Good

Northumberland, Tyne and Wear NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

St Nicholas Hospital
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Date of inspection visit: 31 May-24 June 2016
Date of publication: 01/09/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX4E4	St Nicholas Hospital	Ashby ward	NE3 3XT
RX4E4	St Nicholas Hospital	Lennox ward	NE3 3XT
RX4E4	St Nicholas Hospital	Wilton ward	NE3 3XT
RX4CA	Ferndene	Fraser ward	NE42 5PB
RX4CA	Ferndene	Redburn ward	NE42 5PB
RX4CA	Ferndene	Riding ward	NE42 5PB
RX4CA	Ferndene	Stephenson ward	NE42 5PB

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated child and adolescent mental health ward services as good because:

- The service provided patients with a weekly timetable encompassing a range of care via an individualised structured day programme.
- Information leaflets, 'at a glance' records and post incident debrief documentation provided to patients were in easy read, pictorial and written formats. Riding ward used social stories to orientate patients to the service.
- Staff from different disciplines demonstrated a clear mutual respect and the views of all professionals were valued; the multidisciplinary team worked well together. Patients and carers told us that the staff were respectful, kind and understanding. Staff understood the individual needs of patients. Staff were positive about local and senior managers in the trust and advised that senior managers were visible on the wards.
- Local and senior managers were present on the ward, offering support and leadership to staff. There were clear systems and processes to monitor risk, incidents, appraisals and training that underpinned the Trust's values.
- The education provision had been rated as outstanding by Ofsted and was tailored to the patients' needs. Staff at Ferndene helped patients to set up a healthy snack tuckshop where patients planned what to eat, budgeted and chose what to buy before preparing the snacks for sale as a group.

However:

- Mechanical restraint in the form of emergency response belts and soft handcuffs were used. Use of restraint and seclusion was high on all three wards at Alnwood and on Redburn ward at Ferndene.
- There were high levels of bank and agency staff used and staff were moved to cover staffing levels across wards. Patients and families spoke of their discomfort with agency staff on the wards and a lack of understanding of their needs. Patients, families and staff said activities and section 17 ground leave were cancelled regularly due to a lack of staff and managers reported that releasing staff to supervision and training was difficult for some wards.
- We attended one handover meeting where there was little discussion of the patient or interest by the team; Ferndene wards had short 10 minute handovers however this was the trust standard for Ferndene wards.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Carpeted areas in some of the bedrooms and activity areas conflicted with Department of Health guidance on infection control.
- The service had high levels of bank and agency staff. Staff were moved to cover staffing levels across wards which patients and staff were uncomfortable with.
- The service had under predicted the number of registered nurses and nursing assistants funded to work on the ward; as a result, staff fill rates regularly exceeded these levels.
- The service was funded and substantively staffed to NHS England commissioning levels; however additional nurses had to be provided above these rates to meet patient needs.
- Patients, carers and staff told us that activities and section 17 ground leave was cancelled regularly due to a lack of staff.
- Training records provided by the trust showed staff on Redburn ward and Ashby ward had not met the trust target for basic or immediate life support training and other training compliance levels varied between wards.
- Use of restraint and seclusion was high at Alnwood and on Redburn ward at Ferndene.
- The service used mechanical restraint, in the form of emergency response belts and soft handcuffs to transport patients to off ward seclusion rooms.
- The service provided search training for staff as required. However, Ferndene ward staff had not received this training. Redburn ward conducted 'sheet searches' by holding a sheet up to cover the patient; this did not protect the dignity of the patient.
- Medicines management documentation was of varying quality and care plans did not accurately record medicines prescribed or adverse reactions.

However:

- Ward environments were clean and well maintained. Ferndene wards had direct access to outside space and Riding ward had a newly created sensory room and safe space. Alnwood's facilities were clean but clinical in contrast.
- Ward managers and consultant staff facilitated a comprehensive local induction process for substantive and bank staff.

Summary of findings

- Information leaflets and post incidents of harm debrief documentation provided to patients were in easy read, pictorial and written formats.
- Additional, role relevant training was encouraged and accessed by staff to enable them to meet the needs of patients.
- The ward clinic room had emergency equipment and this was checked at regular intervals
- Staff were encouraged to report all incidents of harm and aggression, so that learning could occur.
- Staff had a good understanding of the safeguarding procedures and systems to learn lessons when things go wrong.
- Child and adolescent mental health wards had developed a resource tool to help the multidisciplinary teams assess the needs of the current patient group in relation to the available staff resources of each ward nursing team.

Are services effective?

Good

We rated effective as good because:

- Care records for patients were patient centred and included communication passports and colourful pictorial communication profiles. Care plans referred to the National Institute for Health and Care Excellence guidance and had hyperlinks to organisational policies.
- Positive support plans were seen in the patient records and progress notes linked into the behaviour plan within the care plan.
- Care plans had director approval for the use of mechanical restraint in line with the trust policy and records identified events leading to patient's seclusion.
- There was a strong focus on physical healthcare including physical health checks offered on admission and ongoing monitoring.
- The service used an individualised structured day program that provided patients with a weekly timetable encompassing a range of care.
- A wide range of therapeutic care was available.
- Staff from different roles demonstrated a clear mutual respect and the views of all professionals were valued; the multidisciplinary team worked well together.
- The education provision has been rated as outstanding by Ofsted and was tailored to the patient's needs.
- Advocacy use was embedded on all wards.

Summary of findings

- Staff had good opportunities for learning and development and demonstrated a practical understanding of the Mental Health Act 1983 (MHA) and issues for patient's capacity to make decisions about their care.

However:

- We saw that on five occasions, no monitoring was documented in accordance with the trust policy and national guidance regarding rapid tranquilisation.
- We attended one handover meeting at Alnwood where there was little interest by the team or discussion of the patient; Ferndene wards also had short 10 minute handovers however this was the trust standard for Ferndene wards.

Are services caring?

Good

We rated caring as good because:

- Patients and carers told us that staff were respectful, kind and understanding; we observed this during the inspection.
- Staff understood the individual needs of patients.
- Patients, where possible, were involved in decisions about their care and the development of their care plans.
- All patients had a named nurse and regular 1:1 time.
- Riding ward used social stories to orientate patients to the service.
- Patients had individualised activity programmes which were developed based on the therapeutic value of activities and the likes and dislikes of patients.
- Patients spoke positively about having access to advocacy services and described their use.
- Patients were encouraged to have families visit and where the distance was too great, patient's skyped and phoned their families.

However:

- Patients and families spoke of their discomfort with agency staff on the wards and a lack of understanding of their needs.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Bed occupancy for the year never exceeded 100% and data provided by the trust showed that they had not exceeded the trust target of 85% since November 2015.

Summary of findings

- Two rooms had been set aside on Lennox ward to enable education activities to continue when the ward was unsettled and patients were unable to attend.
- Information packs such as welcome packs and carer packs included relevant information to the ward and facilities in an appropriate, accessible format. E.g. social stories, easy read and communication passports.
- Staff at Ferndene had helped patients to set up a healthy snack tuckshop where patients planned, budgeted and chose what to buy before preparing the snacks for sale as a group.
- Patients could raise issues with staff and at community meetings; Ashby ward changed the time of their multidisciplinary team meetings to accommodate more staff present at the patients' community meetings.
- Education sessions were provided by Newcastle Bridges School for 25 hours per week. The number of hours of education offered was dependent on the individual needs and ability to access a full curriculum and whether a patient can be taught in a group or on an individual basis.
- Patients told us of trips to external sites of interest and their enjoyment of these visits.
- Ferndene staff described a recent visit to Buckingham Palace by one member of staff to collect eight Duke of Edinburgh awards on behalf of the patients.

However:

- Access to outside space and education was sometimes difficult for patients from Lennox ward due to the location of the ward.
- Visiting rooms were ill equipped to keep families and patients entertained which impacted on the quality of visits.
- Patients and their carers reported that the quality of food was poor.

Are services well-led?

Good

We rated well-led as good because:

- Staff could describe duty of candour.
- Staff delivered care in line with the Trust values; this was reinforced by the appraisal system.
- Local and senior managers were present on the ward, offering support and leadership to staff.
- The Trust exceeded the mandatory training target and had systems and processes in place to monitor compliance.
- The Trust had systems and processes in place to monitor risks and incidents; managers reviewed trends and shared analysis with the teams.

