

Outstanding


Northumberland, Tyne and Wear NHS Foundation
Trust

Wards for people with learning disabilities or autism

Quality Report

St. Nicholas Hospital,
Jubilee Road,
Gosforth ,
Newcastle Upon Tyne,
Tyne and Wear,
NE3 3XT
Tel:0191 2130151 / 0191 2466800
Website:www.ntw.nhs.uk

Date of inspection visit: 31 May 2016 to 10 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)
RX467	Northgate Hospital	Alnwick	NE61 3BP
		Cheviot	
		Hadrian	
		Ingram Unit / Middlerigg Bungalow	
		Lindisfarne	
		Longhirst Ward	
		Tweed	
		Tyne	
		Wansbeck	
		Woodside	
RX4Y0	Rose Lodge	Rose Lodge	NE31 2TH

Summary of findings

RX4K9

Craigavon Short Break Respite
Unit

Craigavon

SR5 3DX

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

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

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 people with learning disabilities or autism as outstanding because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to patients. Staff from different disciplines worked in collaboration and a mutual respect amongst professionals was evident. There was a multi-disciplinary approach to the delivery of treatment at all stages, including the review of referrals prior to admission onto the wards.
- Patients and carers were active partners in the planning and delivery of care. Patients were generally very positive about their level of involvement in the development of care plans.
- There were excellent arrangements in place to assess, monitor and review physical health needs of patients.
- The range of therapeutic activities was excellent. Patients had individualised activity plans that took account of patient preferences, likes and dislikes.
- Staff knew how to report incidents and used analysis of incident data to inform practice. Learning was based on thorough analysis and investigation. Staff undertook a dynamic approach to using data, including in the reformulation of treatment plans. There was evidence of effective debriefing processes for staff and patients following incidents. The trust had robust mechanisms to disseminate learning following reviews of incidents. All staff were encouraged to participate in learning to improve safety.
- Staff demonstrated a proactive approach to anticipating and managing risks. Patients and their carers were actively involved in managing their own risks through the use of collaborative risk assessment tools.
- There were excellent performance management systems in place at service, ward and staff level. Staff were committed to contributing to the achievement of personal and service level targets.
- Staff delivered treatment in a respectful and caring way and demonstrated an advanced understanding of patient needs. Patient and carers spoke very highly of staff and the quality of care received.
- Staff were passionate about their work and spoke with pride about the wards they worked on. Staff were proud to work for the trust.
- Staff were actively encouraged to review practice and identify ways to improve service delivery and patient outcomes.
- There were sufficient staff working on the wards, providing safe and effective care to patients. Managers could bring in additional staff to meet the needs of patients. Mandatory training rates for staff on learning disability and autism wards were above trust targets. Staff had access to a range of specialist training, that was directly linked to the needs of patients. This included additional training for nursing staff in physical health care and monitoring. Staff received regular supervision and appraisal.

However:

Clinic facilities for the wards on Kenneth Day Unit were limited. Medication was stored and administered from the nursing office. This meant there was limited privacy for patients when accessing medication. Staff acknowledged this and hoped to develop one bedroom on each of the wards as a dedicated clinic room. Seclusion rooms on the Kenneth Day Unit had low ceilings with CCTV monitors, which patients could reach. This presented a potential hazard to patients.

Summary of findings

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

Are services safe?

We rated safe as good because:

- All of the environments we visited were very clean and well maintained.
- Ligature points had been identified and were detailed on ward risk registers. Appropriate actions to mitigate these were in place.
- There were sufficient clinical staff working within the wards and the respite service to meet the needs of patients. Managers were able to bring in additional resources when required.
- Staff attended regular mandatory training and the overall compliance rate for training was 95% on learning disability and autism wards and 91% on the short break respite unit. These were both above the trust target of 85%.
- Staff used appropriate, evidence based risk assessment tools and reviewed and updated these regularly.
- Staff had a detailed knowledge of safeguarding procedures and had completed safeguarding training.
- There was a robust process in place for reporting incidents and effective system to review and learn from incidents.

However;

- Clinic facilities for the wards on Kenneth Day Unit were limited. Medication was stored and administered from the nursing office. This meant there was limited privacy for patients when accessing medication. Staff acknowledged this and hoped to develop one bedroom on each of the wards as a dedicated clinic room.
- Seclusion rooms on the Kenneth Day Unit had low ceilings with CCTV monitors which patients could reach. This presented a potential hazard to patients.
- We found restrictive practices on some wards, in relation to patient's access to kitchen facilities and bedroom keys.
- The ward environments on Woodside and Ingram were not fit for purpose. However, a purpose built autism unit had been developed on the hospital site which was due to open in October 2016.

Good



Are services effective?

We rated effective as outstanding because:

Outstanding



Summary of findings

- The multi-disciplinary team worked in a very holistic way to assess, plan and deliver care and treatment. Staff from different disciplines held each other in high regard and there was a mutual respect amongst all of the professionals working within the service.
- The standard of care provided was outstanding. Staff delivered a wide range of evidenced based, therapeutic treatment interventions.
- Staff were proactively undertaking service review and redesign to meet the needs of patients and had developed innovative new models, which had been proven to have positive outcomes for patients.
- There were excellent systems in place to assess, monitor and review the physical health needs of patients.
- Staff had completed a comprehensive range of specialist training, specifically designed around the needs of patients.
- Staff from different disciplines were fully involved in decision making at all stages of the patient treatment journey. This included a multi-disciplinary meeting to review all referrals prior to admission onto the wards.
- Staff undertook comprehensive assessments of patient's needs, which were regularly updated.
- Staff used incident data in a very proactive and dynamic way including in reformulation.
- Staff deployed a wide range of nationally validated tools to assess and monitor patient outcomes.
- Staff took a proactive approach to managing risk and had developed a collaborative risk assessment tool. Patients acknowledged and understood risk and protective factors and felt ownership of their risk management plans.
- Staff had developed excellent links with external stakeholders. Staff from external organisations were very actively involved in discharge planning processes.
- The community transitions team were providing support to patients and community treatment teams to facilitate successful discharge. This included continuing support for up to six months post-discharge, which had contributed to a reduction in readmission rates.

