young people did not always meet the trust target of 18 weeks for certain specialist treatment pathways.

Are services safe?

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

- We rated 14 of the 15 core services as good and one as requires improvement. The rating of the safe domain had improved from requires improvement to good in child and adolescent mental health wards, but the rating had gone down in the safe domain from good to requires improvement in acute wards for adults of working age and psychiatric intensive care units. We took into account the previous ratings of services we did not inspect this time.
- On child and adolescent mental health wards and wards for older people with mental health problems, there was an impressive use and analysis of incident data which staff used to change practice. This had resulted in reduced use of restrictive physical interventions for patients.

Summary of findings

- Staff on wards for older people with mental health problems managed and administered medicines safely. Wards had dedicated pharmacy support.
- Staff maintained high compliancy rates with mandatory training.
- There was an open incident reporting culture. Staff knew how to report incidents and there was evidence of learning from these. Staff received debriefing after serious incidents.
- There were comprehensive arrangements and procedures to safeguard children and young people. Staff in all services inspected demonstrated a good understanding of safeguarding and knew how to protect patients from abuse and report any concerns appropriately.
- Staffing levels were sufficient to meet needs of patients and staff had appropriate skills and knowledge. On child and adolescent mental health wards, the level of bank and agency staff usage and shifts left unfilled had significantly reduced since our last inspection.
- In community specialist mental health services for children and young people there were effective lone working procedures embedded.
- Staff assessed and identified mental and physical health risks and put plans into place to manage these.

However:

- In acute wards for adults of working age and psychiatric intensive care units, staff were not always monitoring the physical health of patients after rapid tranquilisation.
- In acute wards for adults of working age and psychiatric intensive care units, we found a number of blanket restrictions on some wards within this service and these were not being routinely reviewed. Seven of these wards did not have nurse call alarms.
- Whilst there was evidence of significant reduction in the use of mechanical restraint and every use was based on individual risk assessment and subject to director level authorisation, this intervention in the management of violence and aggression was still being used.
- Whist there was an effective process of triage, which enabled the trust to identify higher risk referrals, there was no system for routinely monitoring the risks of young people on the waiting list for treatment.
- Some risk assessments on wards for older people with mental health problems were brief and not dated.

Are services effective?

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

- We rated seven of the 15 core services as outstanding and eight as good. The rating of the effective domain had improved from requires improvement to good in wards for older people with mental health problems, and from good to outstanding in child and adolescent mental health wards. The rating of the effective domain remained outstanding in community specialist mental health services for children and young people and good in acute wards for adults of working age and psychiatric intensive care units. We took into account the previous ratings of the services we did not inspect this time.
- Child and adolescent mental health wards and specialist community mental health services for children and young people had a truly holistic approach to assessing, planning and delivering care and treatment to patients.

Summary of findings

- Patients in child and adolescent mental health wards and specialist community mental health services for children and young people had access to an extensive range of evidence based interventions. Staff worked consistently to ensure patients lived healthier lives and developed individualised approaches to meeting the physical and mental health needs of patients.
- Staff supported patients with complex needs on child and adolescent mental health wards by facilitating training by specialists to enable staff on the wards to deliver the best care and treatment possible.
- Staff on child and adolescent mental health wards and in specialist community mental health services for children and young people worked collaboratively with each other and with patients and their families. Young people were actively involved in reviewing their progress towards goals and outcomes.

However:

- On acute wards for adults of working age and psychiatric intensive care units staff were not consistently documenting assessments of mental capacity and best interest decisions.
- Staff on wards for older people with mental health problems did not always add written recordings of patients' physical health checks and dietary intake to the electronic patient care record in a timely manner.
- Staff in specialist community mental health services for children and young people assessed the competency of young people; however this was not always easily accessible within patient records.

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Are services caring?

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

- We rated eight of the 15 core services as outstanding and seven as good. We found caring had improved from good to outstanding in wards for older people with mental health problems. The rating for the caring domain remained good for acute wards for adults of working age and psychiatric intensive care units and child and adolescent mental health wards. The rating for the caring domain remained outstanding for community specialist mental health services for children and young people. We took into account the previous ratings of the services we did not inspect this time.
- Feedback from people who used the services, those who are close to them and stakeholders was continually positive about the way staff treat people. People said that staff go the extra mile and care exceeded expectations.
- There was a strong and visible person centred culture. Staff in all services we inspected were highly motivated to offer care that was kind and promoted people's dignity. Relationships between staff and people who used services and their carers were supportive and caring.
- Staff knew patients well and the emotional and social needs of patients were valued by staff and informed care and treatment.

However:

- Staff on child an adolescent mental health wards involved young people in their care and treatment, although this was not always reflected in care plans. On acute wards for adults of working age and psychiatric intensive care units, some care plans contained medical terminology which meant these may not be easily understood by patients.

Are services responsive?

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

- We rated six of the 15 core services as outstanding and nine as good. The core services we inspected this time remained rated as good. We took into account the previous ratings of the services we did not inspect this time.

Summary of findings

- Staff in mental health inpatient services worked collaboratively with community teams to support discharge planning. Staff worked closely with families or community teams prior to discharge to ensure the needs of patients were understood.
- Patients had access to a range of activities, including during evenings and weekends.
- On child and adolescent mental health wards, patients had good access to education provision.
- Patients knew how to raise concerns and submit complaints. They reported that staff were supportive and helped them to resolve issues.
- The trust was working collaboratively with commissioners and staff to design specialist community based services for children and young people to prevent admission to hospital.

However:

- Waiting times for treatment in community specialist mental health services for young people did not always meet the trust target of 18 weeks for certain specialist treatment pathways.
- On child and adolescent mental health wards, records showed evidence of discharge planning and discussions but formal discharge plans were not present.
- Four acute wards for adults of working age and psychiatric intensive care wards had dated environments. The trust had recognised this and was implementing an improvement plan.

Are services well-led?

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

- We rated nine of the 15 core services as outstanding and six as good. We found the well-led domain had improved from good to outstanding in child and adolescent mental health wards and in specialist community mental health services for children and young people. The rating for acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems remained rated as good. We took into account the previous ratings of the services we did not inspect this time.
- The leadership, governance structures and culture within the trust were used to effectively drive and improve the delivery of high quality person-centred care.
- The trust had carried out a significant organisational restructure in October 2017, and invested in high levels of staff engagement during this time. The inspection team were struck by how cohesive the new structures and governance arrangements were, in the short period of time since implementation.
- The trust had implemented a collective leadership model which supported the aim of devolved decision making. There was a strong desire to ensure that decisions were taken as close to the delivery of care as possible, to ensure the needs of patients and local populations were met. Devolved decision making was supported by a robust accountability framework which managers at all levels understood. New and aspiring managers had a range of development opportunities.
- Leaders had an inspiring shared purpose and demonstrated integrity and humility in their ambition to continuously improve outcomes for people who used the services and their families and carers. Leaders were visible and approachable and engaged effectively with staff. Staff across the trust spoke highly about senior leaders in the organisation.
- Leaders had a comprehensive understanding of the challenges faced by the trust and worked collaboratively to develop solutions. We saw examples of a wide range of initiatives developed in partnership with other organisations.

Summary of findings

- The trust had developed a truly collaborative approach to working with staff, people who used the services, families and carers and external stakeholders. The trust strategy for 2017-2022 had been developed through a model of co-production. Annual quality priorities were developed in collaboration with staff, patients, families and carers, governors and other stakeholders.
- Strategies and plans in place were challenging and innovative and fully aligned with the wider health economy. There was a systematic and integrated approach in place to monitor the progress against plans. Plans were consistently implemented and had a positive impact on the quality of services.
- Leaders strived to continually review and improve services. The collective leadership model and operational locality delivery structures meant that staff were empowered to drive improvement at all levels of the organisation. Innovation and new initiatives were celebrated both within the trust and externally.
- The trust was committed to driving and improving the delivery of high quality person-centred care. The trust had a high level of commitment to partnership working to ensure holistic pathways were in place to support patients. The trust was a significant partner in the development and delivery of the local transformation and sustainability plan, leading the mental health work stream.
- The quality of performance data was outstanding. Staff at all levels had access to a wide range of real time data which was used to actively inform and shape how services were delivered and how care was provided. There was evidence of significant positive impact on patients as a result.
- The trust identified, monitored and responded to current and future risks. The trust had developed a risk appetite framework which clearly defined the level of acceptable risk to the organisation to meet the strategic aims. Risk management was part of the devolved decision making arrangements, with a clear escalation process in place. This gave managers at different levels of seniority the framework by which to effectively manage risk.

