Good

Northumberland, Tyne and Wear NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX4E6	Campus for Ageing and Vitality	Akenside	NE4 6BE
RX4E6	Campus for Ageing and Vitality	Castleside	NE4 6BE
RX4E2	St George's Park	Hauxley	NE61 2NU
RX4E2	St George's Park	Woodhorn	NE61 2NU
RX4K2	Monkwearmouth Hospital	Marsden	SR5 1NB
RX4K2	Monkwearmouth Hospital	Mowbray	SR5 1NB
RX4K2	Monkwearmouth Hospital	Roker	SR5 1NB
RX4Z3	Hopewood Park	Rosewood	SR2 0NB

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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 wards for older people at Northumberland, Tyne and Wear NHS Foundation Trust as good because:

- Staffing levels were good throughout and managers had the ability to increase these dependent on need. Additional staff were familiar with the environments they worked in.
- Mandatory training compliance was high across all wards.
- Patients had good access to physical healthcare on admission and ongoing monitoring; this included access to specialists when needed.
- A full range of disciplines provided input into the care of patients.
- Staff showed a caring attitude when interacting with patients and their carers.
- Staff ensured carers and families were kept informed and involved throughout the duration of a patient's stay.
- Staff worked with on-going care providers to minimise a patient's trauma when transferred to new care facilities and therefore reduce re-admissions.
- Managers were able to input into decisions relating to bed management.
- Activity co-ordinators were included in the ward's staff mix enabling access to activities seven days a week.
- Staff knew the trust's values and talked about them in a manner that reflected their working practice.
- There was high morale among all staff.
- Staff were able to contribute ideas for quality improvement and innovation.

However:

- We observed staff delivering and discussing person-centred care. This however, was not reflected in the care plans which had limited personalisation and did not reflect the involvement of patients or their carers.
- Staff did not always use the electronic care plans as their first point of reference. This meant that staff did not always deliver patient care as planned.
- Ward managers were working towards ensuring that restrictions were not imposed on all patients due to the risks of some. However, there were still some blanket restrictions on wards and staff did not always individually assess a patient and consider the least restrictive option.
- Staff did not commence discharge planning at the point of a patient's admission.
- Staff did not always ensure a patient's rights were clearly explained to them on admission and routinely thereafter.
- Staff did not always carry a personal alarm.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Wards were clean and well maintained.
- Staffing levels were good throughout and managers had the ability to increase these dependent on need. Additional staff were familiar with the environments they worked in.
- Mandatory training compliance was high across all wards
- Risk assessments were present and mostly up to date.
- Clinic rooms were fully equipped with accessible resuscitation equipment and staff followed good medicines management practices.
- All staff knew what to report as an incident and how to do this. Managers appropriately investigated incidents and fed back lessons learnt to staff teams.

However:

- There were some blanket restrictions on some of the wards visited.The wards had made some reductions in the restrictions previously identified and had an on-going plan for further improvements. However, staff did not always individually assess a patient and consider the least restrictive option.
- Staff on Rosewood ward did not always carry personal alarms. There were insufficient alarms on Akenside and Hauxley wards meaning some staff were unable to have a personal alarm.
- Care plans did not always reflect current prescribed medications.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were not always personalised and varied in the detail they contained.
- Staff did not always use the electronic care plans as their first point of reference. This meant that staff did not always deliver a patient's care as planned.
- Staff had limited time in handover meetings to ensure a person centred approach.
- Staff did not always ensure a patient's rights were clearly explained to them on admission and routinely thereafter.

However:

- Patients had good access to physical healthcare on admission and ongoing monitoring; including access to specialists when needed.

Summary of findings

- Staff followed guidance and best practice.
- Mental Health Act documentation was in order, up to date and stored appropriately.
- A full range of disciplines provided input into the care of patients. Within 72 hours of a patient's admission, staff held a multi-disciplinary meeting to plan on-going care.
- Staff felt supported and received supervision.
- The trust supported staff to access specialist training for their role.

Are services caring?

Good

We rated caring as good because:

- Staff showed a caring attitude when interacting with patients and their carers.
- Staff ensured carers and families were kept informed and involved in the patients duration of stay.
- Staff considered the needs of the carers as well as the needs of the patients.
- Marsden ward had a carer's overnight room and assisted with travel costs for those out of the local area.

However:

- Care plans did not reflect the involvement of patients or their carers.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff made robust plans to prevent a patient's re-admission after they were discharged.
- Managers were able to input into decisions relating to bed management.
- Activity co-ordinators were included in the ward's staff mix enabling access to activities; including at weekends.
- Patients, relative and carers were informed how to complain if they wished.
- The trust's patient advice and liaison service often attended patients' community meetings to help resolve complaints at ward level.

However:

- Staff did not commence discharge planning from the point of admission.
- The trust often placed organic patients onto functional wards due to shortages in beds.

Summary of findings

Are services well-led?

Good

We rated well-led as good because:

- Staff knew the trust's values and talked about them in a manner that reflected their working practice.
- Structures were in place to ensure effective communication from ward to board level and vice versa.
- Staff teams had participated in team events focusing on their wellbeing.
- There was high morale among all staff.
- Staff were able to contribute ideas for quality improvement and innovation.

Summary of findings

Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust provide inpatient services for older people with mental health problems. These services are for both patients admitted informally and those detained under the Mental Health Act 1983.

There are eight wards distributed over four hospital locations. The purpose of the wards is to provide assessment, treatment and rehabilitation to older people who require a hospital admission due to their mental health needs.

These wards are:

Rosewood

This ward is based at Hopewood Park Hospital in Ryhope. It is an assessment ward for male and female patients with mental health problems arising from functional disorders (such as depression and schizophrenia). The ward had 18 beds available. At the time of our inspection there were 18 patients allocated to the ward; of these, seven were detained under the Mental Health Act.