Are services caring?

We rated caring as outstanding because:

- All patients and carers we spoke to held staff in high regard. Patients and carers said the quality of care they received from all members of staff within the multi-disciplinary team was excellent.

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Summary of findings

- Patients and carers were active partners in the development of care plans and involved in meeting where necessary.
- We observed highly caring and respectful interactions between staff and patients.
- Staff demonstrated an advanced understanding of patient's needs.
- Patients had individually tailored therapeutic activity programmes, which took account of their preferences, likes and dislikes.
- Staff used appropriate communication techniques that varied based upon patient need. This meant staff had the necessary skills and resources to meet the needs of patients with communication difficulties.
- Staff had developed specific pictorial aids for patients, which were used within de-briefing sessions with patients following incidents.

Are services responsive to people's needs?

We rated responsive as outstanding because:

- Staff had developed a new discharge planning model which had reduced average length of stay and hospital readmission rates.
- A community transitions team had been developed to provide outreach support to patients following discharge. This included the Responsible Clinician maintaining responsibility for patients in the community for up to six months after discharge. This had had a positive impact on reducing hospital readmission rates.
- Patients had been involved in personalising communal spaces on the wards, including indoor and outdoor space.
- There were carers' champions within staff teams on the wards.
- All patients had communication passports and staff had received additional training in communication techniques including Makaton and intensive interaction model.
- There was excellent information in a variety of formats for both patients and carers, which was provided prior to admission onto the wards.
- Patient and carer feedback was listened to, and things changed as a result.
- Staff provided a flexible approach to the delivery of treatment, including delivering structured programmes through one to one sessions where patients did not function well in group settings.

However:

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Summary of findings

- Patients said the quality of the food was poor. We observed meal times on the wards and found the quality of the food was variable.
- Patients were concerned about the implementation of staff uniforms, particularly when on escorted leave. Patients had not been consulted on this issue.
- The physical environment on Kenneth Day Unit could not accommodate patients with significant mobility issues.

Are services well-led?

We rated well-led as outstanding because:

- There were excellent performance management systems in place at service, ward and staff level. Staff were committed to contributing to the achievement of personal and service level targets.
- Staff were aware of the trust vision and values and felt these were integral to the way care was delivered.
- Team and individual objectives were linked to trust values.
- There was strong leadership on all of the wards. Staff held ward managers in very high regard. All staff said there was effective leadership at all levels of management within the trust.
- Staff morale was high. Staff spoke passionately and with pride about working for the trust.
- There was an open and transparent culture within the trust. Staff felt able to raise issues with senior managers and were confident their views were taken into account.
- There were a wide and varied range of opportunities for staff to develop skills and competencies, linked to meeting the needs of patients.
- Teams worked within a multi-disciplinary framework and there was genuine respect between the disciplines.
- Staff had good opportunities for career development.

Staff were actively encouraged to review practice and identify ways to improve service delivery and patient outcomes.

Outstanding



Summary of findings

Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust provide in-patient services for adults with learning disabilities and autism. There were 11 wards for adults with learning disabilities and autism. These services were provided from two locations, Northgate Hospital in Morpeth, Northumberland and Rose Lodge in Hebburn, Tyne and Wear.

Northgate Hospital had ten wards for adults with learning disabilities and autism which were:

The Kenneth Day Unit, a 28 bedded medium secure unit providing inpatient care to men with a learning disability detained under the Mental Health Act. There were four wards on the unit. Cheviot and Lindisfarne wards had eight beds; Hadrian and Wansbeck had six beds. The wards were managed as separate units, with individual ward managers, but worked together as part of a wider medium secure service.

Alnwick, a 16 bedded locked rehabilitation unit providing longer term on-going treatment and rehabilitation services for male patients who have a learning disability and who either have offended or displayed offending type behaviours.

Longhirst, a 14 bedded low secure unit for females with a learning disability who are detained under the Mental Health Act. Patients have engaged in offending/offending type behaviours or were at risk of doing so.

Tweed, a 26 bedded low secure unit for males with a learning disability who are detained under the Mental Health Act. Patients have engaged in offending/offending type behaviours or were at risk of doing so.

Tyne, a 24 bedded locked rehabilitation unit for male patients with a learning disability who were detained under the Mental Health Act. Patients have engaged in offending/offending type behaviours or are at risk of doing so.

Ingram and Woodside provide specialist autism assessment and treatment for male and female patients. Ingram is an eight bedded unit and Woodside has six beds.

Rose Lodge is a stand-alone 12 bedded assessment and treatment unit in Hebburn, South Tyneside, for people with a learning disability who require treatment within an inpatient environment.

The trust also provide a short break facility in Sunderland for adults with a learning disability, who, due to the complexity of their health care needs, were not able to access other short break services in the area. Craigavon was a five bedded short break respite unit for people with learning disabilities and complex needs. Complex needs in this service relate to high support needs and a requirement for nursing interventions. The trust and commissioners were reviewing this service at the time of the inspection.

