The Newcastle upon Tyne Hospitals NHS Foundation Trust

Inspection report

Freeman Hospital
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Newcastle Upon Tyne
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Date of inspection visit: 30 November - 1 December 2022
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Ratings

Overall trust quality rating	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Our reports

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.

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.

Overall summary

What we found

Overall trust

The Newcastle upon Tyne Hospitals NHS Trust provides a full range of acute and specialist hospital and community services. The main sites are the Royal Victoria Infirmary including the Great North Children's Hospital, Freeman Hospital including the Institute of Transplantation, Northern Centre for Cancer Care and Renal Services, Dental Hospital, Campus for Ageing and Vitality, International Centre for Life and Community Services. The trust serves a population of over 3 million.

We carried out this unannounced focused inspection which looked specifically at the quality and safety of care provided to patients with a mental health need, a learning disability or autism. We carried out inspection activity in five of the acute services provided by this trust because we had concerns about the quality of services provided to people with a mental health need, a learning disability or autism. We also asked for information and reviewed evidence for the well-led key question for trust overall.

We carried out focussed inspection activity in critical care, maternity, medicine, surgery, and urgent and emergency care. Our findings, which are reported in the urgent and emergency care core service report, were found consistently across the all of the core services we inspected.

Following our inspection of the trust's services in December 2022, we formally wrote to the trust to share our concerns about our inspection findings. We asked the trust to take immediate action to improve the quality and safety of services. The trust provided details of the immediate steps taken to ensure patient safety.

In response to our findings, we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability or autism.

We did not re-rate services following this inspection. This is because we undertook a focussed inspection which did not look at all of the key lines of enquiry for each key question in each core service. The trust's current ratings for the services we inspected have not changed.

Our findings

We found the following areas of concern during our inspection:

- We found staff did not consistently undertake an assessment of patients' presenting risk in relation to their mental health. Risk management plans were not consistently documented or implemented. In the emergency department, we found staff did not consistently complete the trust's mental health risk assessment tool. On most wards we found staff did know about or use tools to assess and manage patients' mental health risks. In all services we found there was a strong reliance on the psychiatric liaison service to provide an assessment of patients' presenting risks and an appropriate management plan.
- We found the trust did not have effective systems and processes to ensure patients consented to their treatment, or ensure staff adhered to the requirements of the Mental Capacity Act. In all services we found staff had not undertaken and recorded assessments of mental capacity and decisions made in patients' best interest for patients subject to the Deprivation of Liberty Safeguards. Staff knowledge and awareness of the Mental Capacity Act was inconsistent between different wards and services. In the trust's emergency department, we found staff had not completed mental capacity assessments or recorded decisions made in patients' best interest for patients who had been identified to security staff as requiring restraint to prevent the patients from leaving the department.
- We found staff did not maintain complete and appropriate records to evidence adherence to the Mental Health Act. The records of patients detained under the Mental Health Act did not consistently include copies of detention papers, or proof of authorised leave under Section 17 of the Act, or papers required to authorise medication and treatment under the Act.
- We found the trust did not have effective systems and processes to ensure staff provided and documented holistic approaches to care. Patient records, including those of patients with a confirmed diagnosis of a learning disability, were strongly focussed on the care provided to meet patients' physical health needs. Records did not show evidence that staff had considered patients' additional needs or whether there were reasonable adjustments required because of patients' learning disabilities. There was a strong reliance on external documentation, including hospital passports, to inform how care was provided, although there was limited evidence of holistic care provided in line hospital passports in patient records. Carers and patients told us that the trust was did not always assess whether patients had additional needs or make plans to try to meet these needs.
- We found multiple examples of gaps in patient records in relation to mental health, mental capacity and learning disabilities. This included details of additional needs and reasonable adjustments, applications for Deprivation of Liberty Safeguards, mental capacity assessments and best interest decision, and forms to evidence compliance with the requirements of the Mental Health Act. Our inspection team was supported by trust staff to review patient records and our inspection showed staff repeatedly struggled to find the evidence required.

However:

- On most wards we saw kind and caring interactions between staff and patients, including between staff and patients with a mental health need or a learning disability.
- Across the trust we found staff were committed to providing compassionate care for patients with a mental health need, or a learning disability or autism. Staff at all levels demonstrated a commitment to delivering care in line with the parity of esteem between mental health and physical health and saw this care as integral to their role and the services provided by the trust.

How we carried out the inspection

Our findings

The team that carried out the inspection service comprised a CQC head of hospital inspection, an inspection manager, a Mental Health Act reviewer, four inspectors and an assistant inspector. The inspection team was led by Sarah Dronsfield, Head of Hospital Inspection.

We did not re-rate services following this inspection. This is because we undertook a focussed inspection which did not look at all of the key lines of enquiry for each key question in each core service. The trust's current ratings for the services we inspected have not changed.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, 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 legal requirements. This action related to the services we inspected and the trust overall.