Roker

This ward is based at Monkwearmouth hospital in Sunderland. It is an assessment and treatment ward for older people with mental health problems arising from organic disorders (such as dementia related illnesses). The ward has 12 beds available for male patients. At the time of our inspection there were 12 patients allocated to the ward; of these 10 were detained under the Mental Health Act.

Mowbray

This ward is based at Monkwearmouth hospital in Sunderland. It is an assessment and treatment ward for older people with mental health problems arising from organic disorders. The ward has 12 beds available for female patients. At the time of our inspection there were 12 patients allocated to the ward; of these nine were detained under the Mental Health Act.

Marsden

This ward is based at Monkwearmouth hospital in Sunderland. It is a specialised long term care ward for older people with mental health problems arising from organic disorders. The ward has 16 beds available for both male and female patients. At the time of our inspection there were 11 patients allocated to the ward; all of these patients were detained under the Mental Health Act. The ward managed patients who required more intense and specialised care.

Castleside

This ward is based at the Campus for Ageing and Vitality in Newcastle upon Tyne. It is an assessment and treatment ward for older people with mental health problems arising from organic disorders. The ward has 16 beds available for both male and female patients. At the time of our inspection there were 15 patients allocated to the ward; of these 14 were detained under the Mental Health Act.

Akenside

This ward is based at the Campus for Ageing and vitality in Newcastle upon Tyne. It is an assessment and treatment ward for older people with mental health problems arising from functional disorders. The ward has 18 beds available for both male and female patients. At the time of our inspection there were 11 patients allocated to the ward; of these five were detained under the Mental Health Act.

Woodhorn

This ward is based at the St George's Park hospital in Northumberland. This is a new ward, which opened in May 2016. Patients transferred from Cresswell ward and the challenging behaviour ward, which closed. It is an assessment and treatment ward for older people with mental health problems arising from organic disorders. The ward has 18 beds available for both male and female patients. At the time of our inspection there were 19 patients allocated to the ward (one who was on leave); of these, nine were detained under the Mental Health Act.

Hauxley

This ward is based at the St George's Park hospital in Northumberland. It is an assessment and treatment ward for older people with mental health problems arising

Summary of findings

from functional disorders. The ward has 24 beds available for both male and female patients. At the time of our inspection there were 24 patients allocated to the ward; of these 15 were detained under the Mental Health Act.

The Care Quality Commission last inspected the trust under the old methodology at St George's Park, Monkwearmouth Hospital and the Campus of Ageing and Vitality. There were no compliance actions identified. Hopewood Park was first registered with the Care Quality Commission in September 2014.

Our inspection team

The team was led by

Chair: Paul Lelliott, Deputy Chief Inspector, Care Quality Commission

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

Care Quality Commission

Team leaders: Brian Cranna, Inspection Manager, Care Quality Commission

Jennifer Jones, Inspection Manager, Care Quality Commission

Sandra Sutton, Inspection Manager, Care Quality Commission

The team that inspected wards for older people with mental health problems consisted of an inspector, two nurse specialist advisors, one Mental Health Act reviewer and one occupational therapist specialist advisor.

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 three focus groups.

During the inspection visit, the inspection team:

- visited all eight of the wards at the four hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with eight carers of patients using the service
- spoke with the managers for each of the wards
- spoke with 55 other staff members; including consultants, doctors, nurses, pharmacists, domestic staff and other allied mental health professionals
- attended and observed hand-over meetings and multi-disciplinary meetings
- observed mealtimes and patient activity groups
- collected feedback from patients using comment cards
- looked at 26 treatment records of patients

Summary of findings

- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 16 patients and eight carers across all eight wards.

All patients told us they felt safe while on the ward. They liked the staff and said staff were always about if they needed anything or just wanted to talk. Patients spoke positively about the food and were able to make a choice at mealtimes. They told us snacks and drinks were available throughout the day. Both patients and carers thought the wards were clean throughout. Patients said they liked the activities, which happened every day including weekends.

Carers felt that staff supported them with their needs as well as the needs of the patients. Staff invited carers to all meetings involving the patient. One relative told us they rang the ward twice a day and staff always had the time for their call and kept them fully informed. Staff informed carers that they could ring any time of the day or night if they needed. They told us there was always a high presence of staff and felt the care was good from the nurses to the domestic staff. Carers were confident that their relatives were safe on the ward.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure staff formulate personalised and detailed care plans and that these care plans are used consistently by staff to inform them of a patient's care.

Action the provider SHOULD take to improve

- The trust should ensure that staff individually assess patients to consider least restrictive options and remove restrictions imposed across full wards.
- The trust should ensure all staff carry personal alarms whilst on duty.
- The trust should ensure that staff explain a patient's rights to them on admission and routinely thereafter.

Northumberland, Tyne and Wear NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Akenside Ward	Campus for Ageing and Vitality
Castleside Ward	Campus for Ageing and Vitality
Hauxley Ward	St George's Park
Woodhorn Ward	St George's Park
Marsden Ward	Monkwearmouth Hospital
Mowbray Ward	Monkwearmouth Hospital
Roker Ward	Monkwearmouth Hospital
Rosewood Ward	Hopewood Park

Mental Health Act responsibilities

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

Staff received training in the Mental Health Act 1983. This was a mandatory requirement. At the time of our inspection, staff were 91% compliant with the training. Staff demonstrated a good understanding of the Act relevant to their roles.

On this inspection, we found the following:

- detention records were in good order with the correct legal authority
- staff had made efforts to reduce blanket restrictions.

We also found:

Detailed findings

- there was an inconsistent approach across the wards with regards to reading patients their rights
- staff did not evidence that discharge planning commenced at the start of a patient's admission
- some wards still had blanket restrictions
- the electronic records system still had links to the old Code of Practice
- on Roker ward, there were delays in staff referring patients to independent mental health advocacyservices.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were 94% compliant in training on the Mental Capacity Act. This was a mandatory training unit. Staff had a good understanding of the Mental Capacity Act and the Mental Health interface. They understood the key issues of capacity and compliance and when they should use Deprivation of Liberty Safeguards.