The trust's provision of inpatient beds for adults with learning disability and autism was under review. This was being undertaken as part of the transforming care agenda, a national programme of reducing the number inpatient learning disability beds in England. Plans were in place to close Alnwick and Longhirst wards by March 2017 and the wards were closed to new NHS England admissions at the time of the inspection. The Kenneth Day Unit, previously a 30 bedded unit, was reduced to 28 beds at the time of the inspection. An additional four beds were due to be closed by March 2017.

Our inspection team

Chair: Dr Paul Lelliot, Deputy Chief Inspector (Mental Health), Care Quality Commission.

Head of Inspection: Jenny Wilkes, Care Quality Commission.

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

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

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Sandra Sutton, Inspection Manager (Acute) Care Quality Commission.

The team inspecting the wards for people with learning disabilities and autism consisted of two inspectors, four learning disability nurses, one social worker, one occupational therapist, one Mental Health Act reviewer and one pharmacist.

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 and carers at focus groups. We visited eleven wards between 31 May and 9 June 2016. We visited Craigavon short break respite unit on 20 June 2016.

During the inspection visit, the inspection team:

- visited all 11 of the wards at the two hospital sites and the short break respite service
- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 73 patients who were using the service. This included 24 patients who attended focus groups before the inspection

- spoke with ten carers of people who use the service. This included one carer who attended a focus group before the inspection
- spoke with the managers or acting managers for each of the wards
- spoke with 70 other staff members; including consultant psychiatrists, consultant psychologists, nurses, nursing assistants, occupational therapists, speech and language therapists and domestic assistants
- attended and observed patient activity sessions
- observed meal times on the wards
- attended and observed meetings on the wards including a multi-disciplinary meeting, a care and treatment review meeting, a ward round and a referrals meeting
- looked at 43 treatment records of patients
- reviewed prescription charts and carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients were given the opportunity to provide feedback on the service they received prior to our inspection via comment cards left on the wards. We received 47 completed comments cards from patients on the learning disability wards. There were no comments cards received from Craigavon. Twelve comments were positive. Some

comments cards contained both positive and negative feedback. Patients said that all staff working within the service were kind and helpful, and that staff treated them with respect. Many patients shared information about individual members of staff whom they felt had delivered excellent care. Negative comments related to the poor

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quality of the food served on the wards and there not being enough to do at evenings and weekends. Three of the comments referred to not being able to smoke on the hospital site.

Some patients attended focus groups to share their views of the service. This included eight patients from the Kenneth Day Unit, five patients from Woodside and Ingram wards, five patients from Alnwick, four from Tweed and two from Tyne. Patients told us in the focus groups that staff were very good and caring towards them. The most common negative comment from patients was about the poor quality of food on the wards.

We spoke with 73 patients across all the learning disability and autism wards about the care and treatment they received. Overall, patients spoke very positively about the staff on all of the wards. Patients said they felt

safe. Patients had heard rumours that uniforms for staff were being introduced on the wards. Patients said that they would feel uncomfortable on escorted leave if staff were wearing uniforms. Patients told us they had not been consulted about this change.

One carer of a patient from an autism ward attended a focus group. The carer spoke very highly about staff on the ward. We spoke to ten carers during the inspection. Carers told us that communication between ward staff and families was good. Carers said that staff worked tirelessly to meet the needs of patients, including physical health needs. Two carers specifically mentioned that their loved ones had been very well supported in relation to healthy eating, which had resulted in significant weight loss. This had significantly improved their overall health and well-being.

Good practice

Staff across the services had been involved in research and developing innovative practice. Staff on Alnwick ward had developed a discharge planning model to effectively engage patients on their discharge pathway. This had resulted in a reduction in the average length of stay on the ward, and reduced readmission rates.

Senior managers within the trust had developed effective relationships with commissioners. This positive relationship had resulted in funding being retained following the closure of a unit, to enable the development of a community transitions team. Staff in this team worked with patients on the wards prior to discharge and continued to support patients in community placements after discharge. This had positively impacted on community placements being

successful. As part of this model, Responsible Clinician cover was routinely provided by the consultant psychologist or consultant psychiatrist up to six months after discharge from the ward. The team facilitated risk management workshops for stakeholder groups including community treatment provider and day service providers and gave advice and support for up to six months following discharge. This had resulted in sustainable community placements for patients and a reduction in readmission rates.

Staff within the trust had delivered presentations and workshops at national conferences on models they had developed. Staff also facilitated training workshops to staff from community teams to improve discharge pathways.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should review restrictive practices on the wards and take appropriate steps to address these.
- The trust should consider how the quality of the food, particularly on the Northgate Hospital site, can be improved.
- The trust should review the physical environment on the Kenneth Day unit, particularly in relation to how patients with mobility issues could be supported on the wards, and improvements to seclusion rooms.

Northumberland, Tyne and Wear NHS Foundation
Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Alnwick	Northgate Hospital
Cheviot	Northgate Hospital
Hadrian	Northgate Hospital
Ingram Unit / Middlerigg Bungalow	Northgate Hospital
Lindisfarne	Northgate Hospital
Longhirst Ward	Northgate Hospital
Tweed	Northgate Hospital
Tyne	Northgate Hospital
Wansbeck	Northgate Hospital
Woodside	Northgate Hospital
Rose Lodge	Rose Lodge
Craigavon Short Break Respite Unit	Craigavon

Detailed findings

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 was mandatory for staff. The trust had a required compliance rate of 85% for all statutory and mandatory training. Staff on learning disability and autism wards had an overall compliance rate of 89% for Mental Health Act training. On Craigavon, this was 92%.

Mental Health Act documentation for detained patients was in place and completed correctly. Patients were detained under the correct legal authority. The trust had a

central Mental Health Act office who reviewed all detention paperwork. All detained patients had an automatic referral to an independent mental health advocate. Patients told us they knew who their advocate was.