Summary of findings

- Staff were empowered to make decisions and had sufficient authority to undertake their roles.
- The service sought external scrutiny from Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) to improve and accredit wards.
- The service participated in service improvements; they developed an in house dietetic screening tool and were published in an international journal.

However:

- Releasing staff to supervision and training was described as difficult by some wards.
- Child and adolescent mental health wards appraisal rates were below the trust target of 85% for permanent non-medical staff.

Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) Tier 4 children's services deliver specialist inpatient care to children who have severe and/or complex mental health conditions that cannot be adequately treated by community services.

The child and adolescent mental health wards provided by Northumberland, Tyne and Wear NHS Foundation Trust are in two settings and include the following wards;

Alnwood unit, St Nicholas Hospital;

- Lennox ward, a seven-bed unit providing comprehensive assessment and treatment for patients 12 to18 years old with complex mild to moderate learning disability, needing a high level of supervision in a medium secure environment.
- Ashby ward, a nine-bed unit providing comprehensive assessment and treatment for patients 12 to 18 years old with complex mental health disorders, needing a high level of supervision in a medium secure environment.
- Wilton ward, a six-bed unit providing comprehensive assessment and treatment for patients 12 to18 years old with complex mental health disorders, needing a high level of supervision in a medium secure environment.

Ferndene;

- Riding ward, a six-bed unit providing comprehensive assessment and treatment for patients 4 to 18 years old with mild to moderate learning disability (4 to 12 year olds), or moderate to severe learning disability (13 to 18 year olds). In addition, patients admitted to Riding ward will need assessment and treatment for complex mental health/behavioural and emotional needs.
- Redburn ward, a 14-bed unit providing comprehensive assessment and treatment for patients under 18 with early onset psychosis or complex mental health disorders. Redburn ward comprises of 10 open admission beds and a four bed psychiatric intensive care unit (PICU).
- Stephenson ward, an eight bed low secure unit providing comprehensive assessment and treatment for patients 14 to 18 years old with mild to moderate learning disability and a requirement for high levels of supervision in a safe environment.
- Fraser ward, a 12-bed unit providing comprehensive assessment and treatment for patients 12 to 18 years old with mental health and developmental needs and mild to moderate learning disability.

During our inspection, all patients were formally detained under the Mental Health Act with the exception of two voluntary patients each on Fraser ward, Riding ward and Redburn ward who were able to leave the wards if they wished.

This was the first inspection of inpatient child and adolescent mental health ward services at Northumberland, Tyne and Wear NHS Foundation Trust.

The trust has not been inspected using the new methodology to date. Under the old inspection methodology, 15 registered locations, including St Nicholas Hospital and Monkwearmouth Hospital, have been inspected and complied with relevant regulations.

Our inspection team

The team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector, CQC

Head of Hospital Inspection: Jenny Wilkes, Head of Hospital Inspection (North East), CQC

Team leaders: Brian Cranna, Inspection Manager, CQC

Jennifer Jones, Inspection Manager, CQC

Sandra Sutton, Inspection Manager, CQC

Summary of findings

The team comprised: two CQC inspectors, a consultant psychologist and two mental health nurses specialising in child and adolescent mental health.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all seven of the wards at the two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with 15 patients who were using the service.
- spoke with the managers for each of the wards and one clinical nurse manager.
- spoke with 30 other staff members including; consultant psychiatrists, consultant psychologists, nurses, nursing assistants, assistant practitioners, social workers and occupational therapists.
- spoke with five carers.
- attended and observed one hand-over meeting.
- held one focus group meeting with the multidisciplinary team.
- attended and observed one education session.
- attended and observed one weekly team meeting.
- attended and observed one allocations meeting .
- attended and observed one ward round .
- collected feedback from 19 patients using comment cards.
- looked at 30 care records of patients.
- carried out a specific check of the medication management on two wards and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients were given the opportunity to provide feedback on the service they received prior to our inspection via comment cards left on the wards. We collected 16 comment cards from patients. Positive comments from the patients related to staff. Patients commented that staff were kind, polite and considered their wishes.

Negative comments received related to agency staff use and their understanding of the patients. They also referred to insufficient staffing to cover leave and activities and the poor quality of food.

We spoke to 15 patients across seven wards during the inspection. One patient showed us around Fraser ward and described the ward as 'the best place'.

Summary of findings

One patient on Ashby ward described their discomfort with agency staff, they described one agency member of staff observing them for the day without interacting with them.

Patients spoke positively about having access to an advocate.

Good practice

On Riding ward, staff used social stories to orientate patients to the ward. Riding ward's social stories included photographs of the unit and the patient's named nursing staff. Riding ward also had social stories for the taking of bloods and making amends after disagreements.

Wards used a pictorial seclusion and a restraint-debriefing document with patients following an incident of harm or restraint that considered the comprehension needs of the patients. The template explored why patients thought they were restrained or secluded and what triggered the situation, how they felt about the episode and what staff were most appropriate to be involved, how staff spoke to them, and their preferred restraint hold. The document also raised medication preferences and what the staff should do differently next time.

Fraser ward had developed a dietetic screening tool in house in the absence of anything available nationally and had an article published in the International Journal of Behavioural Support.

Child and adolescent mental health wards had developed a resource tool that enabled the multidisciplinary team to assess the needs of the current patient group in relation to the available staff resources of each ward nursing team. The tool enabled teams to review current and future pressures on the services and included a process where options were reviewed to ensure that practice was safely provided within current resources. Scores were allocated in respect to anticipated behaviour; patients were given a number that described their level of risk, need or responsivity and the numbers added to derive a 'resource level' number between 0 and 30.

Areas for improvement

Action the provider MUST take to improve

The trust were using mechanical restraint as an intervention in the management of violence and aggression in child and adolescent mental health ward services. The use of mechanical restraint to move patients around the building linked to the environment and did not support therapeutic intervention and recovery. The trust must ensure that mechanical restraint is being used in exceptional circumstances when it is in the best interests of the patient and provides the least restrictive intervention.

Action the provider SHOULD take to improve

- The trust should review bank and agency use to create positive interactions with patients.
- The trust should review handover duration.
- The trust should ensure that staff have appropriate equipment and facilities to preserve the dignity of patients while performing searches.
- The trust should ensure sufficient staff to enable patients to make use of outside spaces, staff to attend training and supervision sessions.
- The trust should monitor the cancelling and changing of activities due to staff shortages.
- The trust should engage with patients in relation to the quality of the food.

Northumberland, Tyne and Wear NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ashby ward	St Nicholas Hospital
Lennox ward	St Nicholas Hospital
Wilton ward	St Nicholas Hospital
Fraser ward	Ferndene
Redburn ward	Ferndene
Riding ward	Ferndene
Stephenson ward	Ferndene

Mental Health Act responsibilities

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

Training in the Mental Health Act (MHA) was mandatory, renewable every three years. The trust target was 85% attendance, data provided by the trust showed 84% compliance with the training which is below their target.

Patients and staff confirmed that patients had their rights explained to them every month in a pictorial format where appropriate. All patients accessed the mental health advocate service at least monthly and in some cases weekly. Advocates had their own keys to the wards to allow free movement and discussion with patients.

All staff spoken with told us of the trust's Mental Health Act office and explained how to contact them for clarification on legal advice and implementation of the act.

Detailed findings

We reviewed 11 patient's records in terms of Mental Health Act compliance and found clear capacity assessments supported with good narrative and patient involvement.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) does not apply to patients under 16. For children under the age of 16, the patients' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff should assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to patients aged 16 and 17.

Staff asked about capacity advised of the policies available in the office, information on the trust intranet, copies of the code of practice on the ward and discussion in supervision. The trust target was that 85% of staff had attended the training. Data provided by the trust showed 88% of staff had attended training; this is above the trust target. Mental capacity act audits were performed by the trust's Mental Health Act team.

Capacity assessments were recorded in the electronic Rio notes we reviewed.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Four of the child and adolescent mental health inpatient wards, Fraser ward, Riding ward, Stephenson ward and Redburn ward were in a purpose built one storey environment located at Ferndene. Ferndene has an education building on site which includes four pods for activities, a multi-faith space, library and a sports hall. The other wards Ashby ward, Wilton ward and Lennox ward were across three floors of a recently refurbished Victorian building.