However:

- The trust acknowledged there was more work to do to review restrictive practices including blanket restrictions across all inpatient services. The trust identified this was an area of development.
- Staff appraisal rates were slightly below the trust target. Whilst there was no trust target for clinical supervision rates, some services had lower levels of clinical supervision.
- There were delays in staff receiving formal written outcomes following disciplinary and grievance procedures.

Ratings tables

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

Outstanding practice

We found examples of outstanding practice in all four of the core services we inspected at this time. These were child and adolescent mental health wards, specialist community mental health services for children and young people, wards for older people with mental health problems and acute wards for adults of working age and psychiatric intensive care units.

For more information, see the Outstanding practice section of this report.

Summary of findings

Areas for improvement

We found areas for improvement including three breaches of legal requirements that the trust must put right. We found 19 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

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

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

What happens next

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

Outstanding practice

We found a number of areas of good practice in all of the core services we inspected.

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

The occupational therapy department which covered the four wards at Hopewood Park (Beckfield, Longview, Springrise, and Shoredrift) had introduced a 'social inclusion programme' which was designed to support patients to access services and activities in the community. Examples of activities included a gardening project at a local church and model making as part of preparation for Sunderland's 2018 Tall Ships Race. The social inclusion programme was celebrated in a national magazine in January 2018 as an example of work which both improved patient wellbeing and reduced the social stigma of mental ill-health.

The trust had invested in a trustwide initiative called Talk First which aimed to reduce the need for restrictive interventions including physical restraint. Staff were provided with quality dashboards which allowed them to see the themes and trends of incidents on the ward. The dashboards allowed staff to break down incidents to see themes such as the most common time of day or day of the week for incidents to occur. Staff analysed incident trend data and responded within actions such as ward activities and protected time for staff to engage with patients to reduce the number of incident 'hotspots'. Managers on all wards showed consistent enthusiasm for the Talk First initiative and its role in an overall reduction in incidents.

Wards for older people with mental health problems

The integration of pharmacy services on to the wards meant that staff could respond quickly to any issues around medication. In an instance where this had happened a patient's medication needed to be changed to liquid rather than tablet and the pharmacist was able to change the prescription quickly and this meant the patient did not miss any medication.

Ward staff worked closely with community staff to ensure that placements into the community were properly planned. Staff also provided training and information about patients to care providers to ensure placements were aware of the issues and support needed could be provided.

Child and adolescent mental health wards

Summary of findings

Staff worked in creative and flexible ways to ensure that patients had access to assessment and monitoring of their physical health. They completed formal assessments and created graded exposure plans to work towards physical health monitoring. Staff worked with patients to enable them to take their own physical health measurements.

Lennox and Ashby wards had a responsive on call debrief facilitator who had completed specialist training. They responded to incidents and led patient and staff debriefs following incidents. On all wards, debriefs from incidents fed into reflective practice sessions and into patients' clinical team meetings.

The trust had invested in and developed a model of care and system called Talk First. Talk First focused on positive and proactive care and followed the principles of positive behavioural support, a commitment to reducing the use of restrictive interventions and worked with the initiatives Safe wards and Star wards. The system used information reported from the trusts incident reporting system and analysed and presented this in dashboards. Staff used this information to look at trends and themes in incidents and the use of restrictive interventions. They reviewed patient dashboards in multi-disciplinary team meetings, could track the use of restrictive interventions quickly and used generated data in the risk assessment of care environments. The system and model of care was used to change practice to improve the quality of care and reduce the chance of incidents reoccurring.

Specialist community mental health services for children and young people

The service employed staff as care practitioners providing managers the flexibility to recruit staff based on the needs of the service and the local population opposed to the restrictions of recruiting to specific disciplines. Staff were trained in and delivered of a wide range of therapeutic interventions recommended by the National Institute for Health and Care Excellence.

Staff were supported to go 'above and beyond' to provide care to children and young people, including visiting young people on holiday out of the area to enable the young person and their family to have a holiday.

Well led

The trust had developed an impressive performance dashboard, which provided real time data, accessible from staff at board to ward level. There was a dynamic approach to the analysis and use of data to drive improvements in service delivery.

There was an embedded culture of continuous learning, improvement and innovation. Staff were actively supported to develop new ways of working to improve outcomes for patients. The trust were actively engaged in a wide variety of research and development programmes.

Areas for improvement

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

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with three legal requirements. These actions related to one service.

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

The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation.

Summary of findings

The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.

The trust must ensure patients have access to a nurse call system in the event of an emergency.

Action the provider SHOULD take to improve

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action. Three actions were trust-wide and 16 related to four services.

Trust-wide

The trust should ensure that there are robust systems in place to record and review restrictive practices for trust-wide and ward level blanket restrictions and ensure that restrictions are removed as soon as practicable.

The trust should ensure that all staff complete annual appraisals in line with trust policy and that clinical supervision sessions are carried out and recorded effectively.

The trust should consider that written outcomes following disciplinary and grievance hearings are issued to staff in a timely manner and in line with trust policy.

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

The trust should review the use of mechanical restraint as an intervention in the management of violence and aggression in acute mental health wards and psychiatric intensive care unit services with the aim to reduce its use.

The trust should ensure that a protocol is introduced to support staff to safely transfer patients from Lowry ward to the seclusion room in a way that maintains patients' privacy and dignity.

The trust should ensure that all staff consistently receive appropriate supervision.

The trust should ensure that patients are involved in decisions about their care and treatment and that this is documented in care plans.

The trust should ensure that staff document assessments of mental capacity and best interest decisions in a consistent manner. Systems should be implemented to monitor compliance with the Mental Capacity Act.

The trust should continue implementation of the improvement of acute mental health services in the central locality.

Wards for older people with mental health problems

The trust should ensure all areas are clean and signage is clear and in good order.

The trust should ensure that risk assessments are completed with as much detail as is pertinent.

The trust should ensure that hand written patient information is added to the computer record in a timely way.

The trust should ensure the use of mechanical restraint is only used when all other interventions have failed and patient and safe safety is of concern.

Child and adolescent mental health wards

The trust should continue to reduce the use of restrictive interventions including the use of mechanical restraint.

The trust should ensure that staff show how patients are involved in the creation and review of their care plans and that care plans contain patients' views.

The trust should ensure that staff record discharge planning in patients' care plans.

Summary of findings

The trust should ensure that where practicable that potential ligature anchor points are reduced and removed. Anti-ligature alternatives should be in place wherever possible.

Specialist community mental health services for children and young people

The trust should ensure they have a system for monitoring the risks of young people on the waiting list for treatment.

The trust should ensure the assessment of a child or young person's competence under Gillick competence is readily accessible within the electronic patient record.

Is this organisation well-led?

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

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

- The leadership, governance structures and culture within the trust were used to effectively drive and improve the delivery of high quality person-centred care.
- The trust had carried out a significant organisational restructure in October 2017, and invested in high levels of staff engagement during this time. The inspection team were struck by how cohesive the new structures and governance arrangements were, in the short period of time since implementation.
- The trust had implemented a collective leadership model which supported the aim of devolved decision making. There was a strong desire to ensure that decisions were taken as close to the delivery of care as possible, to ensure the needs of patients and local populations were met. Devolved decision making was supported by a robust accountability framework which managers at all levels understood. New and aspiring managers had a range of development opportunities.
- Leaders had an inspiring shared purpose and demonstrated integrity and humility in their ambition to continuously improve outcomes for people who used the services and their families and carers. Leaders were visible and approachable and engaged effectively with staff. Staff across the trust spoke highly about senior leaders in the organisation.
- Leaders had a comprehensive understanding of the challenges faced by the trust and worked collaboratively to develop solutions. We saw examples of a wide range of initiatives developed in partnership with other organisations.
- The trust had developed a truly collaborative approach to working with staff, people who used the services, families and carers and external stakeholders. The trust strategy for 2017-2022 had been developed through a model of co-production. Annual quality priorities were developed in collaboration with staff, patients, families and carers and governors.
- Strategies and plans in place were challenging and innovative and fully aligned with the wider health economy. There was a systematic and integrated approach in place to monitor the progress against plans. Plans were consistently implemented and had a positive impact on the quality of services.
- Leaders strived to continually review and improve services. The collective leadership model and operational locality delivery structures meant that staff were empowered to drive improvement at all levels of the organisation. Innovation and new initiatives were celebrated both within the trust and externally.