The trust had made 36 Deprivation of Liberty Safeguard applications between 1 November 2015 and 30 April 2016 across all wards with the exception of Marsden ward where all patients were detained.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

All wards were clean and tidy with well-maintained furnishings. Domestic staff maintained cleaning records, which were up to date, and demonstrated that staff had regularly cleaned the environment. On Castleside, we saw an unattended cleaning trolley containing cleaning fluids. This could cause harm to patients. We informed the ward manager immediately who took appropriate action.

Patient led assessments of the care environment (known as PLACE) had been undertaken in 2015 for Northumberland Tyne and Wear NHS Foundation Trust in relation to cleanliness. Independent assessors rated wards at the Campus for Ageing & Vitality (Akenside and Castleside) at 97% for cleanliness, which is slightly below the England average of 98%. The patient led assessments of the care environment scores for all wards at the other locations were above 98%.

The trust had recently redesigned Mowbray, Roker, Woodhorn and Hauxley wards. The trust had designed Mowbray and Roker to Stirling standards. The University of Stirling recommended these standards to provide dementia friendly environments. Marsden, Rosewood, Akenside and Castleside were older wards, all having blind spots in their design. Staff mitigated these by the appropriate placement of staff, use of mirrors and by individually assessing patient's risks.

Wards used motion sensors in the rooms of patients who staff had assessed as being at risk of falls. These sensors activated an alarm when they detected motion and could have their sensitivity individually adjusted as needed.

Mowbray and Roker were the only same sex wards. Akenside, Castleside and Marsden had separated male and female patients with a lockable door and there were individual bathroom facilities in each section. Hauxley and Woodhorn had separate male and female corridors and patients all had en-suite facilities. Rosewood had separate male and female areas for sleeping. Female patients did not have a shower in their area although there were separate bathrooms with baths and toilet facilities. This concern was on the trust's risk register and the ward was due to be re-located in September 2016. Until the move occurred, staff protected a patient's privacy and dignity by ensuring they did not have to pass any male patients to use the showers if they wished.

Ligature audits were in place on each ward. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All wards had ligature points that the trust had referenced on the ligature audits. On all wards, plans were in place to manage these risks which included locking rooms where ligatures existed, for example some bathrooms, observations by staff and individual patient risk assessments. On Akenside, some wardrobes had collapsible rails and some did not. Some staff were unclear which rooms contained the risks and which did not. This meant that staff might accommodate a patient at risk of self-harm, in a room with a potential ligature point. However, we were told staff would check ligatures in each room prior to allocating a patient to a room.

We observed plastic aprons, gloves and incontinence pads accessible around the wards. A patient would be able to ingest these and cause harm to themselves. Staff told us that they would remove these if they assessed a patient and identified a risk.

All wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. There was appropriate equipment in the clinic rooms for the monitoring of medical observations; this included a blood pressure machine and weighing scales. 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 staff monitored temperatures daily in line with national guidance.

Staff adhered to infection control principles. There were anti-bacterial hand gels at the entrance to each ward for visitors and staff to use when entering and leaving the wards. We saw staff using these and encouraging others to do the same.

Good

Are services safe?

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

Staff had access to panic alarms on most wards. However, on Hauxley and Akenside there was a shortage of alarms for staff to use. On Akenside, this was due to maintenance workers also using the alarms. On Hauxley, the ward manager had further alarms on order as some of the current alarms were not working. On Rosewood, panic alarms for staff were available. However, when we asked seven staff if they were carrying an alarm, only one staff member had one on them. Panic alarms ensure staff are easily able to alert other staff members elsewhere on the ward if they required assistance in an emergency. This could compromise the safety of both staff and patients.

Safe staffing

All the wards had good staffing levels. Ward managers, staff, patients and their carers, all felt that there were sufficient staff at all times. Patients received regular one to one time with their named nurse. Wards never cancelled escorted leave or activities due to insufficient staff, physical interventions occurred as needed and staff were able to attend training as required.

Staff worked a shift pattern that covered early days, late days and nights. The trust had established staffing levels across the eight wards as 104 (whole time equivalent) qualified nurses and 158 (whole time equivalent) nursing assistants. Ward managers were able to increase these levels based on the clinical presentation of patients. For example, due to the number of patients requiring a high level of observation. Data supplied by the trust showed that on the 30 April 2016, there were 13 qualified nurse vacancies and 1.5 nursing assistant vacancies. The trust was in the process of recruiting into these positions. There were 14 members of staff on long-term sick or maternity leave. To cover sickness or increased staffing requirements, wards used mainly bank staff. Wards rarely used agency staff. These were mainly used on Woodhorn and Castleside ward. Ward managers were able to request the same bank or agency staff on a regular basis to ensure familiarity with the wards.

Staff were required to attend mandatory training units. These included care pathways, health and safety, infection prevention, information governance and safeguarding. Staff across all the wards for older people with mental health problems wards were 93% compliant in receiving this training. The lowest compliance was 78% in clinical supervision. However, staff had been booked onto future training to increase this.

Assessing and managing risk to patients and staff

There had been two episodes of seclusion on Hauxley ward in the six months leading up to our inspection. One of these related to aggressive behaviour to another patient and one physical assault on staff by a patient. Both incidents lasted 10 minutes and took place in the patient's bedrooms. On Woodhorn ward, there had been two episodes of seclusion relating to harm to others. These took place in the ward's quiet room, one lasting two hours and 55 minutes and the other lasting three hours and 40 minutes. Staff had recorded all details relating to each of these occurrences.