The wards at Alnwood and Ferndene had several blind spots with poor lines of sight that could result in patient harm. The trust had completed an annual clinical environmental risk assessment for all wards between March to May 2016 and had clearly dated action plans in place. The wards increased staffing levels where no environmental solution was possible for blind spots and ligature risks. Photographs of ligature risks were included in the report to help with understanding. The risk assessments included Ferndene's outside, education and common areas.

Riding ward, which admitted patients from four to 18 years old, had access to outside space with a garden, trampoline, play area and a newly created sensory room and safe space. All other wards at Ferndene had courtyard areas and access to gardens. Alnwood wards had two shared outside spaces with access to a football pitch but limited play equipment. One ward manager informed us that there is a business case to install outside gym equipment for the patient's use.

Both sites had some carpeted areas in some of the bedrooms and activity areas. Department of Health guidance, 'infection control in the built environment', advises that carpets should not be used in areas where body-fluid spillage is anticipated. If carpets are to be considered for non-clinical areas (for example, interview rooms, counselling suites, consulting rooms), it is essential that a documented local risk assessment is carried out and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place. This was not visible in the risk assessments we viewed.

Ferndene wards were welcoming, clean environments with art work on the walls. Riding ward had additional sensory items on the hallway walls. Alnwood wards were clean but clinical in comparison with little personalisation in public spaces. A recent quality network review for inpatient people child and adolescent mental health ward services of Alnwood wards, dated May 2016, felt the unit was quite clinical and wasn't very homely. They also found that visiting rooms were small and there weren't enough activities to keep young children entertained. We also saw this during our inspection. Furniture on wards was generally good quality and sturdy with the exception of Redburn ward that had acknowledged this and were awaiting a delivery of new items. There was information available in leaflet racks about medication and mental health needs tailored for patients with plain English and graphics. There was also a wall mounted touch screen monitor to access information in Ferndene wards.

The fridge temperature where medication was stored was within the recommended levels and there was a record in place to show checks of fridge temperature. A grab bag, containing immediate life support equipment was located in each of the treatment rooms. Hook ligature cutters were located in the ward offices and a fish knife ligature cutter was located in Lennox ward's night station. Records showed that staff had made daily checks of the equipment and night staff audited emergency drugs weekly. All drugs checked during the inspection were in date and treatment rooms were clean and tidy.

Alnwood and Ferndene units admit male and female patients. Ferndene wards could lock the doors between their two flats in compliance with same-sex accommodation guidance although this is not enforced for children's units. All wards except Riding ward had en-suite bathroom facilities. Riding ward's bathroom facilities allowed for access by only one patient at a time; the bathroom was lockable by the patient, preserving the dignity of the patients on a mixed gender ward.

Requires improvement

Are services safe?

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

Alnwood wards each had a seclusion room. Seclusion rooms allowed for the clear observation of the patients and had two-way communication facilities. They also had toilet facilities with privacy film and a clock was visible to help patients know the time of day. There was a high volume of seclusion used at Alnwood and when the seclusion rooms were unavailable, patients were secluded on the Gibside and Bede adult wards. There were 13 instances between October 2015 and March 2016 where the off ward process had to be initiated. Director approval, to move a patient to an adult ward in line with the Service Resilience (Business Continuity) Plan, was visible in the patient's care records we viewed.

Ferndene had one seclusion room on Stephenson ward, used by all Ferndene wards. If unavailable, the ward implemented the Service Resilience (Business Continuity) Plan to access Alnwood's seclusion rooms. Redburn ward and Fraser ward are building a new seclusion room with direct access from both wards, which is due for completion in July 2016. Stephenson ward's seclusion room allowed for the clear observation of patients and had two-way communication facilities. They also had direct toilet access with privacy film and a clock to help patients know the time of day. Redburn ward psychiatric intensive care unit and Stephenson ward had refurbished two soft rooms to use for de-escalation to lessen the need for seclusion.

95% of child and adolescent mental health ward services staff had completed hand hygiene training and staff adhered to infection control principles in the ward environment.

Patient Led Assessments of the Care Environment assessments focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services such as cleanliness. The 2015 Patient Led Assessments of the Care Environment score for St Nicholas Hospital was 100% and Ferndene was 99.9% This is around 2.5% above the England average of 97.6%.

Staff used personal alarms and there was a designated response team across the child and adolescent mental health ward services. Alnwood had no nurse call systems in patient's rooms.

Equipment was well maintained and cleaning records viewed were up to date.

Safe staffing

The figures below were provided by the trust and relate to the time period 01 February 2016 to 30 April 2016.

- Establishment levels: qualified nurses, whole time equivalent 102, nursing assistants, whole time equivalent 165.
- Number of vacancies: qualified nurses, whole time equivalent 9 (7%) nursing assistants, whole time equivalent 3 (2.1%).
- 786 shifts were filled by bank staff to cover sickness, absence or vacancies in the three month period.
- 1447 shifts were filled by agency staff to cover sickness, absence or vacancies in the three month period.
- 282 shifts were not filled by bank or agency staff to cover sickness, absence or vacancies in the three month period.
- Ashby ward has the highest qualified nurse vacancy rate of 21%; this is above the trust average of 13.6%.
- Stephenson ward has a nursing assistant vacancy rate of 9%.

The service staffed Alnwood and Ferndene wards in line with safe staffing guidance. The trust submitted data which showed that shifts across some wards were short staffed and frequently covered by bank staff and agency staff; However the trust ensured that there were two qualified nurses during the day shift and one qualified on night shift. At Alnwood, Ashby ward had the highest number of shifts filled by agency staff at 615, followed by Lennox ward at 435 and Wilton ward at 333. An additional 380 shifts across the three wards were covered by bank staff. At Ferndene, Redburn ward had 329 filled by bank staff and 60 shifts filled by agency. Managers prioritised the use of bank staff that were familiar with the service and patients, followed by agency staff they had used before. Many bank staff were retired staff who had previously worked for the trust. Ward managers were able to request specific staff via a centralised human resources system. Staff on the wards often undertook bank shifts and managers would move staff across wards at Ferndene and Alnwood depending on patient needs and staffing levels. We viewed risk meeting minutes that identified recruitment and retention of staff as an issue as well as high agency usage.

The majority of agency staff used were nursing assistants and there was always a qualified nurse on the ward.

Requires improvement

Are services safe?

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

Child and adolescent mental health wards had developed a resource tool to help the multidisciplinary teams assess the needs of the current patient group in relation to the available staff resources of each ward nursing team. The tool enabled teams to review current and future pressures on the services and created a process where options were regularly reviewed to ensure that practice was safely provided within current resources. Scores were allocated in respect to anticipated behaviour; patients were given a number that described their level of risk, need or responsivity and the numbers added to derive a 'resource level' number between 0 and 30.

All ward managers confirmed they were able to adjust staffing levels daily to take account of patient mix however staffing is not always accessible. Redburn ward on Ferndene and Ashby ward on Alnwood were each unable to cover 107 shifts during the period 02 February 2016 to 30 April 2016.

The service was funded, and substantively staffed, to a level commissioned by NHS England Specialised Commissioners. However additional nurses were regularly required to meet the clinical needs of the client group far higher in acuity and need than was commissioned. The fill rate should match the establishment levels and be around 100%. Nursing assistant staff levels for Ashby ward was 465% in April and 352% in March. Lennox ward operated at 242% in April for day nursing assistants. Nursing assistant rates at night for Ashby ward was 223% and Redburn ward 240% at night. Wilton ward qualified day nurses operated 49% under expectation in March and Lennox ward was 15% under. In March Stephenson ward's nursing assistant night rate was 165% and Wilton ward's nursing assistant day rate was 202%

We requested an account of any cancelled section 17 ground leave and cancelled activities due to staff shortages. Under some sections of the Mental Health Act 1983 the responsible clinician approves any period spent outside of the hospital grounds for detained patients. The service manager stated that there had been no section 17 ground leave cancellations on any of the child and adolescent mental health inpatient wards since the recording process began. It was unclear from the response when the recording process was introduced. The trust later confirmed that monitoring had been in place for three months. Patients, carers, and staff told us that leave and activities had been cancelled or rearranged on Lennox, Ashby, Stephenson, Riding and Redburn wards.