Trust wide

- The trust must ensure care and treatment is appropriate, meets the needs of service users, and reflects their preferences. **Regulation 9(1)(a)(b)(c)**.
- The trust must ensure staff carry out an assessment of the needs and preferences for care and treatment of the service user. **Regulation 9(1)(3)(a)**.
- The trust must ensure staff design care or treatment with a view to achieving service users' preferences and ensuring their needs are met. **Regulation 9(1)(3)(c)**.
- The trust must ensure staff make reasonable adjustments to enable service users to receive their care or treatment. **Regulation 9(1)(3)(h)**.
- The trust must ensure staff obtain and record consent from service users with capacity to make decisions about their treatment and care. **Regulation 11(1)**.
- The trust must ensure staff assess and manage the risk to service users presented by their mental health needs. **Regulation 12(1)(2)(a)(b)**.
- The trust must ensure staff comply with the requirements of the Mental Capacity Act. **Regulation 13(1)(5)**.
- The trust must ensure staff have the skills required to identify where service users may lack capacity to make decisions about their treatment and care, and the tools to undertake an assessment of mental capacity and record decisions made in service users' best interest. **Regulation 13(1)(5)**.
- The trust must ensure staff undertake mental capacity assessments and record decisions made in service users' best interest when applying for Deprivation of Liberty Safeguards. **Regulation 13(1)(5)**.

Our findings

- The trust must ensure staff recognise where service users have been deprived of their liberty and make appropriate applications for Deprivation of Liberty Safeguards. **Regulation 13(1)(5)**.
- The trust must ensure staff maintain appropriate, complete, and contemporaneous records of each service user detained under the Mental Health Act. **Regulation 17(1)(2)(c)**.
- The trust must implement effective systems to assess, monitor and improve the quality and safety of the services provided to service users with a mental health need, a learning disability or autism. **Regulation 17(1)(2)(a)**.
- The trust must implement effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users with a mental health need, a learning disability or autism. **Regulation 17(1)(2)(b)**.

Action the trust SHOULD take to improve:

Trust wide

- The trust should implement an effective mental health strategy.
- The trust should ensure all relevant staff have the skills and training to use the electronic patient record system.

Is this organisation well-led?

Vision and strategy

The trust did not have a vision for what it wanted to achieve and or strategy to turn it into action, developed with all relevant stakeholders, to support the care of patients with a mental health need, a learning disability or autism.

The trust did not have a mental health strategy in place at the time of inspection. This was an area for improvement which the trust had already recognised and had started to work on. The trust had held three meetings to discuss the implementation of a mental health strategy and had plans to involve service users in the design of the strategy. The trust aimed to have a mental health strategy in place by Summer 2024.

The trust did not have a strategy to support the care of patients with a learning disability or autism. The trust told us that there was a 'Learning Disability and Autism Trust wide Steering Group' which met on a monthly basis. The trust had a quality account objective for 2022-23 which was 'ensuring reasonable adjustments are made for patients with suspected, or known, Learning Disabilities' and progress with this objective by the time of inspection had included full recruitment of a specialist learning disability team and the delivery of a 'learning disability week'.

Governance

The trust did not consistently operate effective governance processes to ensure all patients with a mental health need, a learning disability or autism received high-quality care which met their needs.

The trust did not have a programme of regular audits to improve practice in relation to mental healthcare or the care of patients with a learning disability or autism. The trust's most recent audit of mental health risk assessments was completed between January and July 2019 and identified areas for improvement. There was a limited action plan which included a plan to undertake further audit within a year. The trust had not undertaken more frequent or more recent audits to evidence whether practice had improved since 2019 and our review of records for patients presenting in urgent and emergency care found continued inconsistencies in practice in relation to how staff assessed and managed risks.

Our findings

The trust had undertaken one audit of the application of the Mental Capacity Act in 2022. This looked at 60 applications for Deprivation of Liberty Safeguards in 2022. This audit found 33 of the 60 service users had received an assessment of their capacity and 8 had a decision recorded in the service user's best interest. Only 5 of the service users had been assessed using the trust's required Mental Capacity Act documents. The trust provided details of the action plan which had been devised to improve practice with actions due to be completed by or before June 2023.

The trust had identified the need for significant improvement in adherence to the Mental Capacity Act in all services, although internal systems had not identified the practices in urgent and emergency care which required staff to prevent people with a mental health need from leaving the department without establishing whether they lacked the mental capacity to make this decision.

The trust's internal governance systems had not identified the quality concerns identified by the inspection in relation to how staff provided and recorded holistic care for patients with a learning disability, although the introduction of new hospital passports was a recognised area for improvement to be led by the Learning Disability and Autism Trust wide Steering Group.

The trust had systems to monitor the use of restrictive interventions in frontline services including restraint and rapid tranquilisation. Staff reported incidents involving the use of restrictive interventions. Individual incident reports and data for incidents involving restrictive interventions were reviewed in regular trustwide governance meetings to identify themes and trends and potential for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not always effective. We found examples where risks and issues had not been identified, and concerns where the trust had not taken effective action to reduce their impact.

Our review of records for patients presenting in urgent and emergency care and in the trust's inpatient services found staff did not always complete appropriate risk assessments or make appropriate plans to manage risks presented by patients' mental health risks.

The trust did not have effective systems to support shared management and oversight of the performance of the psychiatric liaison service, in line with national guidance including the Psychiatric Liaison Accreditation Network standards produced by the Royal College of Psychiatrists.