Between the period of 1 November 2015 and 30 April 2016, there had been 145 episodes of restraint. However, 75 of these episodes referred to Woodhorn. Woodhorn opened in May 2016. The majority of these restraints related to patients from a the former ward (Cresswell) which catered for patients with challenging behaviours. Seven of these incidents resulted in prone restraint. Woodhorn had made significant efforts in changing culture since their move; this included reducing restraints on the patients that transferred from the previous ward. The National Institute for Health and Care Excellence guidance NG10: Violence and Aggression, recommends avoiding prone restraint, and only using it for the shortest possible time if needed. During our inspection, we reviewed records and spoke to staff regarding the episodes of prone restraint. Where patients had placed themselves down on their front during restraint, the staff had quickly turned them, or if staff turned a patient to administer medication, they then documented this as prone restraint. Staff used de-escalation techniques the majority of time to manage behaviour. All staff were trained in the prevention and management of violence and aggression techniques; this included bank and agency staff.

Staff undertook a risk assessment of every patient on admission. They regularly received previous risk assessment if transferred from another ward or the community teams. If this were the case, they would still revisit all risks as an update. The trust used the Functional Analysis of Care Environments risk assessment tool. This assessment included assessment of suicide, self-harm, harm to others, self-neglect, physical conditions, clinical symptoms, history and personal circumstances (for example, isolation, financial and housing). We looked at 26 care records, 24 risks assessment were present and up to date. One assessment from Roker ward and one from Rosewood did not clearly evidence that staff had updated the assessment recently.

Good

Are services safe?

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

Following the CQC Mental Health Act reviews, wards had made some progress in reducing the number of blanket restriction on the wards. A blanket restriction is a restriction imposed on a full ward due to the risks of some patients. On inspection, we noted that staff had locked bedroom doors on Woodhorn, Akenside, Castleside and Mowbray. Staff told us that patients were able to ask a staff member at any time for access to their rooms and that they had locked the rooms to protect patients' possessions. Some patients, or their carers had asked for their rooms to be locked. Patients were able to request their door to be left unlocked if they wished. Staff did not individually assess patients around the possibility of having a key to their room on these wards. However, staff on Roker, had individually assessed patients resulting in two patients having their own keys to their rooms.

Staff told us they kept doors to outside space unlocked for patients to be able to access the gardens when they wished. However, on inspection, Castleside, Rosewood and Roker had the external doors locked; this meant patients were required to ask a staff member to go outside. Outside areas were secure.

Access to hot and cold refreshments and snacks was variable among the wards. Hauxley, Akenside, Rosewood, Marsden and Mowbray wards had readily available snacks and refreshments. Hot drinks were by request on Woodhorn and Roker though cold drinks were freely accessible. On Castleside, staff removed the trolley containing snacks from accessible areas, which meant patients would have to ask staff for refreshments.

Managers we spoke to informed us that they were continuing to consider the least restrictive options whilst at the same time protecting the safety and possessions of their patients.

Staff observed patients in differing degrees depending on their current risks. This ranged from hourly observation to constant observations at arm's length. Staff reviewed observations at all handover meetings and at daily multi-disciplinary reviews. Staff were familiar with the trust's policy on observation.

Staff knew what constituted a safeguarding concern and how to report it. The trust had a central safeguarding team that staff used for advice and to liaise with local safeguarding authorities. Managers discussed safeguarding in team meetings and they discussed any concerns in handover meetings.

We looked at the systems in place for medicines management. We reviewed prescription records and spoke with nursing staff who were responsible for medicines. Staff completed records fully and accurately, and prescribed medicines in accordance with the consent to treatment provisions of the Mental Health Act. 'When required' prescriptions contained relevant information to enable staff to administer them safely. However, staff had not updated the care plans in place as they made changes to prescribed medication. For example, we saw a patient on Roker who had a care plan for challenging behaviour. The medicines listed in the care plan did not accurately reflect the medicines prescribed for this patient.

Ward staff told us about the comprehensive support provided by the pharmacy team, which included a visit by a clinical pharmacist at least three times per week and attendance at multidisciplinary team meetings. Pharmacy staff also labelled medicines on the ward ready for patient discharges or periods of home leave. There were adequate supplies of emergency equipment, oxygen and defibrillators. The wards kept stocks of emergency medicines 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's online reporting system and they were supported by managers to learn from incidents.

Staff carried out a risk assessment prior to visits from children. Children did not visit their relatives in communal areas and mostly used the patient's bedroom or small rooms. Marsden ward had a separate entrance for children visiting so they did not have to pass through communal areas.

Track record on safety

In the period from 1 Jan 2015 to 30 Nov 2015, there were nine serious incidents requiring investigation. Six of these related to fractured neck of femurs and one related to an unexpected death. The other two were still awaiting a conclusion.

Staff were able to tell us what actions the trust or ward had taken following investigations of the incidents.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

Staff across all wards were able to describe and give examples of what constituted an incident and how to report it. We were told that staff involved in serious incidents received a debrief as soon as practicably possible after this had happened. The manager and the band six nurses reviewed the details of all incidents. Staff teams participated in an after action review where they discussed what was done well and what could be done better. Staff were aware of the duty of candour and the need to apologise and be open and transparent when an incident occurred.

Managers attended a monthly learning lessons group. This group looked at trust wide serious untoward incidents. Lessons learnt from these incidents were then cascaded down to staff at ward level via discussions in handover meetings, team meetings and displayed on staff notice boards. Staff also received emailed bulletins which shared lessons learnt.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Staff assessed patients following their admission and on an on-going basis. Staff maintained the assessments as live documents on the trust's electronic system to enable staff to update them as needed. The assessment tool considered patient's needs, expectations, capacity concerns, the views or carers, personal history, social circumstances, family medical and psychiatric history, criminality and advance decisions and statements. Staff used additional assessment tools relating to falls, nutrition, self-harm and carer's needs.

Within 72 hours of admission, wards planned a meeting to discuss the patient's on-going care. These meetings were called 72 hour meetings. The consultant, a doctor and nurse attended these meetings. Other professionals specific to the patient also attended, for example, occupational therapist, social worker, speech and land language therapist, dietician. Staff also invited family and carers.

Following assessment, staff formulated care plans relating to different aspects of the patient's care. These included care plans for challenging behaviours, tissue viability, falls and other patient specific needs. They recorded the care plans onto the electronic system.