The service does not record the cancellation of planned activities due to staffing issues. However we viewed minutes and action plans from the monthly structured day meetings which review the provision of activities, education and therapy sessions. The aim of these meetings was to identify and resolve operational issues and provide patients with meaningful, regular activities.

Patients confirmed that they had 1:1 time with their named nurse on a weekly basis.

The wards follow an on call 3-tier system to ensure there is adequate medical cover day and night and that a doctor can attend the ward in an emergency. The tier system escalates from the care trainee covering the ward up to Newcastle's consultant rota. One consultant at Alnwood asks that staff contact him even if he is not on call. Staff can call 999 in an emergency and service level arrangements are in place with local GPs.

The trust advised that as of 23 May 2016 the standard for statutory and mandatory training was 85%, with the exception of information governance which was 95%.

The trust had a number of mandatory training courses including; equality and diversity, health and safety, moving and handling awareness, management of violence and aggression, safeguarding adults and safeguarding children levels one to three, seclusion training, Mental Health Act and mental capacity training.

Information provided by the trust prior to the inspection showed that overall the staff in child and adolescent mental health wards had achieved 91% of their mandatory training, which is above the trust target of 85%. Fraser ward achieved the highest compliance score of 96%. Wilton ward had the lowest aggregated rate of training with 83%. Ashby ward had achieved 73% compliance for safeguarding children level three. Prevention and management of violence and aggression basic and breakaway training figures for Redburn ward were below the trust target at 72%. Wilton ward had achieved 60% for basic prevention and management of violence and aggression. Training records provided by the trust showed staff on Redburn ward and Ashby ward had not met the trust target for basic

or immediate life support training. Basic life support is important for the preservation of life in the event of an emergency. If applied it could have a significant impact on reducing harm to patients and prolonging life.

Records and record keeping had the highest rate of completion at 99%. Wilton ward showed as achieving 0% for rapid tranquilisation training, however data provided by the trust later explained that Ashby and Wilton figures were combined and that rapid tranquilisation for both was 91%.

Alnwood staff had a one week induction to the service which was facilitated by ward managers and consultant staff. Modules included positive behavioural support, communication and mental disorders, communication and behaviour, formulation workshop and the clinical model. Ferndene staff had a three day induction programme hosted by members of the multidisciplinary team. Modules included consent and capacity, models of care, positive behaviour support, de-escalation and activities and engagement modules including service user experience and how to engage families. Bank staff also received this induction program. Ward managers complete the local induction checklist with agency staff orientating them to the ward and book further training required in line with the essential guide and policies.

Both sites have training in dialectical behaviour therapy, an adaptation of cognitive behavioural therapy that meets the needs of people who experience emotions very intensely; this training was most applicable to Redburn ward. Riding ward, Redburn ward and Fraser ward staff had all completed autism awareness training. Stephenson ward's rate was 97%. However, 79% of staff on Ashby and Wilton wards combined, and 83% of staff on Lennox ward had completed this training.

Assessing and managing risk to patients and staff

We found that across all wards, the use of restraint and seclusion was high for the patient group.

There were 2211 uses of restraint on 66 different patients between 1 November 2015 and 30 April 2016, 902 of which resulted in the use of prone restraint; of these 240 resulted in rapid tranquilisation. 137 of the rapid tranquilisations occurred in Redburn ward at Ferndene.

There were 418 uses of seclusion in the last six months across both sites; 130 at Ferndene and 288 at Alnwood. Lennox ward in Alnwood showed the highest numbers of seclusion at 212; however, Redburn ward had the highest number of restraint incidents for all the wards, 618, involving 26 patients.

There was one instance of long-term segregation on Wilton ward at Alnwood. We viewed the patient's care record and saw evidence that it was documented and discussed at the weekly multidisciplinary team meetings. The trust reported that incidents of restraint had dropped since segregating the patient.

The trust explained that the frequency of restraint and seclusion was largely down to aggression directed toward self or others. The trust stated that staff had to intervene if there were risks of significant harm with patients, particularly those that are committed to harm themselves or others. There was prevention and management of violence and aggression leads on wards with a clear focus on de-escalation best practice. Information was disseminated to all staff. Patient's care records and seclusion records recorded the prevention and management of violence and aggression; high quality positive behavioural support plans were in place to support the management of behaviour that could challenge. One member of staff felt the environment in Lennox ward was challenging and there wasn't sufficient space to de-escalate situations. The trust provided the numbers of staff being assaulted by patients per ward between 1 December 2015 and 31 May 2016. On average across all child and adolescent mental health wards 39% of assaults on the ward were towards staff. The results for Ashby ward were the highest at 68% and Riding ward the lowest at 20%.

The trust used mechanical restraint to manage violence and aggression on child and adolescent mental health wards. Ferndene and Alnwood confirmed that emergency response belts and soft handcuffs were used to transport patients to seclusion rooms off ward. Emergency response belts are 7 inch wide, soft style restraining belts, made from strengthened fabric with straps that are secured by Velcro. They are used to restrict the patient's movement and can be fastened horizontally across the body to restrict arm movement and fastened around the legs to prevent kicking. Soft handcuffs with Velcro fasteners may also be

Requires improvement

Are services safe?

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

attached to loops on the side of the belt to further restrict movement. When mechanical restraint was used, the patient was carried by four members of staff with one staff member at the head.

Stephenson ward at the far end of the Ferndene had the only seclusion room on the site. Figures provided by the trust confirmed that between 1 March and 31 May 2016 4 patients on 21 occasions from Redburn ward were 'walked' out of Redburn ward, past some of the education block, past Fraser ward and past the café used by patients, staff and families in order to use Stephenson ward's seclusion room which impacted on patient dignity. A new seclusion room with direct access from the Redburn ward and Fraser ward is being built and due for completion in July 16.

Although all wards at Alnwood had direct access to a seclusion room, mechanical restraint usage was high and patients had to use alternative seclusion rooms at nearby wards or buildings. Between 01 March 2016 and 31 May, 15 episodes of mechanical restraint were used on four patients to move them from Lennox ward on the third floor to the nearest available seclusion room. To move a patient from Lennox ward to Ashby ward, the nearest alternative, staff and patients had to be 'walked' via three flights of stairs, nine locked doors and one other door to enter the seclusion room. A lift measuring 1.1 by 2.1 metres was available when it was too dangerous to transport the patient via the stairs. Up to four members of staff would be in this small space with the patient restrained on the floor with one member of staff at the patient's head; this process does not protect the dignity of the patients on the ward. Between 01 March 2016 and 31 May, there were 31 instances of mechanical restraint used to transport patients at Alnwood wards to seclusion. A further three uses of mechanical restraint were used on Ashby ward, Wilton ward and Lennox wards to move patients within the wards, for example back to the patient lounge.

Patients from Ashby ward and Lennox ward also accessed seclusion rooms at Bede and Gibside adult wards on 13 occasions between October 2015 and March 2016 when none were available at Alnwood. In addition to the stair and lift access, patients were escorted out of the building to the front of the premises to the trust's unit vehicle. The car is unable to pull directly in front of the entrance of Alnwood and is visible from a public access road on the other side of the carpark. There can be up to five members of staff, the driver and the patient in the vehicle depending on the risk assessment of the patient. Should the unit vehicle not be available a secure taxi would be used.

The trust had a positive and safe strategy, which outlined in detail the organisational position in relation to the prevention and safe and therapeutic management of aggression and violence. This included the use of mechanical restraint, including the use of handcuffs and emergency response belts. The trust also had a practice guidance note for staff on the safe use of mechanical restraint equipment. Eight patient's care plans had director approval for the use of mechanical restraint in line with the trust policy and the service resilience plan to move a patient to an adult ward; records identified events leading to patient's seclusion. Multidisciplinary team meeting minutes showed well-documented notes regarding mechanical restraint use.

The service used the functional analysis of care environments (FACE) risk profile as the primary tool for assessing and managing risk. The functional analysis of care environments risk profile was included in the Department of Health's published guidance 'Best Practice in Managing Risk' (March 2009).