Staff supported patients to understand their rights under the Mental Health Act monthly. This was recorded on patient care records. Staff routinely asked patients to explain their rights in their own words, to ensure understanding.

Patients signed Section 17 leave forms and were given a copy. Staff undertook risk assessments of patients prior to Section 17 leave being granted and this was documented within care records. There was no evidence that post-leave reviews had taken place with patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were trust policies on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of these policies and most staff demonstrated a good understanding of the principles of Mental Capacity Act. Training in Mental Capacity Act was mandatory and overall 93% of staff on learning disability and autism wards had completed this training. On Craigavon, 95% of staff had completed this training.

At Craigavon, 27 applications for Deprivation of Liberty Safeguards had been made between 1 April 2014 and 31 December 2015.

Where capacity assessments had been undertaken, these were recorded within patient care records. We saw two occasions where best interest decisions had been made when patients lacked capacity. Staff documented this within progress notes on the patient care record. Family members had been involved in these discussions.

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

The ward environments were very clean and well maintained. Cleaning staff were on duty in the wards throughout the inspection. Staff maintained cleaning rotas and these were up to date.

Patient-led assessments of the care environment surveys are the national system for assessing the quality of the patient environment. These surveys are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50% members of the public (known as patient assessors). In relation to cleanliness, the 2015 score for the trust was 99.3%. This was above the England average of 97.6%. Wards on Northgate Hospital and Rose Lodge sites scored 99.9% and 99.8% respectively for cleanliness. Craigavon was slightly below the overall trust average for cleanliness with 97%.

Up to date clinical environmental risk assessments were in place for all wards. These were undertaken annually. Ligation points had been identified and were included on ward risk registers. A ligation point is a place where a patient intent on self-harm might tie something to strangle themselves.

CCTV was in place on the wards, with the exception of Alnwick, Ingram and Woodside. Staff monitored CCTV in the nursing offices. Craigavon had CCTV to monitor the car park, however this was not working on the day we inspected the service.

Woodside, Ingram and Rose Lodge were mixed sex wards. On Ingram and Woodside wards, patients had self-contained accommodation including bedroom, bathroom and living area. There was one female patient on Woodside when we inspected this service. The ward manager's office could only be accessed by walking through the female patient's living area. Staff acknowledged that this was not ideal, although the patient told us she did not mind this.

The ward environments on Woodside and Ingram were not fit for purpose. The trust had almost completed building work on a new, purpose built specialist autism unit on the Northgate hospital site. During the inspection, we visited the Mitford unit. This 15 bedded new build unit

incorporated a large number of design features to meet the needs of adults on the autism spectrum. The unit included single person and shared accommodation with individual kitchen facilities; with purpose built sensory and activity rooms, multiple therapy spaces, activities of daily living rooms, patient I.T facilities, multi-faith facilities and personal outdoor space. Patients in the unit would have access to extensive sports and recreational facilities within both the unit and the wider hospital site.

Patient bedrooms for male and female patients at Rose Lodge were on separate corridors. Patients had en-suite facilities and also had access to separate bath and shower facilities. There was a designated female only lounge.

The accommodation at Craigavon was a single storey bungalow, located in a residential area of Sunderland. The environment had a very homely feel and was bright and airy. The sofas in the lounge area were a fabric material, requiring specialist deep cleaning. The ward manager was obtaining quotations to replace the sofas. There were five bedrooms, located at one end of the bungalow. Male and female patients used these bedrooms. There were no en-suite facilities, although each bedroom had a small washbasin. There was a shared bathroom, containing bath, shower and toilet facilities. Due to the level of nursing care required by patients using the service, patients were assisted to use the bathroom facilities by staff at all times.

Clinic facilities were generally good. Clinic rooms were appropriately equipped with accessible resuscitation equipment. There were adequate supplies of emergency equipment, oxygen and defibrillators, although there was no suction on Tweed. We found the defibrillator on the Kenneth Day Unit had out of date pads. On Longhirst, sterile scissors were out of date. These issues were highlighted to ward managers, who took immediate action to resolve these issues. Stocks of emergency medicines were kept in line with the trust policy.

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

Are services safe?

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

There was only one clinic room on Kenneth Day unit, which was used for Cheviot, Hadrian, Lindisfarne and Wansbeck wards. This was located in the communal area of the unit. The wards themselves did not have designated clinic areas. On these wards, medication was kept in the nursing office. This meant that space was limited and patients coming to the office for medication were in full view of other patients. Staff told us that the bed numbers on the Kenneth Day unit were being further reduced by four beds by March 2017. This was part of the transforming care agenda, a national programme of reducing the number inpatient learning disability beds in England. Staff intended to use a bedroom on each of the wards on the unit as dedicated clinic space. This would improve the provision of treatment/clinic space on the wards.

At Craigavon, medicines were kept in the small nursing office. There were no controlled drugs on the premises.

There were seclusion facilities on all wards, with the exception of Wansbeck, Hadrian and Ingram. Patients on Wansbeck and Hadrian who required seclusion would use seclusion facilities on the other wards on the Kenneth Day unit. The seclusion rooms on Cheviot and Lindisfarne were located up a short flight of stairs. The ceilings in these seclusion rooms were low, and a CCTV camera was in place on the ceiling to allow staff to observe patients. Patients could reach these cameras by standing on the mattress in the seclusion room. This issue had been raised with the trust previously following a Mental Health Act monitoring visit. We noted there was no privacy film on the toilet area in seclusion rooms on Lindisfarne and Cheviot. Staff had been using a wooden board to put in front of the window to maintain patient's dignity whilst using the toilet. Staff acknowledged that this was not good practice. The Clinical Nurse Manager had raised this issue at the seclusion steering group meeting. Staff from the trust estates department were to review the seclusion rooms on Kenneth Day unit to agree what remedial work could be undertaken to resolve these issues. All seclusion rooms had two-way intercom systems in place to enable communication between patient and staff. Staff could control the temperature and airflow in the seclusion rooms to ensure patients were comfortable. Patients could use seclusion clothes and blankets if required. Seclusion rooms had speaker systems installed, and music could be piped into the seclusion room if the patients requested this.