Of the 26 electronic records we looked at, 22 had current care plans. The other four patients had been very recently admitted and care plans were still in the formulation process. We found that care plans lacked personalisation and were not being used effectively by staff.

One patient had 22 different care plans and another patient had 16 care plans relating to physical care alone. This meant that staff might easily overlook, dismiss or rely on alternative methods to familiarise themselves on the care required, due to the complexity in accessing the relevant information electronically. We found that staff did not always use the electronic plans as their main point of reference. The wards relied on the knowledge of familiar staff and verbal communication rather than referring to the electronic plans. This meant that staff were not always following the plan for the care agreed. For example, we observed a paper care plan, which was not found on the electronic system or detailed on the patient's handover sheets. We also discussed with a nurse, the care of a patient with pressure wounds. We checked this against the care plan on the electronic system, which the tissue viability nurse had provided. The electronic plan contradicted with the understanding of the nurse.

We did observe personalised and detailed care discussions in multi-disciplinary meetings. However, staff had not always reflected these in care plans recorded on the electronic system. Staff discussed levels of care within handover meetings. However, handover meetings were very short in duration, which meant staff were unable to provide detailed information.

Electronic care plans varied in detail, the level of personalisation and degree of recovery-orientated goals. Of the 22 care plans looked at, 17 had limited or no personalisation. We saw evidence of generic statements. For example, one care plan stated that staff were to "be aware of factors that increase the likelihood of violent behaviour and aggression"; however, the plan did not detail what these factors were specific to the patient. Staff were able to verbally describe what these factors were but they had not recorded them on the care plan.

Wards also used patient 'at a glance' status boards. These recorded diagnosis, observations required, Mental Health Act status, risks, medications and involvement from other professionals.

Doctors carried out physical examination of patients on their admission. Doctors were easily available at all times to undertake physical examinations. Patients with physical health problems received on-going appropriate monitoring, for example physical observations and blood tests, in accordance with national guidance. However, we saw a large variation in the quality of care plans. We saw an example of a comprehensive care plan for a patient with ulceration to both legs, which contained detailed and personalised information about their management. However for another person with diabetes, there was a generalised care plan in place which only stated 'to monitor the patient's blood sugar levels'.

The electronic patient record system used by the trust to store all information needed to deliver care was secure and available for all staff to use. This included other allied mental health professionals, other trust teams and bank staff. This meant that if a patient moved between wards or services, their information was accessible to the new team. The only exception to this was agency staff that would

Are services effective?

Requires improvement

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need to utilise other staff to view or record onto the system. Ward managers told us that as the majority of agency staff were familiar; this was generally not a problem. For a new agency worker, staff would ensure a verbal induction, which included patient details.

Best practice in treatment and care

The Royal College of Psychiatrists provided best practice guidance for older adult mental health wards. This included recommending joint working between the multidisciplinary team in relation to physical healthcare and mental healthcare. Northumberland, Tyne and Wear NHS Foundation Trust embedded psychiatric consultants and doctors within all the wards for older people with mental health problems. Staff on all wards considered a holistic approach to patient care, which included other disciplines specific to the individual needs and physical healthcare concerns.

Staff on the organic wards received training and used the Newcastle Model to inform their care approach. This model provided a framework and process in which to understand the challenging behaviours of patients in terms of unmet needs. It suggested a structure in which to develop effective interventions that kept people with dementia central to their care.

Patients had access to psychological therapies recommended by the National Institute for Health and Care Excellence. Wards were able to refer patients to the psychologists who attended their wards on a weekly basis. Rosewood ward also had staff trained in cognitive behavioural approaches. The occupational therapists implemented cognitive stimulation therapy into the therapy programme.

Patients' nutritional and hydration needs were met and assessed. Staff used nutritional and fluid charts to monitor intake and referred to the dietician if required.

The Department of Health (2003), suggests services should provide opportunities for stimulation through activities, which suit needs, capabilities and preferences. All wards had activity co-ordinators who planned a schedule of activities throughout the week. Staff on Marsden ward used a software package with patients to promote communication, activity and improved well-being. The touch screen software included individualised reminiscence therapy to promote engagement and conversation.

Staff used recognised rating scales to assess and record severity and outcomes. These included the Brayden Scale to rate skin integrity, the model of human occupation screening tool for occupational therapy, Warwick-Edinburgh Mental Well-being Scale , Addenbrookes Mini Mental State Exams and the Health of the Nation Outcome Scales .

The consultant supported junior doctors in audits, for example prescription practice audits. The consultant on Castleside contributed to an audit of antipsychotic prescriptions in dementia on an inpatient ward. This was conducted against trust standards in partnership with Newcastle University.

Skilled staff to deliver care

A full range of mental health disciplines provided input into all wards. These included consultants, doctors, occupational therapists, activity co-ordinators, pharmacists, speech and language therapists, dieticians, psychologist, chaplaincy and challenging behaviour therapists. The teams also included administrative and domestic staff.

Staff were suitably qualified. Most of the staff we spoke to had worked for the trust for some years and had good experience of working with older patients with mental health problems. New staff received a specific ward induction as well as a trust induction.

Staff felt well supported by their managers and received regular supervision. We received data relating to staff supervision prior to our inspection. Between the period of 1 May 2016 to 30 April 2016, there was an overall supervision rate of 78%. This included data relating to the previous Woodhorn ward at 18%. Since the CQC received this data, the manager had worked hard to improve supervision levels. At the time of our inspection, compliance for staff supervision on Woodhorn had increased to 75%. Additional to individual supervision, they also held group supervision led by the nurse lead for challenging behaviour. Bank staff told us they also received supervision.

Staff received annual appraisals. Data provided, informed us that compliance for appraisals over the same period was 89%. The lowest compliance was on Woodhorn at 78%. These figures included staff that managers were unable to appraise due to long term sick or maternity.

Staff attended ward meetings, which were held at least monthly. Agendas included communication from trust

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level, clinical performance, safety, complaints, incidents, training, audits and safeguarding. Managers told us that staff attendance at meetings was good. Minutes were electronically distributed and posted on staff notice boards for those unable to attend.