The inspection team examined 30 electronic care records; all of which had risk assessments present and up to date. Incident numbers and plans of action were recorded in the notes. One risk assessment viewed could have further identified the risk factors involved instead of a generic description. Another used complex language that could have been made simpler. Patients were risk assessed on admission.

We viewed a pictorial seclusion and restraint debriefing document that staff used with patients following an incident; this was easily understood by patients. The template explored why the patients thought they were restrained or secluded and what triggered the situation, how they felt about the episode and what staff were most appropriate to be involved, how staff spoke to them, and their preferred restraint hold. The document also discussed medication preferences and what the staff should do differently next time. If secluded the document prompted for discussion on clothing, how the patients should be secluded in the future, discussed lighting, temperature and

Requires improvement

Are services safe?

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facilities in the room and identified the best way to calm down the patients in the future. We saw one care record out of the 30 we viewed that showed no evidence of a debrief.

For staff at Alnwood we viewed a debrief protocol for nursing staff following an incident. The ward manager arranges a meeting to discuss ward processes and coping with incidents. The facilitator is a member of the debrief team which comprised of a senior nurse, nurse consultant, and consultant clinical psychologist. Staff at Alnwood described the debrief team as external staff. Where possible debriefs were held off ward and alarms were discouraged. They discussed how staff felt, facts and reactions relating to incidents and what could have been done differently.

Ferndene staff had a three tiered system where the individual affected had immediate time with the facilitator. The 20 minute group debrief session occurred immediately, once the situation was under control, and must be carried out before end of working shift. Staff completed a formal incident debriefing within a week and included relevant disciplines. To improve future use, the team discussed the facts of the incidents of restraint, seclusion and harm as well as how staff felt and their personal reactions. Staff completed a debriefing contract emphasising the equality of all views, confidentiality and emotions of the group.

Learning from both approaches was visible in the reflective group notes, bulletins disseminated via the ward manager and the service risk register meeting minutes.

Alnwood wards searched patients on return from classroom sessions such as woodwork and cooking sessions. Although this was sometimes justifiable we identified that patients were searched in an allocated area after cookery classes where tools and cutlery were counted back in. This was raised with one ward manager who agreed that it could be unnecessary. The service provided search training for staff however; no staff on Ferndene wards had the training whereas 64% of Ashby ward staff and 73% of Lennox ward staff had. Redburn ward had no training recorded and told us of the 'sheet searches' conducted on one patient. The ward manager on Redburn ward said that they only used search qualified staff in line with their personal search policy however, the data provided by the trust contradicted this. Staff on Redburn ward held up a sheet instead of purchasing a screen to preserve the patient's dignity.

Staff knew of the observation policies and could describe the process. Training figures provided by the trust showed Riding ward, Stephenson ward, and Fraser wards observation figures were 100%; and Lennox ward and Redburn ward were 98%. 91% of Ashby ward staff had completed this training.

Seclusion records were kept in the staff office in a locked cupboard on all wards. Episodes of seclusion were also captured in Rio.

Staff we spoke to were aware of how to make a safeguarding alert and were aware of the safeguarding team within the trust. Social workers on the wards liaised with patient's local authorities to safeguard and promote the welfare of patients, informing them when a patient remained on the unit for a consecutive period of 3 months. Staff told us they had the opportunity to meet with lead safeguarding nurses and found the safeguarding team helpful and knowledgeable. 13 safeguarding referrals were made to the local authority between 01 December 2015 and 31st May 2016. Child and adolescent mental health wards staff had completed safeguarding children training; level one was 96%, level two was 96% and level three was 89%. However, Ashby ward had only completed 73% for safeguarding children level three.

We looked at the systems in place for medicines management. We assessed four prescription records and spoke with nursing staff that were responsible for medicines. Medicines were stored securely and were only accessible to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines were stored appropriately and temperatures were monitored daily in line with national guidance. Prescription records were completed fully and accurately, and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act for most patients. However one patient was receiving depot antipsychotic treatment which was not identified on the Mental Health Act documents. 'When required' prescriptions contained relevant information to enable staff to administer them safely, but the care plans in place had not been updated as changes were made to prescribed medication. For example, we saw two patients with a 'Mental health care and treatment 'psychoactive medication' care plan. For both of these patients the

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medicines listed did not accurately reflect the medicines currently prescribed. For one person the care plan had no information documented on an adverse reaction to an antipsychotic medicine.

We saw one person had received rapid tranquilisation; however we saw that on five occasions, no monitoring was documented in accordance with the trust policy and national guidance.

Ward staff told us about the comprehensive support provided by the pharmacy team, which included a regular visit by a clinical pharmacist.

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

Staff we spoke with knew how to report medicines errors and incidents via the trust online reporting system and they were supported by managers to learn from incidents.

At Ferndene visiting rooms with viewing panels were off the reception area of the wards. There was also a café at the entrance to the unit that may be used for visiting. At Alnwood visiting rooms were available on the ground floor after reception. The trust has a procedure for children visiting locked wards identifying points to consider at the clinical team assessment.

Track record on safety

NHS trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). Reportable serious incidents include 'never events' which the national Revised Never Events Policy and Framework (NHS England, March 2015) defined as an incident that is 'wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers'.

Of the 94 serious incidents reported by the trust between 1 January 2015 to 31 December 2015 two occurred in children and adolescent mental health wards; these were failing to obtain an appropriate bed for child who needed it and consequently the admission of an under 18 to an adult mental health ward.

In the period 01 January 2015 to 31 December 2015, the trust reported 149 serious incidents through its Serious Incident Requiring Investigation (SIRI) reporting system. Of these, three related to children and adolescent mental health wards.

For the duration of 01 April 2015 to 30 April 2016, the trust reported 34,658 incidents. Children and adolescent mental health wards reported 9,305; 27% of the trust's total. Within children and adolescent mental health wards 4437 (48%) related to reported incidents of aggression and violence; 2586 (27%) of reported incidents were due to self-harm.

Reporting incidents and learning from when things go wrong

There was a clear process detailing how to respond to an incident. This included updating the electronic incident reporting system used by the trust, recording the incident and reporting to managers. One member of staff indicated that they found the reporting system difficult to use and would sit with the registered nurse on duty to capture the incident details. The ward manager was required to review the incident report.

Staff were immediately offered a debrief after an incident of harm, restraint or seclusion and the incident was discussed in individual supervision.

Patients were also offered a pictorial debrief following an incident. Learning from debriefs was visible in the reflective group notes, bulletins disseminated via the ward manager and the service risk register meeting minutes. Families were informed of incidents and incidents were discussed at the multidisciplinary team meetings and clinical team assessment meetings. Care plans were updated when appropriate.

In total 9305 incidents involving 131 patients were reported by the child and adolescent mental health wards from April 2015 to April 2016. 5368 incidents reported involved no harm, 3800 minor harm and 135 incidents caused moderate harm. Two of the incidents were major harm incidents. We saw evidence in the incident description that families were informed and that emergency physical healthcare was provided.

Children and patients services at the trust held a monthly proactive and safe care group to discuss restrictive practice

Requires improvement

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and assess incidents. We viewed an example of an inpatient incident report that showed data and trends and a resulting operational implementation plan showing actions and updates.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We viewed 30 electronic care records. All of the care records had current, comprehensive care plans in place; patients were involved in the creation of the care plans. Patient centred documentation including communication passports and colourful pictorial communication profiles were viewed. Communication goals and difficulties were identified with tools suggested to enhance communication. In the prevention and management of violence and aggression section we saw clear signs, symptoms and triggers written in a simple language and in a coherent manner. Positive support plans were viewed in the records and progress notes linked into the behaviour plan within the care plan. Three records showed evidence of a post incident debrief. Staff completed 'at a glance' care plans with patients using positive behavioural support red, amber and green colour ratings and shared these with patients and staff. A strong focus on physical healthcare was visible including physical health checks offered on admission and ongoing monitoring; however, one record was unclear in the recording of patients' blood tests, pulse rate, blood pressure and temperature. Staff appeared to have a good rapport with patients and described patient's wishes. We viewed director approval for the use of mechanical restraint in eight records and records identified events leading to patient's seclusion. Multidisciplinary team meeting minutes recorded discussion of decisions. Care records were detailed but lengthy in places. This could impact on agency staff understanding. One member of staff showed us a keyword search function within the notes. GPs were trained how to make entries on the Rio system.