Seclusion rooms had toilet facilities and a clock that was visible to patients. We noted that the clock in the seclusion room on Cheviot was displaying the incorrect time. Staff rectified this when this was pointed out to them.

There were no seclusion facilities at Craigavon.

Safe staffing

The trust provided data as of 30 April 2016 on the total number of substantive staff working on each of the wards;

Alnwick 32.90 whole time equivalent staff

Cheviot 28.58 whole time equivalent staff

Hadrian 28.89 whole time equivalent staff

Ingram 95.31 whole time equivalent staff

Lindisfarne 34.72 whole time equivalent staff

Longhirst 53.39 whole time equivalent staff

Rose Lodge 49.40 whole time equivalent staff

Tweed 49.51 whole time equivalent staff

Tyne 55.60 whole time equivalent staff

Wansbeck 28.51 whole time equivalent staff

Woodside 69.95 whole time equivalent staff

There were 156.02 whole time equivalent qualified nurses and 284.52 whole time equivalent nursing assistants working across wards for people with learning disabilities and autism. Staffing levels for each ward were;

Alnwick Qualified nurses – 12 whole time equivalent

Nursing Assistant s – 13 whole time equivalent

Cheviot Qualified nurses – 12 whole time equivalent

Nursing assistants – 14 whole time equivalent

Hadrian Qualified nurses – 12 whole time equivalent

Nursing assistants – 11 whole time equivalent

Ingram Qualified nurses - 25.02 whole time equivalent

Nursing assistants - 102.51 whole time equivalent

Lindisfarne Qualified nurses – 13 whole time equivalent

Nursing assistants – 16 whole time equivalent

Longhirst Qualified nurses – 14 whole time equivalent

Nursing assistants – 31 whole time equivalent

Are services safe?

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

Rose Lodge Qualified nurses – 22 whole time equivalent

Nursing assistants – 23 whole time equivalent

Tweed Qualified nurses – 12 whole time equivalent

Nursing assistants – 22 whole time equivalent

Tyne Qualified nurses – 12 whole time equivalent

Nursing assistants – 30 whole time equivalent

Wansbeck Qualified nurses – 12 whole time equivalent

Nursing assistants – 11 whole time equivalent

Woodside Qualified nurses – 10 whole time equivalent

Nursing assistants - 11.01 whole time equivalent

At Craigavon, there were 13.70 whole time equivalent substantive staff working on the unit. This included;

6 whole time equivalent qualified nurses

4.5 whole time equivalent nursing assistants

As of the 30 April 2016, 28.72 whole time equivalent qualified nursing posts were vacant and 28.38 whole time equivalent nursing assistant posts were vacant on the learning disability and autism wards. At Craigavon, there were 0.5 whole time equivalent nursing assistant vacancies.

The trust average qualified nursing vacancy rate was 13.95%. The trust average nursing assistant vacancy rate was 9.21%. A number of learning disability and autism wards had vacancy rates above the trust average:

Alnwick had a qualified nursing vacancy rate of 35.92%

Cheviot had a qualified nursing vacancy rate of 33.33%

Hadrian had a qualified nursing vacancy rate of 18.58%

Lindisfarne had a qualified nursing vacancy rate of 23.08%

Tweed had a qualified nursing vacancy rate of 16.67%

Wansbeck had a qualified nursing vacancy rate of 20.92%

Ingram had a qualified nursing vacancy rate of 26.42% and a nursing assistant vacancy rate of 24.37%

Rose Lodge had a nursing assistant vacancy rate of 14.78%

Sickness levels overall on the learning disability and autism wards were 4.84% for the period 1 April 2015 to 30 April

2016. This was below the trust average of 5.4%. Hadrian had the highest percentage of permanent staff sickness at 9.93%. Cheviot had the lowest incidence of staff sickness at 1.74%. Sickness rates at Craigavon were 10.65%.

All of the wards used bank staff. From 1 February 2016 to 30 April 2016, there were 1415 shifts filled by bank staff to cover sickness absence or vacancies on the learning disability and autism wards. Eighty shifts had not been filled. At Craigavon, 255 shifts had been filled by bank staff during the same period, with 17 shifts not filled. Bank staff were familiar with the wards and agency staff were very rarely used.

Ward managers were able to bring in additional staff as required, based on patient need. The trust had identified its requirement for Registered Nurses and were addressing this through recruitment campaigns, a retire and return scheme and providing opportunities for employees to complete training to become Registered Nurses.

All patients on learning disability and autism wards had a named nurse. Patients had regular one to one time with their named nurse and this was identified within care plans. Staff documented one to one meetings with patients in care records. Patients we spoke to knew who their named nurse was and told us they saw them regularly.

Escorted section 17 leave and ward activities were never cancelled due to staffing issues. The wide range of staff from different disciplines working on the wards meant that activity plans were tailored to individual patients and appropriate staff provided support for these.

Staff were required to complete statutory and mandatory training courses. These included clinical risk training, deprivation of liberty safeguards, dual diagnosis, equality and diversity, health and safety, infection prevention and control, information governance, prevention and management of violence and aggression basic and breakaway techniques, rapid tranquilisation and safeguarding adults and children training. Overall compliance rates for statutory and mandatory training across learning disability and autism wards was 95%. At Craigavon, training compliance was 91%. These were both above the trust target of 85%.