Additional to mandatory training units, the trust supported staff to participate in additional related specialist training. These included staff who had attended training in cognitive behaviour approaches, dementia care mapping, and the Newcastle model. Wards trained staff to support other professionals providing a link directly between the ward and specialist. These included link roles in phlebotomy, wound care, diabetes and carers support. All managers had received leadership training.

Multi-disciplinary and inter-agency team work

There were regular and effective multi-disciplinary meetings on each ward. All disciplines regularly attended and contributed to ward rounds and we observed fully holistic, personalised and detailed discussions. All professionals involved in the patient's care attended the 72-hour meetings, this included family, advocates and patients where practical. We spoke to various members of the multi-disciplinary team; all felt wholly involved in meetings and their contributions valued.

Staff attended handover meetings between shifts. However, shift patterns only allowed for a ten-minute crossover time. This meant that discussions in the meetings were very brief and were task orientated rather than being a person centred approach. Staff informed us they often came into work earlier to ensure a more effective handover. This was therefore reliant on the goodwill of the staff.

Wards informed us of good relationships with outside agencies, for example, social services and onward care facilities. Rosewood ward had a service level agreement with Sunderland Royal Hospital for a nurse to attend giving general advice on physical health matters, which may reduce admissions to acute services.

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

Training on the Mental Health Act was mandatory for staff. There was an overall compliance rate across the wards of 91% with all wards above 85%. Staff had a good understanding of the Mental Health Act and the new Code of Practice.

We looked at the Mental Health Act paperwork on all eight wards. Documentation was generally in order, up to date and stored appropriately.

Staff gave medications under legal authority and prescriptions were within defined limits.

However, there was an inconsistent approach from staff regarding reading patients their rights. We looked at 19 Mental Health Act records; three patients had not had their rights read during their detention under Section 2 of the act. A further two records had their rights read at the beginning of their section 2 detention and had said they did not understand them. Staff had not repeated these throughout the duration of the Section 2 and staff had not evidenced that they had explored alternative methods of explanation. On four of the records we looked at, patients were read their rights but not until either day three, four, six or eight into the duration of their section. We found no evidence that any wards used easy read materials or had adopted different approaches to assist a patient's understanding.

On Mowbray ward, two records had approved mental health professional reports in patient's files, which were illegible. Generally, staff made referrals to independent mental health advocacy services on admission. However, on Roker, we observed delays ranging from eight days to three months.

The electronic system staff used contained a link to the Mental Health Act Code of Practice. This link was to the old Mental Health Act Code of Practice and not the reviewed Mental Health Act code of practice for 2015.

We carried out Mental Health Act review visits to all wards in the 14 months prior to our inspection. On these reviews, we found blanket restrictions across all the wards. On this inspection, we evidenced that wards were making efforts to reduce these, for example, some wards now had internet access and some had plans to install it. However, we observed some doors to outside gardens still locked and patients on some wards did not have access to cold drinks without request.

Good practice in applying the Mental Capacity Act

Staff were 94% compliant in training on the Mental Capacity Act. This was a mandatory training unit. Staff had

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a good understanding of the Mental Capacity Act and the Mental Health Act interface. They understood the key issues of capacity and compliance and when they should use the Deprivation of Liberty Safeguards.

Staff were able to talk us through the key principles of the Mental Capacity Act in a way that was relevant to their role. It was clear from our observations and reviewing care records that staff assumed a patients' capacity unless reason to decide otherwise. Patients were encouraged to make as many decisions as they could for themselves, no matter how small.

Staff mostly completed capacity assessments within a few days of admission. However, on Castleside, staff had not completed an assessment until a month into one patient's admission. Staff were able to give us examples of when they had assessed a patient's capacity and made decisions in their best interest. Examples of this included, do not attempt resuscitation status and issues around medication being given covertly. We spoke to carers and they confirmed that they had been involved in these decisions.

The trust had made 36 Deprivation of Liberty Safeguard applications between 1 November 2015 and 30 April 2016 across all wards with the exception of Marsden ward where all patients were detained.

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

Staff showed a caring and respectful attitude to patients on all wards. They were responsive to the patients' needs and demonstrated patience in their approach. We observed staff walking with patients and assisting with mealtimes. Staff allowed patients to take their time assisting only when needed. Staff demonstrated empathy when talking to carers. For example, one staff member gave a patient's husband time and understanding when he was describing the life he and his wife had previously enjoyed.

A carer told us that staff showed kindness to their relative who was struggling to eat. They told us that staff prepared a nicely laid out tray of sandwiches and invited the relative and patient into the garden area to enjoy a picnic style meal.

The wards protected patient's privacy by ensuring bedroom windows could not be looked into from outside. Wards used one-way windows, blinds or privacy films to ensure this. Staff knocked on patient's doors before they entered and patient information was covered in staff areas that may be visible to others.

Roker and Mowbray wards used a separate and discreet entrance to move patients that were agitated; this was because the main entrance passed through a public café area.

The layout of Rosewood ward compromised patient privacy as the patients were accommodated in older style dormitories. The dormitories accommodated same sex patients separated by curtains. However, the ward was due to move in October 2016 to premises with single rooms.

However, on Castleside ward we observed staff taking a patient's blood pressure while they were eating breakfast. We also saw patient bowel and fluid charts on a windowsill in the dining area. We addressed both these concerns whilst on inspection and the ward manager responded appropriately.

The involvement of people in the care that they receive

On admission, staff on duty orientated patients around the ward. Staff showed the patients their bedroom and bathrooms and staff introduced them to other staff and patients. For patients with cognitive impairment, staff would do this as many times as was needed to reassure the patient.

Both patients and their carers received a welcome pack at the time of admission informing them about the ward, its purpose, visiting arrangements, meals and how to get further support.