The psychiatric liaison service operated to a key performance indicator of a responding to a referral within one hour, however neither the service nor the trust gathered data about performance against this target. The trust told us that waits of over 12 hours were routinely reported on via the electronic incident reporting system, in order to provide an opportunity to review the circumstances of each patient case and to identify any learning to prevent recurrence.

Trust staff told us that the pressure on the liaison service resulted in regular long delays for patients waiting for assessment and that this was not always reported as an incident. Our review of incidents identified only one between September and November 2022 where the report indicates the patient had a long delay waiting for an assessment. This incident was categorised as communication issue with external organisations and not as delay in assessment or treatment.

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
Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Freeman Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Royal Victoria Infirmary	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Dental Hospital	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall trust	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

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

Rating for Freeman Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Critical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
End of life care	Good May 2019	Outstanding May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Royal Victoria Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Requires improvement Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Critical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
End of life care	Good May 2019	Outstanding May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Maternity and gynaecology	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Urgent and emergency services	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Maternity	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health services for children and young people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community end of life care	Good May 2019	Good May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Community dental services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

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

Royal Victoria Infirmary

Queen Victoria Road
Newcastle Upon Tyne
NE1 4LP
Tel: 01912336161
www.newcastle-hospitals.org.uk

Description of this hospital

Royal Victoria Infirmary (RVI) is located in the centre of the city of Newcastle upon Tyne and has been providing healthcare to communities in Newcastle and the North East for over 250 years.

The RVI provides a wide range of services including accident and emergency, medicine, surgery, maternity, critical care, end of life care, outpatients and diagnostic imaging and a children and young people's service.

Several designated regional centres of expertise are part of this hospital, including the major trauma centre, the specialist referral centre for maternity services in the North East of England and Cumbria and the Great North Children's Hospital, one of the largest children's hospitals in the UK.

We undertook focussed inspection activity across a number of services looking specifically at how the trust provided care to patients with a mental health need, and/or a learning disability or autism. We also looked at the trust's adherence to the Mental Health Act and Mental Capacity Act. We undertook inspection activity in urgent and emergency care, medicine, critical care surgery and in maternity. We specifically looked at the care of patients identified by the trust as having a learning disability or who were detained under the Mental Health Act.

Our findings across services can be found in the medical care (including older people's care) report.

Maternity

Inspected but not rated

Is the service safe?

Inspected but not rated

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Our findings across services can be found in the medical care (including older people's care) report.

Is the service effective?

Inspected but not rated

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Is the service caring?

Inspected but not rated

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Our findings across services can be found in the medical care (including older people's care) report.

Is the service responsive?

Inspected but not rated

Maternity

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Is the service well-led?

Inspected but not rated

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Our findings across services can be found in the medical care (including older people's care) report.

Critical care

Inspected but not rated

Is the service safe?

Inspected but not rated

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Is the service effective?

Inspected but not rated

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Is the service caring?

Inspected but not rated

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Is the service responsive?

Inspected but not rated

Critical care

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Is the service well-led?

Inspected but not rated

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Our findings across services can be found in the medical care (including older people's care) report.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

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Is the service effective?

Inspected but not rated

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Is the service caring?

Inspected but not rated

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Is the service responsive?

Inspected but not rated

Urgent and emergency services

We undertook focussed inspection activity across a number of services looking specifically at how the trust provided care to patients with a mental health need, and/or a learning disability or autism. We also looked at the trust's adherence to the Mental Health Act and Mental Capacity Act. We undertook inspection activity in urgent and emergency care, medicine, critical care surgery and in maternity. We specifically looked at the care of patients identified by the trust as having a learning disability or who were detained under the Mental Health Act.

Our findings across services can be found in the medical care (including older people's care) report.

Is the service well-led?

Inspected but not rated

We undertook focussed inspection activity across a number of services looking specifically at how the trust provided care to patients with a mental health need, and/or a learning disability or autism. We also looked at the trust's adherence to the Mental Health Act and Mental Capacity Act. We undertook inspection activity in urgent and emergency care, medicine, critical care surgery and in maternity. We specifically looked at the care of patients identified by the trust as having a learning disability or who were detained under the Mental Health Act.

Our findings across services can be found in the medical care (including older people's care) report.

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory Training

Staff did not always have the skills and training needed to provide safe, high-quality care to patients with a mental health need, a learning disability or autism.

Training in the Mental Capacity Act and learning disabilities were not mandatory for staff. The trust's training data showed fewer than 3% of staff had received some form of training in the Mental Capacity Act and 8% of staff had received some form of training in learning disabilities.

The trust had introduced new mental health awareness training for staff in October 2022 and compliance with this training had reached 56% by the time of our inspection. However, this training did not include how to recognise and assess mental health risks. Dementia awareness training was mandatory for all staff and had achieved 97% compliance.

Most staff had completed training in conflict resolution although breakaway training was not mandatory for staff. The trust had trained 40 security and portering staff in control and restraint. The restraint training provided by the trust met the standards of the Reducing Restraint network. Clinical staff, including staff on wards, were not required to complete control and restraint training. The trust's restraint policy and missing persons policy permitted only security staff and others with the required training to use restraint to prevent patients from leaving wards. Our review of incidents occurring in the trust in the four months prior to inspection did not identify incidents where clinical staff had restrained patients.