Summary of findings

- The trust was committed to driving and improving the delivery of high quality person-centre care. The trust had a high level of commitment to partnership working to ensure holistic pathways were in place to support patients. The trust was a significant partner in the development and delivery of the local transformation and sustainability plan, leading the mental health work stream.
- The quality of performance data was outstanding. Staff at all levels had access to a wide range of real time data which was used to actively inform and shape how services were delivered and how care was provided. There was evidence of significant positive impact on patients as a result.
- The trust identified, monitored and responded to current and future risks. The trust had developed a risk appetite framework which clearly defined the level of acceptable risk to the organisation to meet the strategic aims. Risk management was part of the devolved decision making arrangements, with a clear escalation process in place. This gave managers at different levels of seniority the framework by which to effectively manage risk.

However

- The trust acknowledged there was more work to do to review restrictive practices including blanket restrictions across all inpatient services. The trust identified this was an area of development.
- Staff appraisal rates were slightly below the trust target. Whilst there was no trust target for clinical supervision rates, some services had lower levels of clinical supervision.
- There were delays in staff receiving formal written outcomes following disciplinary and grievance procedures.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Mental health	Good →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018
Overall trust	Good →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018

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

Ratings for Walkergate Park

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Outpatients	Good Sept 2016	Not rated	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Overall*	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Sept 2016	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Forensic inpatient or secure wards	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Child and adolescent mental health wards	Good ↑ Jul 2018	Outstanding ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Outstanding ↑ Jul 2018	Outstanding ↑ Jul 2018
Wards for older people with mental health problems	Good →← Jul 2018	Good ↑ Jul 2018	Outstanding ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018
Wards for people with a learning disability or autism	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Community-based mental health services for adults of working age	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016
Mental health crisis services and health-based places of safety	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Specialist community mental health services for children and young people	Good →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Good →← Jul 2018	Outstanding ↑ Jul 2018	Outstanding →← Jul 2018
Community-based mental health services for older people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Community mental health services for people with a learning disability or autism	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016
Substance misuse services	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Good →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018	Outstanding →← Jul 2018

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

Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Easter Field Court Residential Care Home	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016

Specialist community mental health services for children and young people

Outstanding ☆ ➔➔

Key facts and figures

Northumberland, Tyne and Wear NHS Foundation Trust provide specialist community mental health services for children and young people aged 0 – 18 across Gateshead, Newcastle, Northumberland, South Tyneside and Sunderland.

There are three teams providing specialist community mental health services and three intensive community treatment service teams for children and young people. Each team provides services across a geographical locality. The localities are:

- Newcastle and Gateshead
- Northumberland
- South Tyneside and Sunderland

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Benton House	**Newcastle and Gateshead Children and Young Peoples Service**	**2012**	**n/a**
Bensham Hospital	**Newcastle and Gateshead Children and Young Peoples Service**	**activity has been combed with Benton House**	**n/a**
Northgate Hospital	**Northumberland Children and Young Peoples Service**	**3620**	**n/a**
Monkwearmouth Hospital	**South Tyneside and Sunderland Children and Young Peoples Service**	**2044**	**n/a**
Chad House	**EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne**	**176**	**n/a**
Monkwearmouth Hospital	**EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne**	**136**	**n/a**
Monkwearmouth Hospital	**ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside**	**n/a**	**n/a**

Specialist community mental health services for children and young people

Benton House	**ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle**	**n/a**	**n/a**
Northgate Hospital	**ICTS (Children and Young People's Intensive Community Treatment Service) - Northumberland**	**n/a**	**n/a**

The children and young people's service provides a single service to all children and young people aged 0-18 years who present with mental health difficulties, learning disabilities or neurodevelopmental difficulties. The intensive community treatment service provides intensive home based treatment for children and young people with complex mental health needs and urgent assessments for self-harm and acute mental health presentations.

This inspection was 'unannounced', which meant staff did not know until the day before that we were coming to inspect the service. However, before the inspection visit, we reviewed information that we held about these services.

As part of this inspection we visited:

- Newcastle and Gateshead children and young people's service
- Newcastle and Gateshead intensive community treatment services
- Northumberland children and young people's service
- Northumberland intensive community treatment services

Newcastle and Gateshead children and young people's service provide services at Benton House and Bensham Hospital. The intensive community treatment services have an office base at Bensham Hospital where they can access interview rooms if required. However, the majority of patients are seen in the community.

The Northumberland children and young people's service and the intensive community treatment services have an office base at Northgate Hospital. However, there are no clinic or interview rooms on site. The children and young people's service provide services across five community hubs in Hexham, Alnwick, Morpeth, Blyth and Berwick, which the intensive community treatment can access if required. The inspection included visits to the base at Northgate Hospital and the Blyth hub.

During this inspection the inspection team;

- Looked at the quality of the environment and observed how staff were caring for patients
- Spoke with 10 patients and 14 parents or carers of children and young people
- Received feedback from 14 patients, 8 carers and 16 staff members on comment cards left during the inspection
- Spoke with the managers of all four teams we inspected
- Spoke to 28 staff members including doctors, nurses, psychologists, social workers, occupational therapists and support workers
- Held a focus group with 18 associate directors responsible for the services
- Attended and observed two clinical case discussions, one risk management meeting and one multidisciplinary team meeting
- Observed four interactions between staff and patients
- Looked at 31 care records

Specialist community mental health services for children and young people

- Reviewed medication records and reviewed physical health monitoring practices at each location
- Reviewed Mental Health Act documentation including consent to treatment records at each location
- Looked at a range of policies, procedures and other documents relating to the running of the service

We last undertook a comprehensive inspection of specialist community mental health services for children and young people in June 2016. At that inspection, we rated the services overall as outstanding. We rated the key question safe, responsive and well-led as good and the key questions effective and caring as outstanding.

Summary of this service

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

- Care records contained up to date individual risk assessments and management plans. Staff could review complex cases in a multidisciplinary risk meeting and seek support and guidance to ensure risks were appropriately managed.
- Staff worked collaboratively with young people and their family/carers to efficiently deliver care in an outcomes based approach. Young people were actively involved in reviewing their progress towards their goals and outcomes.
- Staff were trained in an extensive range of therapeutic interventions in line with National Institute of Health and Care Excellence recommendations.
- Care plans captured the voice of the young person and placed them at the centre of their care.
- Managers and commissioners were working together to reduce waiting lists and ensure the service met the needs of children and young people locally.
- Key performance indicators were embedded within the service and effective governance processes were in place to monitor the quality of the service provided.

However:

- Assessment of Gillick competence was not easily accessible in young peoples care records.
- The service was not always meeting the trusts target of 18 weeks from referral to treatment for certain specialist treatment pathways. Whilst there was an effective process of triage, which enabled the trust to identify higher risk referrals, there was no system for routinely monitoring the risks of young people on the waiting list for treatment.

Is the service safe?

Good 

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

- Facilities were clean and well-maintained.
- Managers actively monitored caseloads and adjusted caseload sizes when staff were dealing with several young people with complex needs.
- Care records contained up to date individual risk assessments and management plans.
- Lone working procedures were embedded and staff were encouraged to use these.

Specialist community mental health services for children and young people

- All staff knew how to report incidents and there was evidence that the service had taken action in response to incident investigations.

However,

- Whilst there was an effective process of triage, which enabled the trust to identify higher risk referrals, there was no system for routinely monitoring the risks of young people on the waiting list for treatment.

Is the service effective?