Both carers and patients told us they felt involved in their care but this was not captured in the care plans. We did not see that patient or carer's views had been documented and little evidence of their involvement reflected in the plans. In addition, out of the 22 care plans we looked at, only 11 had clear evidence that a copy had been offered to either the patient or the carer

However, we saw very good involvement of families and carers. Wards invited carers and families to the 72-hour post admission meeting and all relevant meetings thereafter. Staff carried out carers assessments to ensure they had appropriate support if needed. Some staff on wards took on a carers champion role to ensure the carers and families were integral to the patient's care.

Carers told us that they were kept well informed with events and treatments relating to the patient and that medications and progress was regularly discussed. Wards displayed a good range of information and leaflets for both patients and their carers. These included leaflets relating to specific conditions, treatments, carers support, confidentiality, advocacy and the Mental Health Act.

The wards had flexible visiting times. They requested that families and carers did not visit during mealtimes and that visits were not in communal areas. This was to maintain the privacy and dignity of the other patients on the wards.

Marsden ward had a carer's room for family or carers to use, especially if the patient was not from the local area or approaching end of life. The room contained a bed, tea-making facilities and had an en-suite. They also assisted carers and relatives with travel costs if they were travelling from out of area.

Wards held community meetings either weekly or monthly for patients to view any concerns or contribute ideas. These

Good

Are services caring?

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were also often attended by a member of the patient advice and liaison service (PALS) and a doctor. The trust also used 'points of you' comment cards to enable patients and carers to give feedback on the service.

Staff referred patients to advocacy services; however, we were told that there was a waiting time of approximately two weeks before being seen.

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

Bed management was co-ordinated through a bed management team covering the entire trust. Managers told us that they were able to input into decisions relating to bed occupancy by providing the team with current information relating to clinical need, patient mix and discharge plans.

The average bed occupancy for the six months prior to our inspection was 75%. This was below the national average of 85%. However, Roker and Mowbray wards had bed occupancy of 95% and 96% respectively. All wards accepted out of area patients as needed but priority went to patients from the Northumberland, Tyne and Wear catchment. During this period, the trust placed one patient out of their area.

Bed management sometimes placed patients with organic disorders onto a functional ward. For example, at the time of our inspection, six patients on Rosewood ward had dementia and the ward was for patients on a functional treatment pathway. Staff told us this was due to a shortage of beds for older people with organic disorder and that this appeared to be an increasing problem. Staff used their experiences to ensure that patient care was not compromised due to this. We observed patient care focused on the individual needs of the patient rather than their illness.

Managers told us that new patients admitted might use leave beds if the ward was full. However, this would be risk assessed dependent on whether the patient was likely to return. For example, a leave bed may be used if a patient was on leave in a care home with a high level of support. If a patient had previously failed leave, was on home leave or was a complex case, then staff were clear they could protect that leave bed in case the patient needed to return. During our inspection, a patient occupied one leave bed on Woodhorn ward.

Carers told us of admissions onto wards late at night. Managers informed us this was due to delays in ambulances or assessments and out of their control. Medical staff were available throughout the night to carry out physical examination as needed and staff considered the patient's immediate needs and what may wait until a more appropriate time for the patient.

There were three delayed discharges in the six months prior to our inspection. These were all from Roker ward and were due to delays in social care placements. During the same period, the service re-admitted 24 patients within 90 days following discharge from a trust inpatient bed.

Staff did not routinely plan for a patients discharge from the point of admission. However, staff made robust plans to prevent a patient's re-admittance once the discharge plans commenced. If a patient was moving to on-going care facilities, the patient's named nurse would visit the full team at the new care facility. This gave an opportunity to present all information to effectively manage their future care. This included the patient's likes, dislikes, history, needs and risks. Staff invited family and carers to the presentation and the nurse lead for challenging behaviour would work with onward care facilities if needed. This reduced the trauma patients may face due to being moved and therefore reduce the likelihood of being re-admitted to the wards. Staff from the patient's ongoing care facilities would also be invited on the wards prior to a patient's discharge to observe methods of care proven to give positive outcomes.

The facilities promote recovery, comfort, dignity and confidentiality

Wards had sufficient space for activities and care. Rooms were comfortable, clean and spacious. However, there was limited space for visitors on Castleside and Akenside meaning visiting mostly took place in patient's bedrooms.

Patients could personalise their bedrooms if they wished. Memory boxes were located outside bedrooms on Roker ward. Family and carers had filled these with family pictures, cards or memorabilia to help orientate the patients with dementia and know where their room was. Bedrooms contained clocks and some had digital screens displaying the date and time. Patients could also use these to view photo shows through a personal memory stick.

There was access to a telephone to make a private phone call on each of the wards. For some wards this was a ward mobile phone that patients could use and on others, there was a private booth where patients could sit to make their call.

On Woodhorn, staff had arranged for the daily delivery of newspapers for patients to read if they wished.

Are services responsive to people's needs?

Good

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

All wards had access to outside space. However, this was not easily accessible on Akenside ward where staff would need to escort patients due to the location of the ward.

Patients we spoke to were all positive about the food. All patients were able to have hot drinks and snacks at all times although on some wards they would have to request these.

Activity co-ordinators were included in the staff mix for each ward. The co-ordinators worked flexible hours; this meant that they often arranged their hours around significant events. For example, working on remembrance Sunday to ensure patients celebrated appropriately. Managers, staff, carers and patients all told us that activities were well planned and delivered. We observed a memory group attended by eight male patients where the activities co-ordinator effectively encouraged the men to interact through discussion around Sunderland football club. Patients on Roker and Mowbray ward enjoyed fish and chip nights and carers told us they had brought family pets into the gardens on Marsden ward to promote a patient's recovery. Nursing assistants used ready planned activity boxes to ensure activities took place when the activities co-ordinator was not on their shift.

Mowbray and Roker ward had an on-site hair salon where patients could book appointment as part of their treatment.