The trust had plans to introduce mandatory training for learning disability and autism, and as part of this, the Oliver McGowan training was being considered.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had clear safeguarding escalation processes, including a safeguarding team and committee. Members of the safeguarding team were trained to appropriate levels, with all members being trained to level 3 children and adults and the safeguarding lead nurse being trained to level 4

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw an example of an appropriate safeguarding referral made for a patient.

Environment and equipment

The trust had assessed the risks presented by the design and layout of clinical environments. The design, maintenance and use of facilities, premises and equipment kept people safe.

Medical care (including older people's care)

The trust's accident and emergency department had one room which was designed to support the safe assessment of patients presenting with mental health needs. The room met the requirements of the quality standards for liaison psychiatry services by being minimally furnished with safe and secure furnishings, and no obvious ligature points.

The trust had undertaken environmental risk assessments of clinical areas and had assessed the risk presented by ligature points.

On most wards, we observed that patients had call bells within reach and staff responded quickly when called. For patients that could not understand the use of call bells, staff completed regular visual checks to ensure their needs were met.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient.

Staff in the trust's accident and emergency department had access to risk assessment templates to support the assessment and management of mental health risks. We reviewed 10 records of patients presenting with mental health risks. Risk assessments had not been completed or were partially completed in 6 of the 10 records. In surgery, maternity and medicine we found examples where staff had not undertaken risk assessments or made plans to manage risks for patients presenting with mental health needs.

Patients with a learning disability did not always receive a full assessment of their needs including an assessment of risks presented by their learning disability. However, we found that there was inconsistent use of hospital passports and information in these documents were not always used to inform the care patients received.

Staff completed intentional rounding of patients. This helped ensure there were regular observations of patients assessed at greater risk such as those with a learning disability.

Shift changes and handovers included all necessary key information to keep patients safe including information regarding the patient's mental health, mental capacity, any disabilities, if a deprivation of liberty safeguards (DoLs) or do not attempt cardio pulmonary resuscitation (DNACPR) was in place.

The service used an electronic system which displayed risk information about patients to help staff identify risks about patients quickly, such as whether they had a DNACPR. The system used symbols to maintain confidentiality of patients from visitors, such as a heart with a line through for a DNACPR. There was a flagging system to identify if patients had a learning disability. Staff were knowledgeable about what each symbol meant.

Records

Staff kept records of patients' care and treatment although these were not always clear and up to date. Records were not always stored securely. On some wards, staff struggled to navigate electronic systems and access records.

Patients with a learning disability or autism did not have comprehensive notes in place. We saw no plans of care on how to deliver care tailored to people's needs although there was limited evidence staff considered additional needs within records. Staff did not always follow policy to keep patient care and treatment confidential, on 4 wards we saw computers left unlocked where patient electronic records were stored.

Medical care (including older people's care)

Staff could not easily access records. We found staff struggled to locate documents to evidence how they were providing care for patients with a mental health need, learning disability or autism. This included DNACPR records, and records to evidence compliance with the Mental Health Act and Mental Capacity Act. Records were not always complete as information related to whether patients had consented to treatment, and information specific to additional needs and reasonable adjustments was not consistently included within patient records. Following our inspection, we asked the trust to urgently review and provide assurance that all patients with a DNACPR had a valid order in place in line with the trust's process. The trust provided this assurance and told us that a new system was already planned to be implemented shortly after the inspection which would improve record keeping in relation to DNACPR orders.

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The trust did not always use systems and processes to safely administer and record medicines.

Staff did not maintain records of T2 consent to treatment or T3 certificate of second opinion forms to evidence that the medication prescribed and administered to service users to manage their mental health was authorised and in accordance with the Mental Health Act. The trust did not have records of T2 or T3 forms for two patients who were detained under the Mental Health Act and using the service at the time of our inspection.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The trust did not always provide care and treatment for patients with a mental health need, learning disability or autism based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff did not maintain evidence to show they protected the rights of patients subject to the Mental Health Act 1983.

Patients with a learning disability or autism did not have plans of care in place to meet their needs, instead a paper hospital passport was used. This was kept with the patients at all times and added to by different services that the person had contact with. However, not all patients with a learning disability had a hospital passport, and staff were not always aware of what the hospital passport was or its location.

We reviewed the records of patients who were detained under the Mental Health Act. Patient records did not include copies of transfer under the Mental Health Act or Section 17 leave papers. The trust could not evidence that patients continued to be appropriately detained under the Mental Health Act.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs, but did not always record reasonable adjustments appropriately.

Patients were given food and drink upon request. A patient asked for more food following their lunch and staff provided additional snacks for them. Staff had provided specialist feeding techniques, including percutaneous endoscopic gastrostomy (PEG) feeds, to meet the needs of patients who had difficulty eating.

Staff were aware of patient's dietary requirement. We saw staff offering the correct textures of food and assistance when eating for those who needed it. Patients' hospital passports documented whether patients had specialist eating routines or needed additional support, although this information was not included in the patient's electronic record or plan of care. We did not see evidence of staff documenting how care was provided in line with hospital passports within patients' electronic record.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs, we saw staff regularly asking and observing patients for signs of pain.