Outstanding ☆ ➔➔

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

- Care records demonstrated a truly holistic approach to assessing, planning and delivering care and treatment to young people and their families or carers.
- All staff were actively engaged in monitoring quality outcomes for the service and planning to improve these.
- Staff teams were committed to working collaboratively. The service worked collaboratively with young people and their family/carers to efficiently deliver care in an outcomes based approach.
- Young people were actively involved in reviewing their progress towards meeting their goal based outcomes
- There was a holistic approach to planning people's discharge, transfer or transition to other services which enabled the service to work with young people past 18 if this was believed to be in the young persons' best interest.
- The service offered an extensive range of National Institute of Health and Care Excellence approved psychological interventions covering the full range of need.
- There was a culture of continuous training and development with most staff undertaking training in evidence based interventions. Staff were supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- Engagement with stakeholders informed the direction of the service. Care pathways were well-defined and provided clear goal based outcomes in partnership with children and young people.
- The Newcastle and Gateshead children and young peoples' service was developing a single point of access in partnership with stakeholders to ensure children and young people could access the right support from the point of referral.

However,

- Evidence of an assessment of a child or young person's competence under Gillick competence was not easily accessible within progress notes.

Is the service caring?

Outstanding ☆ ➔➔

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

Specialist community mental health services for children and young people

- Young people were respected and valued as individuals and were empowered as partners in their care, practically and emotionally. Staff interactions were at an appropriate level for young people. Staff were observed to deliver care in a thoughtful and sensitive way that was adaptive to the needs of the young person.
- Feedback from young people their parents, carers and stakeholders is continually positive about the way staff treat people.
- Young people their parents and carers said that staff go the extra mile and their care and support exceeded their expectations. People's individual preferences and needs were always reflected in how care is delivered. Staff were supported to push the boundaries to deliver care including visiting young people on holiday out of the area and providing informal support to parents following discharge from the service to reduce the need to access services unnecessarily.
- There was a strong, visible person- centred culture. Young people using services were partners in their care. We saw that care plans were written in a way that captured the voice of the young person and placed them at the centre of their care.
- Young people, their parents and carers were active partners in their care. Relationships with staff were seen to be strong, caring, respectful and supportive. Staff empowered young people to have a voice and to realise their potential.
- Staff included parents and carers in the care of the young people and provided them with training in therapeutic interventions to enable them to support young people outside of appointments.
- Young people were always treated with dignity by all those involved in their care, treatment and support. Staff discussed treatment options with children and young people and supported them to set their own goals and outcomes.

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Is the service responsive?

Good

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

- Managers were aware of the waiting lists and were actively working to reduce these in line with the trust target.
- Managers were working proactively with commissioners to ensure care pathways met local needs.
- The service offered a flexible approach to appointment times including evenings and weekends.
- The service recognised the needs of young people exploring their gender identity and could change peoples' gender on the electronic system to reflect their chosen identity. The service had a clear care pathway and could access adult services for advice and support.

However:

- At the time of the inspection the service was not always meeting the trust target of 18 weeks from referral to treatment for certain specialised treatment pathways.

Specialist community mental health services for children and young people

Is the service well-led?

Outstanding ☆ ↑

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

- Managers had the experience and capability needed to deliver excellent and sustainable care.
- Managers were inspiring and strove to motivate staff to succeed. Staff were proud to work for the service and spoke highly of the culture of strong collaboration, team-working and support. Staff were universally positive about local managers and local managers were in turn positive about their relationships with senior management.
- Managers had a thorough understanding of issues and challenges the service faced and how these aligned with the priorities of the local population and commissioners.
- Managers took a systematic approach to working with other organisations to improve care outcomes for young people. Strategies and plans are fully aligned with commissioners and demonstrated a commitment to system-wide collaboration.
- There was a visible commitment to focusing on improving the quality and sustainability of care and people's experiences through delivering best practice, performance and risk management systems and processes.
- The dashboard used by managers for measuring and reporting on performance management and outcomes was found to be accurate, valid, reliable, timely and relevant. The use of key performance indicators was embedded in the service and all staff understood their individual and team performance objectives.
- There was a commitment to quality improvement and the service was accredited with the Quality Network for Community Child and Adolescent Mental Health Services.

Outstanding practice

- The service employed staff as care practitioners providing managers the flexibility to recruit staff based on the needs of the service and the local population opposed to the restrictions of recruiting to specific disciplines. Staff were trained in and delivered a wide range of therapeutic interventions recommended by the National Institute for Health and Care Excellence.
- Staff were supported to go 'above and beyond' to provide care to children and young people including visiting young people on holiday out of the area to enable the young person and their family to have a holiday.

Areas for improvement

- The trust should ensure they have a system for monitoring the risks of young people on the waiting list for treatment.
- The trust should ensure the assessment of a child or young person's competence under Gillick competence is readily accessible within the electronic patient record.

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

Good 

Key facts and figures

Northumberland, Tyne and Wear NHS Foundation Trust has ten acute wards for adults of working age and one psychiatric intensive care unit which provide services to a population of approximately 1.4 million people living in Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. The eleven wards are based at four hospital locations: The Campus for Ageing and Vitality, Hopewood Park, Queen Elizabeth Hospital and St. George's Park.

- Campus for Ageing and Vitality
  - Collingwood – 16 bed male acute ward
  - Lowry – 16 bed female acute ward
- Hopewood Park
  - Beckfield – 14 bed mixed sex psychiatric intensive care unit
  - Longview – 18 bed female acute ward
  - Shoredrift – 18 bed male acute ward
  - Springrise – 18 bed male acute ward
- Queen Elizabeth Hospital
  - Fellside – 20 bed male acute ward
  - Lamesley – 18 bed female acute ward
- St. George's Park
  - Alnmouth – 19 bed female acute ward
  - Embleton – 19 bed male acute ward
  - Warkworth – 19 bed male acute ward

The locations have been registered since 2010 and provide the following regulated activities relevant to the service:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury

We last inspected the acute wards for adults of working age and psychiatric intensive care unit in June 2016. We rated these services as good overall with ratings of good in all the key questions.

We have completed Mental Health Act monitoring visits on all eleven wards since May 2017. Themes from these visits included poor evidence of patient involvement in care plans, and blanket restrictions including locked rooms on wards with restrictions on patients having their own bedroom keys. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice. These remained ongoing issues in the service at this inspection.

This inspection took place between 23-27 April 2018. The inspection was unannounced which meant that the service had no prior notice that we would be inspecting. We inspected the service using all the key lines of enquiry in the five key questions (safe, effective, caring, responsive and well-led).

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

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

- visited all 11 wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 47 patients who were using the service
- spoke with 14 carers of patients who were using the service
- spoke with the ward managers of all wards and with eight members of the trust's senior management team responsible for the service
- interviewed 89 other staff including administrators, chaplains, consultant psychiatrists, domestics, junior doctors, nurses, nursing assistants, occupational therapists, occupational therapy assistants, peer support workers, psychologists, and technical instructors
- looked at the care and treatment records of 64 patients
- reviewed medication management including reviewing 199 patient medication administration records
- reviewed 22 seclusion records
- attended and observed 23 ward meetings and activities including daily reviews, handovers, patient activities, and '72-hour' meetings
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- The service was providing effective care. All patients had a care plan which was regularly updated. Patients had access to a range of care and treatment options which were in line with national guidance. Staff were supervised effectively and had access to additional specialist training. Staff understood and implemented the Mental Health Act and Mental Capacity Act effectively.
- Staff were caring. Feedback from patients and carers was consistently positive about staff attitudes. The service was organised in a way that ensured staff focussed on interacting and engaging with patients as opposed to administrative tasks. Care records showed evidence of ongoing patient involvement and engagement through regular one to one sessions with nursing staff. Carers told us that they felt appropriately informed and involved in the care provided by the service.
- The service was providing care in a way that was responsive to people's needs. Beds were managed appropriately to ensure that people could access the service when they needed it. Wards had a range of facilities to promote comfort, privacy and dignity. Most wards had good accessibility. The service could access interpreters, translators and other services designed to meet individual needs.
- The service was well-led. There was a stable management team with managers at all levels who had the skills, knowledge and experience to perform their roles. Ward managers and senior managers were highly visible on the wards and staff told us that managers at all levels were approachable. Almost all staff we spoke to told us that they felt respected, supported and valued. There were good systems and processes in place to assess and monitor quality and safety on the wards.