All staff were competent at using the Rio system and could locate relevant information. Additional paper files were kept in locked cabinets in the ward offices and contained summaries of the care plans, Mental Health Act documentation and seclusion records.

Best practice in treatment and care

We viewed 30 electronic care records. Care records viewed referred to the National Institute for Health and Care Excellence guidance and had hyperlinks to organisational policies. Staff were aware of National Institute for Health and Care Excellence guidance and reported the availability of the guidance within the workplace and the expectation to remain informed. Medicines were monitored daily in line with national guidance. However we saw that on five occasions, no monitoring was documented in accordance with the trust policy and national guidance in relation to rapid tranquilisation. One nurse told us that appropriate guidance could be difficult to follow because patients had multiple diagnoses but did emphasise the trust's expertise and involvement in producing National Institute for Health and Care Excellence guidance.

The service had implemented a structured day programme that provided patients with a weekly timetable encompassing a range of care. Each timetable was individualised to meet the needs of the patient, with a focus on integrated and multidisciplinary working. Planning where possible was in conjunction with the patient, the multidisciplinary team including the community team and their family. A range of therapeutic care was available including psychology, pharmacology, occupational therapy, speech and language therapy, exercise therapy, art psychotherapy, drama therapy, horticultural activities, music therapy, and dance movement therapy. Other focus group approaches included group skills training like dialectical behavioural therapy (DBT) approach, social skills training, self-esteem, managing difficult feelings, problem solving, relaxation, self-control, cognitive behavioural approaches and creative therapies. Some patients also participated in the Duke of Edinburgh award scheme. Patients accessed individual therapy sessions or group sessions depending on the patient's care plan.

Physical healthcare was provided and patients accessed GPs weekly onsite or would visit GP surgeries. Patients were weighed, measured and their pulse and blood pressure taken. Patients had blood tests to check hormones, sugar and cholesterol/fat levels. This was evidenced in the care records we viewed however one record was unclear in the recording of this information. One care record included a referral to paediatric services in the patient's locality. A pharmacist also visited both sites weekly. However two 'share your experience' respondents raised concerns regarding the weight gain of patients on the wards at Alnwood. They felt that the multidisciplinary team blamed medication for weight gain and that healthy eating and exercise were not encouraged despite care plans being in place.

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Overall the trust had participated in 37 local audits and 24 clinical audits. Health of the nation outcome scales for child and adolescent mental health were used to measure the health and social functioning of people with severe mental illness. Staff at Ferndene completed an audit to monitor the quality of behaviour support plans, specifically evaluating the quality of assessments, treatment fidelity, and skills development. One Alnwood consultant told us of an audit they had completed on patients with borderline personality disorder where they had been identified as performing above the standard.

Skilled staff to deliver care

The multidisciplinary teams at Alnwood and Ferndene included psychiatrists, psychologists, occupational therapists, general and mental health nurses, activity coordinators, education staff, dieticians, speech and language therapists, music, drama and art therapists, exercise therapists as well as social workers. Staff were experienced in working with patients and some staff had been working in the trust more than 20 years. All staff had received trust and local inductions to the wards. One member of staff described how an agency member of staff was not permitted to start work on their ward as they had not completed their Disclosure and Barring Service (DBS) check.

In addition to the mandatory training provided records showed that staff had training in positive behavioural support, de-escalation and dialectical behaviour therapy. Ashby ward, Wilton ward and Lennox wards had also completed seclusion training.

The trust had a clinical supervision policy which was approved in October 2013, fully implemented in November 2014 and reviewed in May 2015. The policy set a standard for clinical supervision to be delivered a minimum of once a month to all clinical staff. The trust had a compliance target of 85% for clinical supervision. The trust's initial submission had a lower than average compliance rate for three of the wards. The trust later clarified this data and provided us with a complete data set which showed that the average compliance rate of clinical supervision was 89% from 1 May 2015 to 30 April 2016.

The trust appraisal policy set the standard that all staff would undertake an appraisal once a year. The trust had a compliance target of 85% for appraisals. Child and adolescent mental health wards fell below the trust target at 79% for permanent non-medical staff. Alnwood wards appraisal rates were all below, with Wilton ward completing 55%, Ashby ward at 63% and Lennox wards at 76%. 100% of all permanent medical staff had received appraisals during this period. NHS employers advise that quality appraisals provide staff with a clear understanding of their role and the part they play in their team and organisation. By ensuring staff are clear about what they are doing and why and have the skills to do their jobs, are crucial factors for delivering high quality patient care.

Multi-disciplinary and inter-agency team work

Staff worked in a truly holistic way to assess, plan and deliver care and treatment to patients. Multidisciplinary meetings took place on the wards weekly although these would be increased dependent on the patient's presentation. Staff from different disciplines demonstrated a clear mutual respect and the views of all professionals were valued. We attended one weekly team meeting where all professionals gave feedback and we witnessed respect for each other's views. One staff member at Alnwood spoke of an allocations meeting for a patient turning 18 and how they had worked with the trust safeguarding team and the local authority towards discharge. Education staff spoke highly of the staff describing them as a strong caring team that works well together and looks to improve. Education connections were very positive and patients accessed education on both sites. The education provision had been rated as outstanding by Ofsted.

However we attended one handover meeting on Ashby ward where patient's notes were read through at pace and there was little discussion regarding each patient. The team receiving the information were disengaged. We were advised that handovers occur five times a day. We were also advised by two staff at Ferndene that the trust standard of 10 minute handovers were insufficient to capture enough information and their staff stayed beyond shift to communicate patient needs.

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

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

Training in the Mental Health Act (MHA) was mandatory, renewable every three years. The trust target was 85% attendance; data provided by the trust showed 84%

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compliance with the training which is below their target. Fraser ward achieved 96% compliance. Lennox ward scored the lowest compliance for staff training in the Mental Health Act (1983) with 73%, and Redburn ward 74%, both wards were below the 85% target.

Mental Health Act reviewers had visited all wards except Riding ward since August 2015. The latest visit was a visit to Redburn wards patients unit in March of this year. Visits to Redburn ward, Lennox ward and Fraser ward all highlighted the use of emergency response belts to move patients to seclusion rooms. We found this still to be the case during our inspection. Mechanical restraint used in this way did not support the therapeutic intervention and recovery of children on the wards. Alnwood wards were a medium secure environment and Stephenson ward on Ferndene was a low secure environment. The last report for Redburn ward highlighted that there were several gaps in recording linked to section 132 rights and in two records, there was no Approved Mental Health Professional (AMHP) report available. During our inspection, our review of electronic patient records found that Redburn ward's documentation and practice on patient's rights was lacking.

Patients and staff confirmed that they had their rights explained to them every month in a pictorial format where appropriate. One patient had their rights read weekly. All patients accessed the mental health advocate service provided by CoramVoice charity at least monthly and in some cases weekly; these are independent advocates specially trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment. One ward manager told us how beneficial advocacy services were to the patients and to the service; they explained that advocates helped to challenge restrictive practices. Advocates had their own keys to the wards to allow free movement and discussion with patients.

All staff spoken with told us of the trust's Mental Health Act office and explained how to contact them for clarification on legal advice and implementation of the Act. One staff member in Lennox ward explained that they had received interface training between the Scottish and English mental health acts for patients returning to Scotland.

One member of staff explained that the consultant psychiatrist on Lennox ward was the Mental Health Act champion for the service and described how they had a new advocate appointed nurse to arrange tribunals.

Staff explained that the Mental Health Act office conducted audits and Stephenson ward audited community treatment order (CTO) forms attached to medication charts. We reviewed 11 patient's records in terms of Mental Health Act compliance and found clear capacity assessments supported with good narrative and patient involvement. However, we found that Redburn ward's practice on patients' rights was lacking. There was no evidence that patients understood their rights, set dates were missed and no care plan for the deterioration of one patient. Several reviews were not maintained centrally so were a challenge to find.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act (MCA) does not apply to patients under 16. For children under the age of 16, the patients' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff should assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to patients aged 16 and 17.