Patients received pain relief soon after requesting it.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The trust had 24-hour access to psychiatric liaison, specialist mental health support and a specialist learning disability team. The specialist learning disability team was available Monday to Friday. In most services there was a reliance on the psychiatric liaison service to provide an assessment of patients' risks and a management plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. They did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not use measures to limit patients' liberty appropriately.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patients' records.

We reviewed the records of ten service users in urgent and emergency care and found consistent poor practice in relation to the Mental Capacity Act. Staff identified the service users had mental health needs. During the admission, staff completed the trust's 'Request for Security Staff to Restrain a Patient' form and indicated that the service users lacked the mental capacity to consent to or refuse care and restraint was necessary to prevent the service users causing harm to themselves. Staff did not complete an assessment of the service users' mental capacity or record a decision made in the service user's best interest before identifying the service user to security staff as requiring restraint.

Medical care (including older people's care)

We found multiple examples where patients consent to treatment and care had not been recorded. In one patient's records we found in their hospital passport information that identified there was reason to doubt their mental capacity for specific decisions. We also found documented in their records they were able to make an informed decision and consented to a surgical procedure. We saw no evidence as to how staff had made an assessment of the person's mental capacity and ability to give informed consent.

When patients potentially lacked capacity to consent, staff did not always undertake appropriate assessments of their mental capacity or make specific decisions in their best interest, taking into account patients' wishes and the views of relevant people. We found examples where staff had not established whether the patients lacked mental capacity to make decisions about the care and treatment including patients whose records indicated their care was being provided 'in their best interests'. This meant that treatment and care was being provided without consent or capacity assessment.

Staff did not understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act although they knew who to contact for advice.

Deprivation of Liberty Safeguards were not always applied for in line with the Mental Capacity Act. We found examples of where staff were unable to locate Deprivation of Liberty Safeguards authorisations for patients. We found multiple examples where staff had made applications for Deprivation of Liberty Safeguards without having established whether the patients lacked mental capacity to make decisions about the care and treatment or recording a decision in made in the patients' best interest.

The trust audited 60 applications for Deprivation of Liberty Safeguards in between April and November 2022. This audit found 33 of the 60 service users had received an assessment of their capacity and 8 had a decision recorded in the service user's best interest. Only 5 of the service users had been assessed using the trust's required Mental Capacity Act documents. The trust provided details of the action plan which had been devised to improve practice with actions due to be completed by or before June 2023.

Staff in some examples had sought input from independent mental capacity advocates to support decision making in patients' best interest.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

Staff were able to discuss the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with a disability or autism.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. For one patient that was experiencing delusions, staff recognised their deterioration and conducted frequent observations and escalated to medical staff appropriately.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure families and loved ones were involved in medical decisions about patient care. We saw an example where a patient's family was involved in decision making around enteral feeding and the risks and benefits this could have to the persons health.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Most families told us they were involved in decision making around their loved one's care although some told us that staff did not always assess whether patients had additional needs or make plans to try to meet these needs.

On one ward, we saw a patient requesting to leave the ward independently to go to the shop. Staff respected their decision and encouraged this and reminded them of their appointment time that day.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff knew about and understood the standards for mixed sex accommodation.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services, but these were not always recorded. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff made sure patients living with learning disabilities and dementia, received the necessary care to meet all their needs.

Patient hospital passports were the main source of information for staff to support patients living with dementia and learning disabilities. Staff were unable to locate hospital passports for 2 patients with a learning disability. For one patient they were admitted to hospital without a hospital passport and therefore staff had commenced one.

Patients were given a choice of food and drink to meet their preferences or dietary requirements.

Is the service well-led?

Inspected but not rated

Vision and strategy

The trust did not have a vision for what it wanted to achieve and or strategy to turn it into action, developed with all relevant stakeholders, to support the care of patients with a mental health need, a learning disability or autism.

The trust did not have a mental health strategy in place at the time of inspection. This was an area for improvement which the trust had already recognised and had started to work on. The trust had held three meetings to discuss the implementation of a mental health strategy and had plans to involve service users in the design of the strategy. The trust aimed to have a mental health strategy in place by Summer 2024.

The trust did not have a strategy to support the care of patients with a learning disability or autism. The trust told us that there was a 'Learning Disability and Autism Trust wide Steering Group' which met on a monthly basis. The trust had a quality account objective for 2022-23 which was 'ensuring reasonable adjustments are made for patients with suspected, or known, Learning Disabilities' and progress with this objective by the time of inspection had included full recruitment of a specialist learning disability team and the delivery of a 'learning disability week'.

Governance

The trust did not consistently operate effective governance processes to ensure all patients with a mental health need, a learning disability or autism received high-quality care which met their needs.

The trust did not have a programme of regular audits to improve practice in relation to mental healthcare or the care of patients with a learning disability or autism. The trust's most recent audit of mental health risk assessments was completed between January and July 2019 and identified poor practice. There was a limited action plan which included a plan to undertake further audit within a year. The trust had not undertaken more frequent or more recent audits to evidence whether practice had improved since 2019 and our review of records for patients presenting in urgent and emergency care found continued inconsistencies in practice in relation to how staff assessed and managed risks.