However;

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

- There were areas of improvement to maintain safety on the wards. Staff were not monitoring the physical health of patients after the administration of rapid tranquilisation. Several wards had implemented blanket restrictions. The service was not regularly reviewing blanket restrictions. Nurse call alarms were not available in patient bedrooms on seven of the eleven wards. Ligature risk assessments on two of the eleven wards had not identified all potential ligature points in patient accessible rooms.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Staff were not monitoring the physical health of patients after the administration of rapid tranquilisation. Staff were not recording the reasons why physical health monitoring could not be completed.
- There were blanket restrictions on some wards including locked doors to patient accessible rooms, plastic cutlery and crockery, and restrictions on patients having a key to their own bedroom. The service was not regularly reviewing blanket restrictions.
- The trust did not have a clear protocol for staff to follow to ensure that transfers to seclusion from Lowry ward were carried out safely and in a way that promoted patients' privacy and dignity.
- Seven of the eleven wards did not have nurse call alarms.
- The trust continued to use mechanical restraint as an intervention in the management of violence and aggression in acute mental health wards and psychiatric intensive care unit services.

However:

- All patients had a risk assessment completed during their admission. Risk assessments were updated regularly and following any incidents.
- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The trust provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Is the service effective?

Good 

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

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

- All patients had a care plan which was regularly reviewed and updated. Care plans were goal-orientated and discharge focussed.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. All wards had effective daily multidisciplinary meetings.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and knew how to support patients experiencing mental ill health.

However,

- Prior to the inspection not all staff on Beckfield, Fellside and Springrise were receiving regular supervision, although this had improved by the time of inspection.
- Staff were not consistently documenting assessments of mental capacity and best interest decisions using the appropriate forms within the trust's electronic patient record system. Instead staff relied on progress notes which meant that the evidence of good implementation of the Mental Capacity Act was difficult to find.

Is the service caring?

Good 

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. Carers told us that they felt informed and involved in the care being provided by the service.
- Staff provided emotional support to patients to minimise their distress.

However,

- Within progress notes we found examples on all wards of good patient involvement and interaction, although this was not reflected in care plans.
- On some wards care plans were written using medical and nursing terminology and there was limited evidence that staff had adapted the language within care plans to make them more personalised and accessible.

Is the service responsive?

Good 

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

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

- The trust planned and provided services in a way that met the needs of local people. The trust had recognised that four of the eleven wards were dated and in need of modernisation and had a plan to transfer and improve services.
- People could access the service when they needed it. Beds were managed in a way that meant there was a bed normally available for people to access the service.
- The service took account of patients' individual needs. The service could access interpreters, translators and other services designed to meet individual needs. Most wards were accessible for people with mobility issues.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However;

- The four wards within the central locality (Collingwood, Fellside, Lamesley and Lowry) were environments which were dated. The trust had recognised this and was in the process of implementing an improvement plan.

Is the service well-led?

Good ➔➔

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

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Outstanding practice

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

- The occupational therapy department which covered the four wards at Hopewood Park (Beckfield, Longview, Springrise and Shoredrift) had introduced a 'social inclusion programme' which was designed to support patients to access services and activities in the community. Examples of activities included a gardening project at a local church and model making as part of preparation for Sunderland's 2018 Tall Ships Race. The social inclusion programme was celebrated in a national magazine in January 2018 as an example of work which both improved patient wellbeing and reduced the social stigma of mental ill-health.

- Talk First was a trustwide initiative which aimed to reduce the need for restrictive interventions including physical restraint. Staff were provided with quality dashboards which allowed them to see the themes and trends of incidents on the ward. The dashboards allowed staff to break down incidents to see themes such as the most common time of day or day of the week for incidents to occur. Staff analysed incident trend data and responded within actions such as ward activities and protected time for staff to engage with patients to reduce the number of incident 'hotspots'. Managers on all wards showed consistent enthusiasm for the Talk First initiative and its role in an overall reduction in incidents.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation.
- The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.
- The trust must ensure patients have access to a nurse call system in the event of an emergency.

Action the trust 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 mental health wards and psychiatric intensive care unit services with the aim to reduce its use.
- The trust should ensure that a protocol is introduced to support staff to safely transfer patients from Lowry ward to the seclusion room in a way that maintains patients' privacy and dignity.
- The trust should ensure that all staff consistently receive appropriate supervision.
- The trust should ensure patients are involved in decisions about their care and treatment and that this is documented in care plans.
- The trust should ensure that staff document assessments of mental capacity and best interest decisions in a consistent manner. Systems should be implemented to monitor compliance with the Mental Capacity Act.
- The trust should continue implementation of the improvement of acute mental health services in the central locality.

Child and adolescent mental health wards

Outstanding ☆ ↑

Key facts and figures

Northumberland, Tyne and Wear NHS Foundation Trust provide specialist assessment and treatment for children and young people, male and female, who have severe and complex mental health conditions, learning disabilities and autism that require treatment in hospital. These types of services are also referred to as tier 4 services.

The trust has seven child and adolescent mental health wards based at two locations; Ferndene in Prudhoe and St Nicholas Hospital in Gosforth, Newcastle. The wards have the capacity to care for up to 56 patients. The service comprised the following wards:

Alnwood at St Nicholas Hospital

Lennox

Lennox is a seven-bed ward providing assessment and treatment to children and young people within a medium secure environment. The ward accepts patients aged between 12 and 18 with complex mild to moderate learning disabilities.

Ashby

Ashby is a nine-bed unit providing assessment and treatment to children and young people within a medium secure environment. The ward accepts patients aged between 12 and 18 with complex mental health problems.

At Ferndene

Redburn

Redburn is a 10-bed unit provides comprehensive assessment and treatment for patients under the age of 18 with early onset psychosis and complex mental health disorders.

Ferndene PICU

Ferndene PICU is a four bed psychiatric intensive care unit that supports young people in an acute phase of their illness. It is a locked environment providing a safe, low stimulus environment for young people to receive care and treatment. PICU works predominantly with young people experiencing acute mental illness but can also support young people with a learning disability if required, for short-term admission and stabilisation.

Riding

Riding is a six-bed ward providing comprehensive assessment and treatment for patients aged 4 to 18 years of age. Four to 12 year olds with mild to moderate learning disabilities and 13 to 18 year olds with moderate to severe learning disabilities.

Fraser

Fraser is a 12-bed ward providing comprehensive assessment and treatment for patients aged between 12 and 18 years with mental health and developmental needs, mild to moderate learning disabilities.

Stephenson

Child and adolescent mental health wards

Stephenson is an eight-bed low secure ward providing comprehensive assessment and treatment for patients aged between 14 and 18 years with mild to moderate learning disability and requirement for high levels of supervision in a safe environment.

We last inspected child and adolescent mental health wards in June 2016 and published our report in September 2016. At that inspection, we rated the core service as 'good' overall. We rated the key questions effective, caring, responsive and well-led as 'good' and we rated the key question safe as 'requires improvement'. At that inspection we identified a breach of regulation 12 Safe care and treatment of the Health and Social Care Act (Regulated Activity) Regulations 2014. That was due to the use of mechanical restraint and its use was identified as not therapeutic and did not promote recovery.

At our previous inspection in June 2016, at Alnwood in St Nicholas Hospital, there was a ward called Wilton. At this inspection, we found that the beds on this ward had been decommissioned and only staff accessed this space for office use.

This inspection took place between 16 and 18 April 2018. We inspected the whole core service and all of the key questions as part of our routine ongoing inspection activity. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection visit, the inspection team:

- visited all seven wards and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 13 patients who were using the service and seven carers or relatives of a patient who was using the service
- received feedback from five patients using comment cards
- interviewed 52 members of staff including: clinical nurse managers, ward managers, clinical leads, registered nurses, assistant practitioners, activities co-ordinators, education staff, doctors, pharmacists, psychologists, occupational therapists, a pharmacy technician and a speech and language therapist
- looked at 23 care and treatment records of patients
- reviewed the records of 13 episodes of seclusion and two episodes of long-term segregation
- reviewed 13 incident reports involving the use of restrictive interventions
- observed five activity and therapy sessions
- observed 10 patient clinical team meetings and one care programme approach meeting
- spoke with one independent mental health advocate and an officer from Patient Advice Liaison Service
- undertook a review of medication management including 32 medication charts and a review of consent to treatment documentation
- reviewed a range of documents, policies and procedures relating to the running of the services.