Staff asked about capacity told us of the policies available in the office, information on the trust intranet and copies of the code of practice on the ward. One nurse confirmed that capacity was also addressed in supervision. The trust target was that 85% of staff had attended the training within the timescales. From the data provided by the trust 88% of the staff had attended the training within the timescales which is above their target. Redburn ward, Lennox ward and Ashby wards were below the 85% target at 83%, 82% and 82% respectively. Mental capacity act audits were performed by the Trust's Mental Health Act team.

One ward manager explained how a best interest decision was reached for a patient that self-harmed and how this was discussed and recorded on Rio. Another member of staff described best interest decisions taken regarding tattoos and hair dye. Capacity assessments were recorded in the Rio notes we reviewed. One nurse explained that if a patient's capacity is questioned then the doctor seeks a second opinion.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke to 15 patients and five carers. We observed positive interactions between one nursing assistant on Lennox ward and a patient; the patient gained the confidence to speak with us as the staff member stayed by their side during the conversation. Lennox ward patients said that staff were polite and knocked on their bedroom doors before entering. One patient on Ashby ward described their dislike of the staff gathering and chatting outside of bedrooms as this attracted more patients; they felt uncomfortable leaving their room. One Ashby ward patient described how a cleaner had shouted at them and said that they had been unable to access their bedroom until the cleaner had left. However, patients also described staff as experienced and understanding. One patient described staff as respectful when they provided a towel to cover themselves when clothing had come off during an incident.

One patient on Ashby ward described their discomfort with agency staff; they described one agency member of staff observing them for the day without interacting with them. This made the patient highly anxious.

On Fraser ward one patient showed us around, describing the ward as 'the best place'. We witnessed a warm confident interaction between the patient and staff. Three patients on Fraser ward described the staff as 'kind, polite staff that listen'.

We collected feedback from 16 patients using comments cards. 13 comments cards were collected from Ferndene. Comments were mainly positive about staff and the environment. Patients said that the 'staff were nice, caring and supportive' although patients on Redburn ward reported that 'agency staff levels were high and staff often came onto the ward with no idea'. They also commented that there were not enough staff to facilitate leave. Three comments cards were received from Alnwood wards. One patient on Lennox ward commented that 'the bad things about the service is the agency staff; they don't understand me'. Patients spoke positively about having access to an advocate and were able to describe their role.

All patients had a named nurse and regular 1:1 time with staff. Patients on Riding ward also had named support staff.

PLACE assessments focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. The 2015 PLACE score for St Nicholas Hospital was at 100% and Ferndene was 99.9% This is around 2.5% above the England average of 97.6%.

The involvement of people in the care that they receive

Staff explained that patients were given a tour of the ward environment upon arrival and in some cases, ward staff visited the patient at home prior to admission for a full assessment. Staff arranged preadmission meetings, provided leaflets and advised patients and carers to view the website. Patients received an 'all about me' book to complete. Staff explained the ward rules and expectations. One member of staff described their use of communication passports to help with the admission process. This included clinical information, as well as key personal preferences which had been developed by patients, carers and staff from different organisations that the patient had been in contact with. Information from the initial meeting is transferred into a pen portrait of the patient and then entered into the patient's care plan. Riding ward had 3 patients waiting for planned admissions at the time of our inspection. Patients each had a care co-ordinator assigned who updated the inpatient team of any significant changes that would require an admission escalated; Riding ward held a weekly referral meeting where all cases were reviewed. No other wards had a waiting list at the time of inspection.

Riding ward used social stories to orientate patients to the ward. Social stories were created to help teach social skills to people on the autism spectrum. They are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. Riding ward's social stories included photographs of the unit and the patient's named nursing staff. Riding ward also had social stories for the taking of bloods and making amends after disagreements.

Patients were not currently involved in recruiting new members of staff, however they attend weekly community meetings on all of the wards. This gave patients the opportunity to raise any issues they had with the service. The trust also used 'Points of You' survey cards to obtain

Good

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feedback from servicer users and carers across the trust, with a version tailored specifically for patients. Both wards also held patients and carer engagement meetings at carer open days.

Patients were encouraged to have families visit and where the distance was too great, patients skyped and phoned their families. One family member from Riding ward described how an emergency admission had been very emotional and how the staff had made it better. They described how they were kept up to date and offered family approach sessions. One Ashby ward patient spoke of staff not calling their family fortnightly, as agreed, to update them of their progress.

Patients had individualised activity programmes, which were developed, based on the therapeutic value of activities and the likes and dislikes of patients. Patients were happy that they had a choice in deciding which activities to participate in and their choices were respected. There were an extensive range of activities provided both on and off the ward.

All patients had an independent mental health advocate from CoramVoice charity. Patients told us they knew who their advocates were and that they saw them when they needed to. We saw evidence that advocates had supported patients at tribunals and review meetings.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The trust provided details of bed occupancy between 01 November 2015 and 30 April 2016; these are a measure that show the average number of beds occupied overnight that are under the care of consultants. The average bed occupancy rate was 84% across all wards and 67% on child and adolescent mental health wards. The bed occupancy rate included leave days. The lowest rate was on Wilton ward at 59% and the highest was 79% on Redburn ward. Both are within the Royal College of Psychiatrists recommended average occupancy rate of 85%. Bed occupancy for the year never exceeded 100% and data provided by the trust showed that they had not exceeded the trust target of 85% since November 2015. Staff spoke of closing beds in line with NHS England guidance. When on leave patient's room remained theirs until they returned from leave. The wards admitted patients from all over the United Kingdom and Ireland and offer specialist services. One parent on Stephenson ward described their difficulty at getting their child admitted due to the community processes not being in place.

Patients were discharged at the most convenient time for the patient. One patient, originally on Lennox ward, moved wards to have better access to seclusion rooms. The average length of stay for all patients across the seven wards as of April 2016 was 238 days; with Redburn ward patients staying the least amount of time at 79 days; Lennox ward patients staying the longest at 634 days. The number of days reported were those spent on the ward only and do not include any time spent previously on other NTW wards during the same patient episode. Leave days were included.

There were four readmissions within 90 days between 1November 2015 and 30 April 2016; three of these were to Redburn ward.

There were five delayed discharges over the same period, all at Ferndene. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. Staff at the trust spoke of the difficulty of finding suitable placements for patients and how the delays can set back the patient's recovery. The 5 delayed discharges were due to availability of placements and the staff ensuring that the patients had the correct level of support in their placements.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environments were clean and comfortable with solid furniture. Patients had access to rooms and equipment to support treatment and care. There was access to outside space, although Lennox ward patients could not easily go outside because the ward was on the third floor of the premises. One member of staff told us that if the ward was unsettled it was too dangerous to attempt taking patients outside because of the three flights of stairs.

We saw that patients had personalised their bedrooms and staff encouraged this; patients could access their bedrooms at any time. There were secure lockers for patients to store their belongings. Patients on all wards had internet access and were able to use the ward phones in private to make personal telephone calls. All wards had access to a family visitor's room although one parent on Lennox ward said that the rooms were ill equipped to entertain siblings and patients on the ward. This negatively impacted on the time spent together as a family.

Patients and their carers reported that the quality of food was poor. Menus were on a four weekly rotation. One patient on Redburn ward explained that although they had access to fresh fruit and juice, they were unable to make hot drinks. Patient-led Assessment of the Care Environment (PLACE) survey in 2015 had rated food quality for the trust overall at 88.8%. This was above the England average. There was no score recorded for child and adolescent mental health wards.

One member of staff on Lennox ward told us that sometimes patients could not attend education sessions off the ward so they had set aside two rooms on the ward to enable education activities. Activities and social events were available seven days a week although activities coordinators on all wards did not work at weekends. Staff on Stephenson ward told us that patients could access the sports hall, Zumba classes, nature programs and pottery sessions. Education sessions were provided by Newcastle Bridges School for 25 hours per week. The number of hours of education offered was dependent on the individual needs and ability to access a full curriculum and whether a

Are services responsive to people's needs?

Good

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

patient can be taught in a group or on an individual basis. One patient on Redburn ward described a recent trip to Prudhoe castle and another to a swimming pool and told us that there were arts and crafts activities seven days a week. They also told us that activity workers and occupational therapists worked weekends and holidays.