The trust had undertaken one audit of the application of the Mental Capacity Act in 2022. This looked at 60 applications for Deprivation of Liberty Safeguards in 2022. This audit found 33 of the 60 service users had received an assessment of their capacity and 8 had a decision recorded in the service user's best interest. Only 5 of the service users had been assessed using the trust's required Mental Capacity Act documents. The trust provided details of the action plan which had been devised to improve practice with actions due to be completed by or before June 2023.

Medical care (including older people's care)

The trust had identified the need for significant improvement in adherence to the Mental Capacity Act in all services, although internal systems had not identified the practices in urgent and emergency care which required staff to prevent people with a mental health need from leaving the department without establishing whether they lacked the mental capacity to make this decision.

The trust's internal governance systems had not identified the quality concerns identified by the inspection in relation to how staff provided and recorded holistic care for patients with a learning disability, although the introduction of new hospital passports was a recognised area for improvement to be led by the Learning Disability and Autism Trust wide Steering Group.

The trust had systems to monitor the use of restrictive interventions in frontline services including restraint and rapid tranquilisation. Staff reported incidents involving the use of restrictive interventions. Individual incident reports and data for incidents involving restrictive interventions were reviewed in regular trustwide governance meetings to identify themes and trends and potential for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not always effective. We found examples where risks and issues had not been identified, and concerns where the trust had not taken effective action to reduce their impact.

Our review of records for patients presenting in urgent and emergency care and in the trust's inpatient services found staff did not always complete appropriate risk assessments or make appropriate plans to manage risks presented by patients' mental health risks.

The trust did not have effective systems to support shared management and oversight of the performance of the psychiatric liaison service, in line with national guidance including the Psychiatric Liaison Accreditation Network standards produced by the Royal College of Psychiatrists.

The psychiatric liaison service operated to a key performance indicator of a responding to a referral within one hour, however neither the service nor the trust gathered data about performance against this target. The trust told us that waits of over 12 hours were routinely reported on via the electronic incident reporting system, in order to provide an opportunity to review the circumstances of each patient case and to identify any learning to prevent recurrence.

Trust staff told us that the pressure on the liaison service resulted in regular long delays for patients waiting for assessment and that this was not always reported as an incident. Our review of incidents identified only one between September and November 2022 where the report indicates the patient had a long delay waiting for an assessment. This incident was categorised as communication issue with external organisations and not as delay in assessment or treatment.

Surgery

Inspected but not rated

Is the service safe?

Inspected but not rated

We undertook focussed inspection activity across a number of services looking specifically at how the trust provided care to patients with a mental health need, and/or a learning disability or autism. We also looked at the trust's adherence to the Mental Health Act and Mental Capacity Act. We undertook inspection activity in urgent and emergency care, medicine, critical care surgery and in maternity. We specifically looked at the care of patients identified by the trust as having a learning disability or who were detained under the Mental Health Act.

Our findings across services can be found in the medical care (including older people's care) report.

Is the service effective?

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Is the service caring?

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Is the service responsive?

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Is the service well-led?

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Freeman Hospital

Freeman Road
High Heaton
Newcastle Upon Tyne
NE7 7DN
Tel: 01912336161
www.newcastle-hospitals.org.uk

Description of this hospital

Freeman Hospital is situated just outside of the city of Newcastle upon Tyne and has over 1000 beds. It opened in 1977, when services from several hospitals across the city and elsewhere in the North East were relocated into one centre. Freeman Hospital provides a wide range of services including medicine, surgery, critical care, end of life care and outpatients and diagnostic imaging. There are highly specialised services at the hospital, including the UK's first Institute of Transplantation, which opened in 2011, and the Northern Centre for Cancer Care, which opened in 2009.

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Critical care

Inspected but not rated

Is the service safe?

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Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory Training

Staff did not always have the skills and training needed to provide safe, high-quality care to patients with a mental health need, a learning disability or autism.

Training in the Mental Capacity Act and learning disabilities were not mandatory for staff. The trust's training data showed fewer than 3% of staff had received some form of training in the Mental Capacity Act and 8% of staff had received some form of training in learning disabilities.

The trust had introduced new mental health awareness training for staff in October 2022 and compliance with this training had reached 56% by the time of our inspection. However, this training did not include how to recognise and assess mental health risks. Dementia awareness training was mandatory for all staff and had achieved 97% compliance.

Most staff had completed training in conflict resolution although breakaway training was not mandatory for staff. The trust had trained 40 security and portering staff in control and restraint. The restraint training provided by the trust met the standards of the Reducing Restraint network. Clinical staff, including staff on wards, were not required to complete control and restraint training. The trust's restraint policy and missing persons policy permitted only security staff and others with the required training to use restraint to prevent patients from leaving wards. Our review of incidents occurring in the trust in the four months prior to inspection did not identify incidents where clinical staff had restrained patients.

The trust had plans to introduce mandatory training for learning disability and autism, and as part of this, the Oliver McGowan training was being considered.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had clear safeguarding escalation processes, including a safeguarding team and committee. Members of the safeguarding team were trained to appropriate levels, with all members being trained to level 3 children and adults and the safeguarding lead nurse being trained to level 4

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw an example of an appropriate safeguarding referral made for a patient.