Are services safe?

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

Staff at Rose Lodge and Craigavon were the only teams to complete care pathways and clustering training. Compliance rates for both of these teams were below the trust target, with Rose Lodge having trained 75% of staff and Craigavon trained 64% of staff.

Assessing and managing risk to patients and staff

Staff used a variety of risk assessment tools including the functional analysis of care environments tool adapted for learning disability and forensic services, the Northgate offender risk assessment package, historical clinical risk management -20 and narrative risk assessment. Risk assessments were carried out in line with the Department of Health best practice in managing risk guidance (2007). Staff carried out risk assessments with patients upon admission and these were updated regularly. In addition to documenting and detailing risk issues and risk management plans, staff used these tools to monitor and evaluate patient progress. Staff used a dynamic risk assessment process to review risks following any change in risk status and also as part of patient's care and treatment reviews and care programme approach meetings. We reviewed 43 patient care records. We found fully completed risk assessments in all records we reviewed.

The trust had an observation policy. Patients on the wards were subject to varying levels of observation. The multi-disciplinary team determined the level of observation required for each patient. This was based on risk assessment and patient need. Nursing staff were able to increase observation levels, but not reduce levels of observation levels without authorisation from the multi-disciplinary team or the responsible clinician. Most patients were on general observations, with only a small number of patients on eyesight observations. On Woodside and Ingram, the autism wards, there were high staff to patient ratios. Staffing numbers on these wards were dictated by patient needs, and the funded packages of care. At Craigavon, there was a minimum staff to patient ratio of two to one.

All patients were detained at the time of the inspection, with the exception of people using Craigavon for respite.

The trust had a search policy, but there were no routine searches of patients or rooms taking place on any of the wards. Staff told us searching would only be undertaken if there was a clear risk identified.

Patients on some wards did not have keys to their bedrooms and relied on staff to get access to their rooms if these were not kept unlocked. Patients on some wards did not have free access to the ward kitchens to make hot drinks and snacks without being escorted by staff. These were blanket restrictions, not based on individual assessment of risk.

The trust provided data on seclusion between 1 November 2015 and 30 April 2016. During this time, there had been 180 uses of seclusion and two episodes of long-term segregation. Longhirst had the highest level of seclusion with 126. We reviewed seclusion records on all of the wards. Staff had completed these fully and in line with the Mental Health Act Code of Practice. Staff completed 15-minute observations for the duration of the seclusion episode, and nursing and medical reviews had been completed in a timely manner. Staff ended seclusion as soon as the patient was settled. Patients had a seclusion care plan, which clearly documented what the patient needed to do in order for the seclusion to end. Staff recorded details of the incident which led to seclusion being used, including de-escalation techniques to prior to seclusion being initiated. Seclusion was used only after other interventions to de-escalate behaviour had been exhausted.

Restraint data was provided for the period 1 December 2015 to 31 May 2016. During this time, there were 1501 episodes of restraint involving 57 patients. Levels of restraint varied from holding and guiding patients through to prone restraint. Prone restraint involves patients being laid on the floor in a face down position. There were 448 episodes of prone restraint with 34 involving rapid tranquilisation. Rapid tranquilisation is the use of medication (usually intramuscular) if oral medication is not possible or appropriate and urgent sedation with medication is needed. The trust had a rapid tranquilisation policy, which was in line with national institute for health and care excellence guidance (NG10). The highest number of incidents of restraint was on Woodside and Ingram wards. These wards provided individual packages of care to very complex and challenging patients. Woodside had the highest number of restraints at 397, of which 95 resulted in prone restraint and seven episodes of rapid tranquilisation. Ingram unit had 326 restraints, 209 of which were prone restraint and nine episodes of rapid tranquilisation. Rose

Are services safe?

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

Lodge had 245 restraints, 20 of which were prone and five episodes of rapid tranquilisation. Longhirst had 345 restraints, 73 of which were prone restraint and 11 episodes of rapid tranquilisation.

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. These documents were in line with the Mental Health Act Code of Practice on the use of mechanical restraint. During the period 1 December 2015 to 31 May 2016, mechanical restraint had been used 14 times. Five episodes of mechanical restraint had been on the Kenneth Day unit, the medium secure forensic learning disability wards. Nine episodes of mechanical restraint were on Longhirst, the female low secure ward. Emergency response belts had been used on Longhirst ward to enable patients to be safely moved into seclusion. There were care plans in place for the use of mechanical restraint and appropriate authorisations had been sought, in line with trust policy. Staff had sought guidance from the prevention and management of violence and aggression tutors and again, this was documented within care records. We saw notes from discussions at multi-disciplinary team meetings about the use of mechanical restraint and where this had happened this was well documented in patient care records.

Prescription records were completed fully and accurately, and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act. 'When required' prescriptions contained relevant information to enable staff to administer them safely. We found that some patients had clear care plans in place for the administration of 'when required' medications, but not in every case. For example, we saw a person who was prescribed a variable dose of a medicine for agitation on Cheviot who had been given the highest possible dose. There was no information to guide staff what dose to administer, and no rationale had been recorded in the progress notes to support this decision.

Staff knew how to report medicines errors and incidents via the trust online reporting system and they were supported by managers to learn from incidents. The environment for

storing and giving medicines on the Kenneth Day Unit was not fit for purpose; the space was also used as an office, which meant there were frequent interruptions, and people were in full view of others on the ward.

Staff had received safeguarding training and knew how to make a safeguarding alert when appropriate. In the period 1 April 2015 to 31 March 2016, staff from learning disability and autism wards had made 83 safeguarding alerts. The majority of these were categorised as low-level incidents.