Summary of this service

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

Child and adolescent mental health wards

- Staff worked in creative and flexible ways to ensure that patient's physical health was monitored effectively and that patients lived healthier lives. Physical health care was fully embedded into care and treatment. Where patients had complex needs, staff created graded exposure plans informed by formal assessments to work towards physical health monitoring. Staff worked with patients to enable them to take their own physical health measurements.
- The services worked in a truly holistic and individualised way to assess, plan and provide care and treatment to patients. This involved where appropriate seeking specialist treatments including input from experts, specialist training for staff and following best practice guidance and recommendations for meeting the needs of patients with eating disorders.
- Staff committed to an open culture and commitment to reflection following incidents. A dedicated trained responsive oncall debrief facilitator was present on Lennox and Ashby. They responded to incidents and led patient and staff debriefs following incidents. On all wards, debriefs from incidents fed into reflective practice sessions and into patients' clinical team meetings.
- The trust had invested in, built and developed a model of care and an innovative bespoke system. Talk First focused on delivering safe and positive care and followed the principles of positive behavioural support, reducing the use of restrictive interventions and worked well with the initiatives Safe wards and Star wards. The system was not burdensome on staff as it generated an automated dashboard to analyse incidents live from incident reporting systems. The data could be reviewed by many different factors. Staff teams embedded individual patient dashboard reviews into patients' clinical team meetings where they used the information to change practice. Trends and themes from incidents were integrated into ward environmental risk assessments. External lessons learnt were also incorporated into environmental risk assessment to assess dynamic risks.
- The services had clear leadership and governance structures following the recognised collective leadership model. The trust had invested in training to ensure leaders had the capacity and capability to deliver effective leadership in practice. Staff reported high levels of engagement, satisfaction and morale. They felt confident if they had any concerns to raise these. The services had clear frameworks of meetings with mechanisms to escalate and cascade information from ward to clinical business unit levels.
- Leaders and frontline staff were working with commissioners to deliver changes in service models in line with the Transforming Care Agenda. This had led to the closure of some beds and more beds were expected to close. The trust was developing specialist community based mental health services aimed at providing effective treatment and preventing hospital admission.
- Three wards had achieved Full Monty award from Star wards for implementing all 75 positive initiatives. They had also increased the duration of handover time to 30 minutes for all wards and reduced the use of bank and agency staff including the amount of shifts left unfilled.
- Patients and their carers were meaningfully involved as partners in care and treatment. Staff knew patients and their individual needs very well. Observations demonstrated that staff were calm, positive and responsive to patients' needs. Patients were involved in local recruitment for some staff vacancies.
- The trust had invested in improving the environments to ensure these were more therapeutic, recovery focussed and comfortable. This had included work to overcome the environmental challenges of the historical build of Alnwood and the opening of a dedicated area at Ferndene for day service activities to take place.
- The services had 91% compliance rate for mandatory training.
- Staff understood and demonstrated their responsibilities in relation to safeguarding, Mental Health Act and the Mental Capacity Act.

However:

Child and adolescent mental health wards

- Although the trust had invested in and made a significant commitment to reducing the use of restrictive interventions including reducing mechanical restraint by 68%, there were 84 uses of mechanical restraint between January to December 2017. All use of mechanical restraint was subject to individual risk assessment and subject to director level authorisation.
- We found some ligature points that the trust could remove on Fraser and Riding wards to further reduce risk.
- Care plans did not always reflect patient involvement and patient views that staff had sought. Although staff discussed discharge and made plans, care plans did not contain information on discharge planning.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The trust had invested, built and developed a model of care and an innovative, bespoke system called Talk First. The model was based on positive and proactive care and reducing the use of restrictive interventions. Staff received training on the approach and some staff had completed diplomas in positive behavioural support. The system was comprehensive, intelligent and generated live dashboards from the trust's incident reporting system. Teams used the data to analyse incidents and to influence changes in practice to reduce the chance of incidents recurring in the future. This included incorporating incident themes and trends into environmental risk assessments. Clinical teams reviewed individual incident patient dashboards in their clinical team review and used this information to change practice. On Lennox ward, staff had changed the timing of shifts to provide staff to support one patient at the time of day when incidents increased.
- Teams developed action plans to show how they would implement innovation and improvements in their service through implementation of the Talk First initiatives.
- The services had an open culture and commitment to reflection following incidents. Staff and patients received debriefs following incidents. At Alnwood, staff who had completed specialist training to facilitate debriefs were on call between 9am and 5pm. They responded to all incidents to provide debriefs. Debriefs from all wards were fed into staff reflective practice and patients' debriefs fed into their multi-disciplinary team meetings. The services completed reviews of specific incidents through thematic and after action reviews. Lessons learnt were communicated through safety bulletins and alerts to inform staff across the trust of important safety information.
- The amount of bank and agency staff usage and shifts left unfilled had reduced significantly since our last inspection. Where possible regular bank staff were used and they received regular supervision. Agency staff had allocated buddys. In the six months leading up to our inspection, there was no cancellation of section 17 leave due to staffing shortages.
- Since our last inspection, the trust had increased the length of staff handover to 30 minutes to enable staff to have detailed discussions of pertinent information for staff arriving on shift and to facilitate debriefs and well-being checks for those ending shift.
- The services had comprehensive arrangements and procedures to safeguard children and young people. Staff understood their safeguarding responsibilities and where they could seek advice and support around concerns.
- The overall mandatory training compliance rate was 91%.

However:

Child and adolescent mental health wards

- The trust had taken action in response to the concerns we raised at our last inspection by committing to reducing the use of restrictive interventions and increasing the seclusion facilities available by building an additional two seclusion suites. Although we saw significant reductions in the use of restrictive interventions including the use of mechanical restraint by 68% (from 266 uses to 84 uses); there were 84 uses of mechanical restraint between January to December 2017. All use of mechanical restraint was subject to individual risk assessment and subject to director level authorisation.
- Environmental risk assessments identified all ligature risks and staff mitigated the risks through observation. However, Fraser and Riding wards had blinds with a pull cord and Stephenson had a lounge window with a standard handle. These ligature points could be removed to further reduce risk.

Is the service effective?

Outstanding ☆ ↑

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

- The service had a truly holistic approach to assessing, planning and delivering care and treatment to patients. Staff designed care and treatment individually for each patient. Where appropriate, they offered specialist treatments, sought the input from external specialists, provided information and involved patients and their carers. Patients had access to a wide range of care and treatment interventions including medicines, therapies, activities and education. Patient care plans were holistic and personalised. Staff ensured that they reviewed and updated these regularly including following incidents and in response to emerging risks.
- Staff worked consistently to ensure patients lived healthier lives. They worked flexibly and took all practicable steps to ensure they assessed and monitored patients' physical health effectively. Physical health monitoring was fully embedded into patients' care and treatment. Patients had access to physical health care professionals and comprehensive physical health monitoring. In some cases, staff developed graded exposure plans based on formal assessments and involved patients in taking their own physical health observations to maximise compliance. Representatives from across the services attended a service wide physical health group, which had implemented initiatives including a healthy tuck shop, trailing nutrition screening tools and adapting the National Early Warning Score for young people.
- Staff teams worked collaboratively and comprised of all the specialisms needed to effectively meet patients' care and treatment needs. All professionals involved in patients' care and treatment attended patients' multi-disciplinary meetings routinely to review their progress.
- The trust ensured that when patients had complex mental health needs, staff received input from specialists and provided specialist training for staff so that they could deliver the best care and treatment possible. Staff followed recognised best practice guidance and recommendations on assessing risk and meeting the needs of patients with eating disorders.
- The services used a range of recognised outcome measures to measure the effectiveness of care and treatment including the Health of the Nation Outcome Scales for Children and Adolescents, Children's Global Assessment Scale and the Vineland Adaptive Behavioural Scale.
- Staff understood and carried out their responsibilities under the Mental Health Act and Mental Capacity Act and the associated codes of practice.