Environment and equipment

The trust had assessed the risks presented by the design and layout of clinical environments. The design, maintenance and use of facilities, premises and equipment kept people safe.

Medical care (including older people's care)

The trust's accident and emergency department had one room which was designed to support the safe assessment of patients presenting with mental health needs. The room met the requirements of the quality standards for liaison psychiatry services by being minimally furnished with safe and secure furnishings, and no obvious ligature points.

The trust had undertaken environmental risk assessments of clinical areas and had assessed the risk presented by ligature points.

On most wards, we observed that patients had call bells within reach and staff responded quickly when called. For patients that could not understand the use of call bells, staff completed regular visual checks to ensure their needs were met.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient.

Staff in the trust's accident and emergency department had access to risk assessment templates to support the assessment and management of mental health risks. We reviewed 10 records of patients presenting with mental health risks. Risk assessments had not been completed or were partially completed in 6 of the 10 records. In surgery, maternity and medicine we found examples where staff had not undertaken risk assessments or made plans to manage risks for patients presenting with mental health needs.

Patients with a learning disability did not always receive a full assessment of their needs including an assessment of risks presented by their learning disability. However, we found that there was inconsistent use of hospital passports and information in these documents were not always used to inform the care patients received.

Staff completed intentional rounding of patients. This helped ensure there were regular observations of patients assessed at greater risk such as those with a learning disability.

Shift changes and handovers included all necessary key information to keep patients safe including information regarding the patient's mental health, mental capacity, any disabilities, if a deprivation of liberty safeguards (DoLs) or do not attempt cardio pulmonary resuscitation (DNACPR) was in place.

The service used an electronic system which displayed risk information about patients to help staff identify risks about patients quickly, such as whether they had a DNACPR. The system used symbols to maintain confidentiality of patients from visitors, such as a heart with a line through for a DNACPR. There was a flagging system to identify if patients had a learning disability. Staff were knowledgeable about what each symbol meant.

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Staff kept records of patients' care and treatment although these were not always clear and up to date. Records were not always stored securely. On some wards, staff struggled to navigate electronic systems and access records.

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Is the service effective?

Inspected but not rated

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Staff were aware of patient's dietary requirement. We saw staff offering the correct textures of food and assistance when eating for those who needed it. Patients' hospital passports documented whether patients had specialist eating routines or needed additional support, although this information was not included in the patient's electronic record or plan of care. We did not see evidence of staff documenting how care was provided in line with hospital passports within patients' electronic record.

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Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs, we saw staff regularly asking and observing patients for signs of pain.

Patients received pain relief soon after requesting it.

Multidisciplinary working

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Staff worked across health care disciplines and with other agencies when required to care for patients. The trust had 24-hour access to psychiatric liaison, specialist mental health support and a specialist learning disability team. The specialist learning disability team was available Monday to Friday. In most services there was a reliance on the psychiatric liaison service to provide an assessment of patients' risks and a management plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. They did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not use measures to limit patients' liberty appropriately.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patients' records.

We reviewed the records of ten service users in urgent and emergency care and found consistent poor practice in relation to the Mental Capacity Act. Staff identified the service users had mental health needs. During the admission, staff completed the trust's 'Request for Security Staff to Restrain a Patient' form and indicated that the service users lacked the mental capacity to consent to or refuse care and restraint was necessary to prevent the service users causing harm to themselves. Staff did not complete an assessment of the service users' mental capacity or record a decision made in the service user's best interest before identifying the service user to security staff as requiring restraint.

Medical care (including older people's care)

We found multiple examples where patients consent to treatment and care had not been recorded. In one patient's records we found in their hospital passport information that identified there was reason to doubt their mental capacity for specific decisions. We also found documented in their records they were able to make an informed decision and consented to a surgical procedure. We saw no evidence as to how staff had made an assessment of the person's mental capacity and ability to give informed consent.

When patients potentially lacked capacity to consent, staff did not always undertake appropriate assessments of their mental capacity or make specific decisions in their best interest, taking into account patients' wishes and the views of relevant people. We found examples where staff had not established whether the patients lacked mental capacity to make decisions about the care and treatment including patients whose records indicated their care was being provided 'in their best interests'. This meant that treatment and care was being provided without consent or capacity assessment.

Staff did not understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act although they knew who to contact for advice.

Deprivation of Liberty Safeguards were not always applied for in line with the Mental Capacity Act. We found examples of where staff were unable to locate Deprivation of Liberty Safeguards authorisations for patients. We found multiple examples where staff had made applications for Deprivation of Liberty Safeguards without having established whether the patients lacked mental capacity to make decisions about the care and treatment or recording a decision in made in the patients' best interest.

The trust audited 60 applications for Deprivation of Liberty Safeguards in between April and November 2022. This audit found 33 of the 60 service users had received an assessment of their capacity and 8 had a decision recorded in the service user's best interest. Only 5 of the service users had been assessed using the trust's required Mental Capacity Act documents. The trust provided details of the action plan which had been devised to improve practice with actions due to be completed by or before June 2023.