Meeting the needs of all people who use the service

All wards were suitable for people requiring disabled access. Wards were equipped with hoists, adjustable baths, and grab rails. There were some bedrooms on each ward designed to enable access by wheelchair users. Both Akenside and Castleside wards would require patients to use lifts or stairs; all other wards were at ground level.

Wards did not have faith rooms. However, they each contained multi-faith boxes containing spiritual materials for differing religions. At the time of our inspection, Castleside were still awaiting delivery of their multi-faith box. Patients on wards were able to attend multi-faith services around the trust.

All wards had information boards for patients and carers. They included available leaflets on treatments, local services, advocacy, support groups, rights and how to complain. If required, staff could obtain this information in different languages. The trust also had access to translator services if needed.

We saw appropriate signage around the wards. This included a mixture of pictures and text and different coloured doors to aid a patient's orientation.

There were relaxation areas for females on the wards. However, on Castleside, we saw that male patients were also using the female lounge.

Pictures were used by staff to offer patients a choice of foods. Staff told us they made every effort to ensure that they could accommodate patient's wishes. For example, planning for last minute changes by ordering a wide range from the menu.

Listening to and learning from concerns and complaints

Wards for older people with mental health problems received 11 formal complaints between 1 November 2015 and 30 April 2016. Of these, the trust had fully upheld three, partially upheld seven and referred one to the ombudsman. Four of the complaints referred to care, support and restraint, three referred to discharge and transfer, two referred to communication, one related to an alleged assault and one in relation to falls. There were no formal complaints received for Roker, Rosewood and Akenside.

We saw information displayed informing patients and carers how they could complain. This was also included in their welcome packs on admission. Managers told us they always aimed to resolve complaints at ward level if possible. The wards held community meetings which provided a forum for patients to view their concerns; the trust's patient and liaison service often attended these meetings. Staff were aware of the complaints procedure and how to advise a patient or carer of the steps they would need to take.

Managers shared lessons learnt from complaints in staff team meetings, supervisions, emails and action plans.

The service received 14 compliments in the 12 months leading up to our inspection; Roker ward received eight of these.

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 wellbeing of everyone they served through the delivery of services that matched the best in the world. Their values were to be caring, compassionate, respectful, honest and transparent. Staff knew the trust's values and talked about them in a manner that reflected their working practice. One staff member told us they felt very honoured to be working on the wards.

Recruitment within the trust used a values based approach. This approach recruited employees on the basis that their individual values and behaviours aligned with that of the trust. Potential employees participated in group activities, which managers would assess prior to the normal aptitude and skills assessment process. Managers observed group activities for all disciplines. They told us that, although sceptical at first, they had seen improvements in the attitudes of new staff since its introduction.

Managers embedded and reflected the trust's values in staff appraisals and supervisions.

Staff knew who their senior managers were and told us they had seen them on the wards. Visits from the directorate leadership team took place at least quarterly.

Good governance

The trust had good systems in place for managers to oversee the performance of their wards. This included monitoring the training, supervision and appraisals of staff and ensuring shifts were effectively covered.

There was a structure in place to ensure communication from ward to board level was effective. Staff told us that communication was not only from the top down but also believed they had opportunities to escalate concerns and ideas. They were able to give us examples of how information was fed through governance systems to make improvements throughout the trust.

There were many examples of clinical audits happening across the service. These included medication audits, care records audits and mental health act audits. Staff were involved or aware of these audits at all levels and information was fed back to the appropriate people at meetings, in supervision and via email from the ward managers.

We spoke to staff and asked them about the incident reporting process. Staff were able to tell us how this worked and when and how to report incidents. We saw evidence of learning from incidents and changes made following this learning.

All ward managers felt they had sufficient authority and administrative support to run their wards. They felt able to approach their managers with suggestions and contribute towards decisions at a higher level. Managers had the ability to submit items to the trust risk register and all were aware of the current concerns for their wards.

Leadership, morale and staff engagement

Staff morale across all wards was high. Staff at all levels told us they felt empowered and well supported by their managers. We did not encounter any evidence of bullying or harassment on any of the wards. All staff knew about the whistleblowing policy and told us they would not hesitate to use it if they needed to or be fearful of any repercussions. Sickness and absence levels were well managed across all wards and reducing.

Staff were given opportunities to develop and told us they were encouraged to identify any training needs and that their managers would fairly consider all requests.

Some of the wards had recently taken part in a team wellness and recovery action plan. This is a plan which promoted team wellbeing. It focused on techniques to strengthen the culture of a team to manage situations that may be difficult.

Wards had trained some of their staff to deliver training within the ward. The identified staff attended training in specific areas. Then using the skills they had learnt on a 'train the trainer' course, shared and delivered the training area to their colleagues. This improved training compliance as it meant staff did not have to travel to attend training. It also meant that the training would be more appropriate as it was delivered specific to the ward and gave staff a sense of ownership in ensuring its implementation.

Commitment to quality improvement and innovation

Staff were encouraged to be involved in quality improvements. The trust held 'speak easy' events. These events, hosted by managers, were open to all staff giving them an opportunity to contribute ideas for innovation and improvements through all aspects of the trust's delivery.

Are services well-led?

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At the time of our inspection, Woodhorn ward was taking part in a pharmacy pilot called Adapt. The pilot provided the ward with a pharmacy technician to support medication rounds. This was due to the high number of medications dispensed on the ward. Managers told us that the aim of the pilot was to reduce staff time and medication errors.

All wards with the exception of Marsden had current accreditation for inpatient mental health services awarded by the Royal College of Psychiatrists. Marsden ward was not accredited, as at the time of our inspection, there was no current accreditation process for older people's challenging behaviour services.

Both Mowbray and Roker wards at Monkwearmouth Hospital had received a design award from the world leading Dementia Services Development Centre at the University of Stirling. These were the first buildings in the country to receive the Gold award.

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 9 HSCA (RA) Regulations 2014 Person-centred care How this regulation was not being met: Care plans were not personalised or being used by staff as their point of reference to deliver planned and consistent care. This was a breach of regulation 9 (3) (b)