Child and adolescent mental health wards

Is the service caring?

Good ➔➔

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

- Feedback from patients and their parents and carers was positive about the way staff treated them. We observed staff being calm, positive, respectful and responsive to the needs of patients. It was clear that staff knew patients and their individual needs very well.
- Staff used flexible methods to ensure that patients and those close to them were involved as partners in their care and treatment. Where patients had complex needs, staff had used equipment to facilitate patient involvement. They recorded patient voices expressing their views and questions to be played in multi-disciplinary meetings they could not attend. Staff assisted patients in understanding their conditions and in accessing external support.
- The wards had accessible resources that staff could use to maximise patient involvement and understanding of care and treatment.
- Patients were meaningfully involved in local recruitment panels for some vacancies in the services.
- Staff involved families and carers by sharing information where appropriate, asked for feedback and held regular carers groups. Patients and carers could provide feedback on the services that they received confidentially through the Points of You survey.

However:

- Although staff involved patients in their care and treatment, care plans did not always show patient involvement and patient views.

Is the service responsive?

Good ➔➔

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

- The trust had responded to government visions including the implementation of the Transforming Care Agenda and the new care models for patients with learning disabilities and autism. They had closed Wilton ward and reduced the amount of beds on Riding ward. There were plans to close Riding ward permanently and reduce the amount of beds on Stephenson ward from 12 to eight beds. Staff told us that this had enabled them to improve safety and quality of care.
- The trust was working with commissioners and staff to design specialist community-based services to ensure the right care and treatment could be provided in the community and to prevent hospital admissions.
- This service had not placed any patients outside of the local area. All of the wards except Redburn acute ward and Ferndene PICU had low occupancy rates which enabled the services to have flexibility to accept patients when required.

- The care environments provided space that promoted recovery and comfort. Staff and patients had access to sufficient space and facilities. The trust had invested in environmental improvements to the environment at Alnwood to reduce the impact of the historical building and its associated limitations. Patients had good access to education provision. Ferndene had a day unit specifically for patients on Redburn and Ferndene PICU to provide structured therapeutic days.
- Patients knew how to raise concerns and submit complaints. They reported that staff were supportive and helped them to resolve issues that they experienced.

However:

- Staff reported and data submitted by the trust indicated challenges in timely discharge of patients. Staff reported the largest barrier to timely discharge was appropriate social care provision in the community. Although care records showed evidence of discharge planning and discussion, care plans did not contain formal discharge plans.

Is the service well-led?

Outstanding ☆ ↑

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

- The trust had successfully implemented a leadership change across the services in the six months leading up to our inspection. Leadership structures were clear and followed the collective leadership model. The trust had provided leaders with the training and skills required to ensure they had the capacity and capability to deliver the model in practice.
- The services were working on national government strategies and objectives in line with Transforming Care Agenda with commissioners and in consultation with staff to deliver innovative and effective care to meet the needs of patients in the community and prevent hospital admissions wherever possible. The trust had closed one ward and reduced beds on another. There were further plans to reduce the amount of inpatient beds at Ferndene and the service was developing community based mental health services.
- There were high levels of staff satisfaction and morale. All staff felt supported, respected and valued by the trust, their leaders and their colleagues. There was an open and honest culture. Staff reported that they would raise any concerns with confidence and did not fear retribution. Some staff had been recognised for their work and contribution to services. They nominated and won awards in recognition.
- The services had proactive and clear governance arrangements from ward level up to the clinical business unit level. There was a clear framework of meetings with dedicated chairs and scope. Information from meetings was clearly escalated upwards and cascaded downwards.
- The trust had invested in and developed intelligent systems to interpret and analyse information. These provided live information on dashboards to enable staff and leaders to have oversight of performance and issues without the burden of collating this data. Information from these systems was embedded into the work of frontline teams and influenced changes to practice.
- Staff were involved in research, publications and in quality improvement in the services. Wards were reviewed by the Quality Network for Inpatient Child and Adolescent Mental Health Services. Three wards had achieved the full monty award from Star wards for implementing all 75 positive initiatives.

Child and adolescent mental health wards

Outstanding practice

We found the following areas of outstanding practice in child and adolescent mental health wards.

- Staff worked in creative and flexible ways to ensure that patients had access to assessment and monitoring of their physical health. They completed formal assessments and created graded exposure plans to work towards physical health monitoring. Staff worked with patients to enable them to take their own physical health measurements.
- Lennox and Ashby wards had a responsive on call debrief facilitator who had completed specialist training. They responded to incidents and led patient and staff debriefs following incidents. On all wards, debriefs from incidents fed into reflective practice sessions and into patients' clinical team meetings.
- The trust had invested in and developed a model of care and system called Talk First. Talk First focused on positive and proactive care and followed the principles of positive behavioural support, a commitment to reducing the use of restrictive interventions and worked with the initiatives Safe wards and Star wards. The system used information reported from the trusts incident reporting system and analysed and presented this in dashboards. Staff used this information to look at trends and themes in incidents and the use of restrictive interventions. They reviewed patient dashboards in multi-disciplinary team meetings, could track the use of restrictive interventions quickly and used generated data in the risk assessment of care environments. The system and model of care was used to change practice to improve the quality of care and reduce the chance of incidents reoccurring.

Areas for improvement

In child and adolescent mental health wards, we found the following areas the trust should take action to improve:

- The trust should continue to reduce the use of restrictive interventions including the use of mechanical restraint.
- The trust should ensure that staff show how patients are involved in the creation and review of their care plans and that care plans contain patients' views.
- The trust should ensure that staff record discharge planning in patients' care plans.
- The trust should ensure that where practicable that potential ligature anchor points are reduced and removed. Anti-ligature alternatives should be in place wherever possible.

Wards for older people with mental health problems

Good ➔➔

Key facts and figures

Northumberland, Tyne and Wear NHS Foundation Trust has eight wards for older people with mental health problems, which provide services to a population of approximately 1.4 million people living in Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. The eight wards are based at three hospital locations; The Campus for Ageing and Vitality, Monkwearmouth Hospital and St. George's Park.

- Campus for Ageing and Vitality
  - Akenside– 18 bed male and female functional disorders ward
  - Castleside – 20 bed female and male organic disorders ward
- Monkwearmouth Hospital
  - Marsden– 18 bed male and female organic disorders ward
  - Roker – 12 bed male organic disorders ward
  - Mowbray – 12 bed female organic disorders ward
  - Cleadon – 18 bed male and female functional disorders ward
- St. George's Park
  - Hauxley – 18 bed male and female functional disorders ward
  - Woodhorn – 14 bed male and female organic disorders ward

The locations have been registered since 2010 and provide the following regulated activities relevant to the service:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury

The wards offer a range of assessment and treatment including nursing care, medical input, occupational therapy, psychological interventions and physiotherapy and a range of recovery focused therapeutic interventions to aid patients' recovery as far as possible.

The Care Quality Commission inspected the older people's wards in June 2016. We rated the service good overall, however, there was a breach of the following regulations:

Regulation 9 (3) (b) of Health and Social Care Act (Regulated Activities) Regulations 2014, person centred care.

We have carried out Mental Health Act monitoring visits on all eight wards since July 2016. Themes from these visits included; (1) patients records not showing whether they have been read their section132 rights; and (2) capacity to consent assessments not being carried out. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice. This inspection found that these issues had been resolved.

On this inspection, we looked at all five key questions. The inspection was unannounced.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information. During the inspection visit, the inspection team:

- visited eight wards, looked at the environments and observed how staff were caring for patients

Wards for older people with mental health problems

- spoke with eight ward managers
- spoke with 57 staff, including a doctor, healthcare assistants, nurses, a psychologist,

pharmacy technicians, an occupational therapist, and domestic staff

- spoke with 18 patients who were using the service
- spoke with 18 carers of patients who were using the service
- looked at the care and treatment records of 32 patients
- reviewed medication management including the medication administration records of 67 patients
- attended and observed three formulation meetings, one handover and one multi-disciplinary meeting
- looked at policies and procedures and other documentation relating to the running of the service.