Staff in some examples had sought input from independent mental capacity advocates to support decision making in patients' best interest.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

Staff were able to discuss the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with a disability or autism.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. For one patient that was experiencing delusions, staff recognised their deterioration and conducted frequent observations and escalated to medical staff appropriately.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure families and loved ones were involved in medical decisions about patient care. We saw an example where a patient's family was involved in decision making around enteral feeding and the risks and benefits this could have to the persons health.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Most families told us they were involved in decision making around their loved one's care although some told us that staff did not always assess whether patients had additional needs or make plans to try to meet these needs.

On one ward, we saw a patient requesting to leave the ward independently to go to the shop. Staff respected their decision and encouraged this and reminded them of their appointment time that day.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff knew about and understood the standards for mixed sex accommodation.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services, but these were not always recorded. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff made sure patients living with learning disabilities and dementia, received the necessary care to meet all their needs.

Patient hospital passports were the main source of information for staff to support patients living with dementia and learning disabilities. Staff were unable to locate hospital passports for 2 patients with a learning disability. For one patient they were admitted to hospital without a hospital passport and therefore staff had commenced one.

Patients were given a choice of food and drink to meet their preferences or dietary requirements.

Is the service well-led?

Inspected but not rated

Vision and strategy

The trust did not have a vision for what it wanted to achieve and or strategy to turn it into action, developed with all relevant stakeholders, to support the care of patients with a mental health need, a learning disability or autism.

The trust did not have a mental health strategy in place at the time of inspection. This was an area for improvement which the trust had already recognised and had started to work on. The trust had held three meetings to discuss the implementation of a mental health strategy and had plans to involve service users in the design of the strategy. The trust aimed to have a mental health strategy in place by Summer 2024.

The trust did not have a strategy to support the care of patients with a learning disability or autism. The trust told us that there was a 'Learning Disability and Autism Trust wide Steering Group' which met on a monthly basis. The trust had a quality account objective for 2022-23 which was 'ensuring reasonable adjustments are made for patients with suspected, or known, Learning Disabilities' and progress with this objective by the time of inspection had included full recruitment of a specialist learning disability team and the delivery of a 'learning disability week'.

Governance

The trust did not consistently operate effective governance processes to ensure all patients with a mental health need, a learning disability or autism received high-quality care which met their needs.

The trust did not have a programme of regular audits to improve practice in relation to mental healthcare or the care of patients with a learning disability or autism. The trust's most recent audit of mental health risk assessments was completed between January and July 2019 and identified poor practice. There was a limited action plan which included a plan to undertake further audit within a year. The trust had not undertaken more frequent or more recent audits to evidence whether practice had improved since 2019 and our review of records for patients presenting in urgent and emergency care found continued inconsistencies in practice in relation to how staff assessed and managed risks.

The trust had undertaken one audit of the application of the Mental Capacity Act in 2022. This looked at 60 applications for Deprivation of Liberty Safeguards in 2022. This audit found 33 of the 60 service users had received an assessment of their capacity and 8 had a decision recorded in the service user's best interest. Only 5 of the service users had been assessed using the trust's required Mental Capacity Act documents. The trust provided details of the action plan which had been devised to improve practice with actions due to be completed by or before June 2023.

The trust had identified the need for significant improvement in adherence to the Mental Capacity Act in all services, although internal systems had not identified the practices in urgent and emergency care which required staff to prevent people with a mental health need from leaving the department without establishing whether they lacked the mental capacity to make this decision.

The trust's internal governance systems had not identified the quality concerns identified by the inspection in relation to how staff provided and recorded holistic care for patients with a learning disability, although the introduction of new hospital passports was a recognised area for improvement to be led by the Learning Disability and Autism Trust wide Steering Group.

The trust had systems to monitor the use of restrictive interventions in frontline services including restraint and rapid tranquilisation. Staff reported incidents involving the use of restrictive interventions. Individual incident reports and data for incidents involving restrictive interventions were reviewed in regular trustwide governance meetings to identify themes and trends and potential for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not always effective. We found examples where risks and issues had not been identified, and concerns where the trust had not taken effective action to reduce their impact.

Our review of records for patients presenting in urgent and emergency care and in the trust's inpatient services found staff did not always complete appropriate risk assessments or make appropriate plans to manage risks presented by patients' mental health risks.

The trust did not have effective systems to support shared management and oversight of the performance of the psychiatric liaison service, in line with national guidance including the Psychiatric Liaison Accreditation Network standards produced by the Royal College of Psychiatrists.

The psychiatric liaison service operated to a key performance indicator of a responding to a referral within one hour, however neither the service nor the trust gathered data about performance against this target. The trust told us that waits of over 12 hours were routinely reported on via the electronic incident reporting system, in order to provide an opportunity to review the circumstances of each patient case and to identify any learning to prevent recurrence.

Trust staff told us that the pressure on the liaison service resulted in regular long delays for patients waiting for assessment and that this was not always reported as an incident. Our review of incidents identified only one between September and November 2022 where the report indicates the patient had a long delay waiting for an assessment. This incident was categorised as communication issue with external organisations and not as delay in assessment or treatment