All wards had designated space for patients to meet with visitors. Patients also utilised their section 17 leave to see family and friends off the ward environments. On the Northgate Hospital site, patients could use the Gees Club and Andrews Café as more informal venues to meet visiting friends and relatives. Patients and staff told us that the trust had made a decision to close the onsite café at weekends. This decision had been taken without consultation with staff or patients. Patients were unhappy that this would have a negative impact on visits with family and friends. Patients did still have access to a lounge and vending machine in the café area. On the Kenneth Day Unit, a family friendly meeting room contained toys and books for children. All visits involving children under the age of 18 would be subject to a risk assessment.

Track record on safety

The trust reported 149 serious incidents between 1 January 2015 to 31 December 2015. Only two incidents related to wards for people with learning disabilities and autism. These incidents both related to patients absconding from Gees Club. This is an on-site resource, providing leisure and social activities for patients from the forensic learning disability services. Staff notified the police on both occasions. Following both incidents there was an investigation. Managers within the trust reviewed systems and processes and as a result, radio access was installed within Gees club to allow rapid communication with clinical areas on the hospital site.

Reporting incidents and learning from when things go wrong

The trust reported 34,658 incidents between 1 April 2015 and 30 April 2016. Of these, 4,149 related to incidents reported by wards for learning disabilities and autism. Over half of all reported incidents related to aggression and

Are services safe?

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

violence, with 2,120 incidents of this type. Craigavon reported 34 incidents in the same time frame. Seven of these incidents related to patient accident. The majority of incidents resulted in no or minor harm.

Staff recorded incidents on the trust electronic incident reporting system. Staff knew how to report incidents and what incidents should be reported and recorded. Staff reported all incidents of aggression, including verbal aggression. Staff understood the principles of duty of candour and were open and transparent with patients and carers when something went wrong. Ward managers, clinical nurse managers and service managers saw copies of all incident reports. Ward managers reviewed all incidents recorded on the system for their wards. The trust held a positive and safe meeting each month, where all incident data was reported and reviewed. This included all restraint and self-harm episodes. Ward managers received detailed reports, which provided analysis of all incidents.

Ward managers attended a monthly communications meeting for forensic services. Risks and incidents were reviewed and discussed within this meeting. This gave managers an opportunity to share learning across the whole service.

The trust had an internal central alerting system, which generated alerts to staff from incident activity and observations reported through electronic incident reporting system. The trust also operated a 'key card' system, which was a communication system designed to share lessons learned following incident reviews. These were emailed to all staff outlining the nature of the incident and key lessons learned. After action reviews were held after incidents to ensure that learning from incidents had been actioned and embedded into practice.

There were post-incident debriefs in place for staff and patients. Staff told us of a particularly distressing incident involving the unexpected death of a patient on one of the wards. Staff and patients had received immediate debrief following this upsetting event and ongoing support from managers and psychology. Staff and patients had accessed both group and one to one support.

Are services effective?

Outstanding



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 reviewed 43 care records and found all contained comprehensive assessments of patient's needs.

Staff undertook a range of routine assessments for new patients within the learning disability and autism wards. These included:

- physical health assessment
- sensory profile
- communication assessment
- medication assessment
- functional behaviour assessment
- activities of daily living assessment

Alnwick provided a treatment model based on a 5P's formulation. This provides a structured approach to considering the factors that have led to particular behaviours, potential triggers for negative behaviours, what factors perpetuate behaviours and the strengths and resources patients have to call upon to cease negative behaviours. The focus of the ward was to discharge patients to the most suitable and sustainable community placement to meet needs and effectively manage risks. Staff on the ward had developed an innovative discharge-planning model – the 'house' model.

On Woodside and Ingram wards, staff worked within a positive behaviour support and formulation based approach. All patients had a detailed positive behaviour support plan. Patients were supported to improve overall quality of life as well as behaviour change. Staff were completing antecedent behaviour consequences charts to document and monitor behaviour. This was then used to inform behaviour support plans.

Longhirst, Tweed, Tyne, Rose Lodge and wards on the Kenneth Day unit all provided a biopsychosocial treatment model. This model is the basis of the World Health Organisation's International Classification of Functioning, Disability and Health, which is a standard framework for disability and rehabilitation. All of these wards worked within a risk focused approach, where risk assessment and management were at the centre of the model of care. The approach to risk management was informed by the Department of Health 'See, Think, Act' document.

All patients had a comprehensive physical health assessment. As a minimum, patients had an annual physical health check. In addition, the core physical health monitoring tool was reviewed six-monthly for care programme approach meetings. People with physical health problems received appropriate monitoring, for example physical observations and blood tests, in accordance with national guidance. Staff had on-line access to pathology laboratory results of blood tests. This meant that any issues identified could be dealt with immediately.

We saw examples of excellent, very detailed care plans to meet the physical health needs of patients. These included specific, comprehensive plans on the management of long-term conditions including diabetes, epilepsy and one patient with dextrocardia. However, we found a lack of care planning for some high risk medicines, for example lithium. Ward staff had comprehensive support provided by the pharmacy team, which included a visit by a clinical pharmacist several times per week.

Staff made practical use of the incident data, which was provided at a service, ward and patient level. Staff used the information in these reports to support the identification of trends and triggers in challenging behaviours amongst patients. This information was reviewed in multi-disciplinary meetings and used in a very dynamic way in formulation of treatment and care plans.

Nursing staff had completed additional training in physical health skills to enable ward staff to contribute to the ongoing treatment and care of physical health needs of patients. This was in addition to the robust working arrangements with GPs. Wards on the Northgate Hospital site were supported by a local GP practice, which provided triage nurses onto the wards and rapid appointments and assessments of physical health issues amongst the patient group.