Meeting the needs of all people who use the service

Alnwood was a building over many levels with several sets of stairs however a lift was available to transport patients through the wards with mobility needs. Ferndene was built all on one level and fully accessible. At the time of our inspection there were no patients on the wards with mobility issues. Staff had access to interpreters and there was access to a chaplain and cultural friends for spiritual support. One nurse told us how they had facilitated the payment of Fidyah for one Muslim patient; this is when the person who is unable to fast for unavoidable reasons such as ill health, pays for someone else to be fed during Ramadan.

Prior to admission onto the wards, patients and carers were provided with a detailed information pack. This contained information on the service, the treatment provided and essential information on the ward, including visiting arrangements and complaints procedure. Information in the patient welcome pack was available in a variety of formats, including pictorial, social stories and easy read. Some patients had communication passports to ensure that the most effective form of communication was used to aid understanding. Families were encouraged by staff to spend time on Stephenson ward to aid with their understanding of treatment. One mother requested different visiting arrangements and these were accommodated.

Staff at Ferndene described a healthy tuckshop initiative created by a dietician, occupational therapist and food technology teacher. Patients planned what to eat and budgeted before preparing the snacks as a group that they could buy at the tuckshop. Ferndene staff also described a recent visit to Buckingham palace by one member of staff to collect eight Duke of Edinburgh awards on behalf of the patients.

Listening to and learning from concerns and complaints

Patients and carers told us they knew how to complain. Information on the complaints process was included in the patient and carer welcome packs. Patients and carers said that if they had any issues, they would feel comfortable raising these directly with staff.

Patients and carers could provide feedback through the trusts' 'Points of You' system. This was a comments card system. Staff updated 'You said, we did' boards within ward environments to inform patients and carers what had changed as a result of feedback. Patients could raise issues at community meetings; Ashby ward changed the time of their multidisciplinary team meetings to accommodate more staff present at the patient's community meetings.

The service had received 10 complaints with three complaints fully upheld and two partially upheld during 01 November 2015 to 30 April 2016. Three complaints related to the care and treatment of patients and two complaints related to breach of confidentiality. Zero complaints were referred to the ombudsman.

Lessons learnt were discussed at multidisciplinary team meetings and Lennox ward staff spoke of a 'wellbeing space' at the end of their team meetings where staff raise any worries that patients have communicated to them. One patient on Redburn ward told us that they had informally complained about agency staff use however, they never heard back from the service. Staff received updates via emails from ward managers and staff meetings.

Children and adolescent mental health wards received four compliments between 01 May 2015 and 30 April 2015; two in Fraser ward and one each in Riding ward and Redburn ward. The trust also explained that wards and services receive many compliments and thank you cards locally which were not included in the data provided. We viewed thank you cards sent by patients and families in the nurses stations during our inspection.

Are services well-led?

Good

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

Our findings

Vision and values

The trust's vision was 'to improve the well-being of everyone we serve through delivering services that match the best in the world'. The trust had three values:

- Caring and compassionate.
- Respectful.
- Honest and transparent.

We found that staff awareness of the specific wording of the values was not clearly described to us however we saw staff's behaviour reflected these values during our inspection. We witnessed staff to be caring and respectful towards patients. Staff could describe duty of candour, which is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. One member of staff described how the appraisal system was underpinned by the trust's values.

Staff were positive about local and senior managers in the trust and said that senior managers had visited the wards, although, two members of staff from Lennox and Ashby wards said that they had never seen the senior executive team. Staff described the 'speak easy' events that enabled feedback to the senior leadership team, and how they were accessible to all staff. We viewed themes and feedback from these events in board of directors meeting minutes. Local managers were positive about the senior management and described how they were supported by them. Staff were confident at seeking guidance from their ward managers.

Good governance

Some ward managers explained that releasing staff to supervision and training was difficult even though local governance systems were in place. The trust had a compliance target of 85% for clinical supervision. The trust's initial submission had a lower than average compliance rate for three of the wards. The trust later clarified this data and provided us with a complete data set which showed that the average compliance rate of clinical supervision was 89%. Information provided by the trust prior to the inspection showed that overall the staff in child and adolescent mental health wards had achieved 91% of their mandatory training, which is above the trust target of 85%. Training records provided by the trust showed staff on Redburn ward and Ashby ward had not met the trust target for basic or immediate life support training. There was an ethos where additional specialist training was encouraged and we found that many staff were engaged in or had recently completed some form of additional training.

We found that all staff knew how report incidents and that managers had oversight of reported incidents. Staff had a comprehensive understanding of safeguarding procedures and spoke of the safeguarding team visiting the wards. Incidents were investigated and actions were taken to prevent incident recurrences. Lessons learnt were communicated out. Staff had a reasonable knowledge of the Mental Health Act, Mental Capacity Act and Gillick competence and knew where to go for further information and advice if needed.

The service undertook clinical audits and the service was able to provide examples where audits were used to examine areas such as family engagement, risk assessments and behavioural support plans in care records. There was administrative support in both settings, we observed positive interactions and staff knew the location of information and data.

Staff reported that they had sufficient authority to undertake their roles successfully in all areas. Staff were positive about their local managers and local managers in turn were positive about the trust's senior management team. Wards had a local risk register and managers could explain the process for escalating risks to the service-level risk register and to higher level registers if needed.

The service was required to report every three months on key performance indicators to the local NHS England Specialised Commissioners. There had been changes in the NHS England specialised commissioned services contract for 2016/17 and we viewed that reporting structures were in place to accommodate this change. Data, including seclusion and restraint usage, were submitted to the NHS England Specialised Commissioners. NHS England Specialised Commissioners and staff we spoke to were aware of the levels of use; this was communicated regularly to staff.

Leadership, morale and staff engagement

The trust provided staffing figures for sickness, staff turnover and vacancies by ward. The staff sickness rate of

Are services well-led?

Good

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

4.4% was below the trust's average of 5.4%. Ashby ward had the highest sickness rate of 9.26%. The service had a lower rate of leavers at 6.6% than the trust average of 7.9%. Wilton ward had the highest number of staff leavers in the last 12 months with 22%. Staff vacancy rates in the 12 month period was 5.6% across all wards; Stephenson ward had the highest number of vacancies overall with 10.15% which is above trust average.

There were no bullying and harassment cases in the service. Feedback from the staff was positive about working on the wards. They were passionate about their role which was evident in the interactions with patients. Staff reported that they were happy and part of a supportive team; this view was echoed by the patients and carers we spoke with. Staff morale could be low after incidents on the ward but staff spoke of support offered via debriefs and Lennox ward staff spoke of daily well-being checks. There was a high regard for all staff despite their background or experience and differing opinions were sought and welcomed. One member of staff described development days for the staff throughout the year and how this gave them the chance to share concerns and good practice. The trust's overall score of 3.80 was above average for staff engagement in the NHS staff survey when compared with trusts of a similar type. This data could not be split at ward level.

Staff said that they would be able to whistle-blow if they felt it was necessary and were aware of the process.

Commitment to quality improvement and innovation

All wards were peer reviewed by the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC). Stephenson ward on Ferndene had been accredited and rated as excellent until 4th April 2017. There were areas for development from the review which the trust had been working to improve such as reducing agency staff usage and clarity around emergency admissions.

A peer review visit by the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) team of Riding ward identified the limitations of the 10 minute handover to staff; this was also an issue for the other peer reviews of Ferndene wards. During the inspection, Riding ward staff explained that they intend to apply for accreditation with the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC).

A peer review visit by the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC) undertaken at Alnwood in May 2016, highlighted the starkness and challenges of the physical environment; staff on the ward had responded to this and were in the process of making the environment less bare. The physical limitations of the environment are still an ongoing issue for Lennox ward.

Fraser ward had developed a dietetic screening tool in house in the absence of anything available nationally and had an article published in the International Journal of Behavioural Support.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust were using mechanical restraint as an intervention in the management of violence and aggression in child and adolescent mental health wards. The use of mechanical restraint to move patients around the building linked to the environment and did not support therapeutic intervention and recovery of children on the wards. The trust must ensure that care and treatment including the use of mechanical restraint is planned to support therapeutic intervention and recovery. **This was a breach of regulation 12 (1) (2) (b)**