Summary of this service

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

- There were good patient risk assessments on each ward. The service provided a safe environment and managed risks well. Patients told us they felt safe. Risk assessments included monitoring of existing and potential physical health risks.
- Staff understood that the use of restraint was a last resort. They used de-escalation and low levels of restraint to manage incidents of aggression wherever possible. Staff ensured they documented episodes of seclusion, restraint, and rapid tranquilisation in accordance with trust policy. The ward took part in the trust restrictive interventions reduction programme and reported incidents of restraint appropriately.
- Patients had detailed, personalised care plans, which included information about physical health needs. Patients and their carers felt involved in decisions about their care. Staff gathered information from families and carers to complete the Newcastle model of assessment record for patients with cognitive impairment. This reflected a patient's history and preferences and contributed to their care plan. They used the five P's assessment tool for patients with a functional mental health issue.
- There was effective multi-disciplinary team working with regular reviews of patients care and treatment needs. We saw the Mental Health Act, detention papers and associated records completed appropriately. Staff understood the application of the Mental Capacity Act. They recorded best interest decisions including when significant decisions were made for patients who lacked capacity.
- Patients, families, and carers appreciated and spoke highly about the quality of care and treatment the service provided. Staff involved patients in decisions about their care where possible. They engaged with and supported families and carers where appropriate. Staff contacted families and carers with updates on patient progress, held regular carers meetings, and invited them to reception meetings.
- The service accommodated patients in trust beds and sent them out of locality rather than out of area, they moved patients back to their local areas as soon as they were able, this meant carers could visit more easily. Staff worked towards discharges from the point of admission and where possible staff visited care homes and/or families to discuss the level of support the patient would need when they left hospital.

Wards for older people with mental health problems

- On the functional disorder wards, activities were structured and planned whilst in the organic wards activities were ad-hoc and individualised. All of the wards had activity workers who worked shift patterns; this meant they were available to assist staff with activities on evenings and weekends.
- Internal changes within the service had led to a positive change in culture. Staff focused on the needs of the people using their service, providing high quality patient centred care, which reflected the trust's vision and values. However:

However:

- On Castleside, there was an unpleasant smell and signage on the doors had been ripped off as well as flooring that had been damaged by a patient.
- We looked at 32 patient records and each patient had a risk assessment in place. However, some of the information was very brief, a question was answered with a tick and no explanation, and some of the information was not dated.
- Staff kept written records throughout the day of the patients' dietary intake, their health checks and how their mood was. This information was added to the progress notes on the computer. However, we saw that these notes were not always added to the record in a timely way.

Is the service safe?

Good

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

- Staff used supportive engagement to manage patient risks. Patients we spoke with felt safe on the wards and felt staff provided appropriate levels of support.
- Staff assessed and identified mental and physical health risks and put plans in place to manage these.
- Staff managed and administered medicines safely. Each ward had pharmacy support and they ensured that prescribing practice met national guidance and good practice standards.
- The ward took part in the trust restrictive interventions reduction programme. Staff used de-escalation and low levels of restraint to manage incidents of aggression wherever possible.
- All wards received debriefing after serious incidents. They discussed incidents and lessons learned during handover and team meetings. Information about lessons learnt from within the trust was shared through a Safer Care bulletin, which was sent to all staff.

However:

- Some risk assessments were brief and not dated.

Is the service effective?

Good 

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

- Care plans had improved from the last inspection. Patients had personalised care plans that addressed mental and physical health needs. Staff were knowledgeable about the patients they were caring for.

Wards for older people with mental health problems

- There was effective multi-disciplinary working with regular reviews of patients care and treatment. Each ward benefited from a range of appropriately trained specialists.
- Staff adhered to the principles of the Mental Health Act. Documentation was up to date and available on the wards.
- Staff received training in the Mental Capacity Act. Best interest decisions were well recorded where decisions were made about patients who lacked capacity.
- Staff received formal, individual clinical supervision as well as informal supervision. They also benefit from support from the psychology service for reflective practice sessions.

However:

- Staff kept written records throughout the day of patients' dietary intake, their health checks and how their mood was. This information was added to the progress notes on the computer. However, we saw that these notes were not always added to the record in a timely way.

Is the service caring?

Outstanding ☆ ↑

Our rating of outstanding improved from the last inspection. We rated it as outstanding because:

- All those involved in their care, treatment and support treated patients with dignity.
- Consideration of people's privacy and dignity was consistently embedded in everything that staff did including awareness of any specific needs as these were recorded and communicated.
- Staff understood the needs of their patients and provided individualised care and treatment. Patients and their carers were active partners in their care planning.
- Patients and carers gave positive feedback about the care they received. We observed positive interactions between patients and staff.
- Staff supported patients in a caring way and treated them with kindness and respect. They acted in a professional manner and respected patients' privacy.
- Staff recognised that patients needed to have access to, and links with, their advocacy and

support networks in the community and they supported people to do this. They ensured that people's communication needs were understood and recorded.

- Patients and carers had opportunities to give feedback about the care and treatment the service provided. This was through surveys, comment cards, and regular meetings.
- The service engaged with carers, holding regular carers meetings and inviting them to reception meetings and patient reviews. Carers said they felt supported.

Is the service responsive?

Good ● →←

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

Wards for older people with mental health problems

- Patients could access a bed in their locality. Staff worked with the community teams to arrange support packages to enable patients discharge to home wherever possible. Staff from the ward worked with community teams and/or care homes to ensure carers understood the needs of the patient before they moved.
- Each ward was equipped to care and treat people with significant mobility issues. Disabled access was available on all wards including access to outdoor space. There was a range of equipment available to support patients' needs, such as sensor mats for those at risk of falls and assisted bathrooms.
- Patients had access to their bedrooms at all times of day and a locked space for their possessions. There was a range of rooms to promote dignified care to older people.
- Activities were available on both wards. Activity workers worked over seven days including some evenings and weekends.
- There was a good choice of food for patients including special dietary requirements whether that was for religious or health reasons or just personal choice.

Is the service well-led?

Good

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

- The leadership and culture of the ward reflected the trusts vision and values. Staff provided high quality person-centred care and participated in reflective practice, which supported their learning.
- Associate directors had a good understanding of the service and governance systems and processes.
- Staff told us they felt valued, respected, and supported by their colleagues and managers and were able to function as a high performing team.
- Staff had access to the equipment and technology necessary to undertake their role. They had access to computers and laptops to access patient records. Staff were supported by the information and technology unit.
- Patients, their relatives and staff were able to give feedback about the quality of the service and were able to access information about the trust on the trust website.
- Staff were using safe wards initiative with the aim to reduce conflict on the wards. Several wards had been awarded 'The Full Monty' award, someone who had experience of mental health services founded the Star wards organisation in 2006. They work in partnership with mental health wards to improve everyone's experiences and outcomes.

Outstanding practice

- The integration of pharmacy services on to the wards meant that staff could respond quickly to any issues around medication. In an instance where this had happened a patients medication needed to be changed to liquid rather than tablet and the pharmacist was able to change the prescription quickly and this meant the patient did not miss any medication.
- Ward staff worked closely with community staff to ensure that placements in to the community were properly planned. Staff also provided training and information about patients to care providers to ensure placements were aware of the issues and support needed could be provided.

Wards for older people with mental health problems

Areas for improvement

We found areas for improvement in this service.

- The trust should ensure all areas are clean and signage is clear and in good order.
- The trust should ensure that risk assessments are completed with as much detail as is pertinent.
- The trust should ensure that hand written patient information is added to the computer record in a timely way.
- The trust should ensure that the use of mechanical restraint is only used when all other interventions have failed and patient safety is of concern.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Our inspection team

Brian Cranna, Head of Hospital Inspections led this inspection. Two executive reviewers, Neil Carr, Chief Executive and Olubukola Adeyemo, Medical Director, supported our inspection of well-led for the trust overall.

The team included an inspection manager, eleven further inspectors, an assistant inspector, a Mental Health Act reviewer, sixteen specialist advisors and three experts by experience.

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