Nurses were trained to undertake national early warning scores. This is a screening tool, developed by the Royal College of Physicians to determine the degree of illness in patients. The tool assesses vital signs including respiratory rate, heart rate, temperature and blood pressure.

All patients completed 'my shared pathway'. This is a national tool, which promotes a recovery, and outcomes based approach to care planning across the secure treatment system. Patients were supported by staff to

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complete their 'my shared pathway' booklets. These had been adapted to include easy read and pictorial formats for patients. The quality of the care plans we reviewed was excellent. Patients were clearly involved in the development of their plans, and all were patient centred. Care plans were holistic and comprehensive. We saw evidence of family and carer involvement in care plans.

The trust used an electronic case management system and all patient care records were stored securely on this system.

Best practice in treatment and care

Staff delivered effective packages of care to patients on learning disability and autism wards. Care was in line with national institute for health and care excellence guidance. Staff provided a range of interventions based on a positive behaviour support model reflecting the principles in the national guidelines. Trust policies were based on national best practice guidance. Staff were proactively engaging in service review and redesign to improve outcomes for patients.

Patients had access to a wide range of evidence based psychological therapies as recommended by the national institute for health and care excellence. These included cognitive behavioural therapy, dialectical behaviour therapy, work based therapies, art psychotherapy, psychodynamic therapy and systemic therapy. Patients completed in-depth psychological assessments and completed specific programmes to address forensic risks. Structured programmes included sex offender treatment programme, fire setter's programme, substance misuse and alcohol awareness. The psychology team, supported by the multi-disciplinary team, lead on a number of psychological therapies including emotions courses, anxiety treatment, anger management, drug and alcohol education.

Staff deployed a wide range of nationally validated tools to assess and monitor patient outcomes. These included the Glasgow anxiety scale, challenging behaviour interview, behaviour problem inventory, health of the nation outcome scale and recovery star.

Staff took a proactive approach to managing risk and developed a collaborative risk assessment tool. Patients worked alongside staff to identify risks and agree a risk management plan. This collaborative approach meant that patients acknowledged and understood risk and protective factors and had ownership of their risk management plans.

Patients had communication passports, which clearly set down approaches to provide effective communication between staff and patients. On autism wards, we saw staff using Makaton and the intensive interaction model. This is a model to create a communication environment that is enjoyable and non-threatening to the individual on the autistic spectrum, or with severe learning difficulties. We observed staff communicating with patients by providing eye contact, touch, copying the sound the patient made. This was clearly a positive interaction between patient and staff.

There were excellent systems in place to assess, monitor and review physical health care for patients. The trust had a service level agreement with a local GP practice for the Northgate Hospital site. Triage nurses worked onto the wards, and facilitated timely access to GPs as required.

Clinical staff were actively participating in clinical audit. Local clinical audits included cardio-metabolic monitoring of inpatient at Rose Lodge (August 2015), quality of smoking cessation in forensic inpatient units (August 2015). Medics working on Tyne ward had undertaken a clinical review of benzodiazepine medication on the unit in May 2016. The trust participated in a number of national clinical audits. These included the national audit of schizophrenia, prescribing for people with a personality disorder, antipsychotic prescribing in people with a learning disability and the national audit of psychological therapies for anxiety and depression.

Skilled staff to deliver care

All of the wards had a full multi-disciplinary team, which included psychiatry, psychology, occupational therapy, speech and language therapy, nurses and nursing assistants. Occupational therapists and speech and language therapists were based on the wards and provided valuable input into the development of treatment programmes.

Occupational therapists used the model of human occupation screening tool to assess patient's needs to formulate intervention plans. This is an internationally validated tool, which provides an overview of patient's occupational functioning and monitors changes to this. Patients worked with occupational therapists to devise individual therapeutic activity plans. We observed patients taking part in a wide variant of activities based on their assessed needs. The trust had invested in a training programme to ensure all occupational therapists were

Are services effective?

Outstanding



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trained in assessment of motor process skills. This approach, developed by the Centre for Innovative Occupational Therapy Solutions, evaluates a person's quality of performance of personal or instrumental activities of daily living skills.

Speech and language therapists provided specialist support to meet the communication needs of patients and provided training to staff in communication techniques. We observed very skilled interaction between therapists and patients. One example of this was a speech and language therapist undertaking an assessment with a patient, whilst in the patient bedroom and styling her hair. This created a very informal and relaxed setting, which put the patient at ease.

Staff were experienced and appropriately qualified. All staff had an electronic personal performance 'dashboard'. This enabled staff to monitor their compliance with statutory, mandatory and specialist training.

Staff had access to a wide range of specialist training. Nursing staff had attended a three-day foundation training programme, which included training in physical health needs and communication skills for patients with learning disabilities and autism. Staff had completed autism and learning disability awareness training. Nursing staff had attended specific training to meet the needs of the patient group. This included training in tissue viability, dementia awareness, personality disorder and suicide prevention.

Staff had regularly appraisals and supervision. As of 30 April 2016, 92% of non-medical staff on learning disability and autism wards had completed an annual appraisal. On Craigavon, 89% of staff had received an appraisal. Due to the small staffing numbers at Craigavon, this equated to one member of staff who had not completed an annual appraisal. The appraisal rate for medical staff on wards and the respite unit was 100%.

Multi-disciplinary and inter-agency team work

Staff worked in a truly holistic way to assess, plan and deliver care and treatment to patients. Multi-disciplinary meetings took place on the wards weekly. We observed a multi-disciplinary meeting on Wansbeck ward. Staff from different disciplines demonstrated a clear mutual respect and the views of all professionals were valued. All staff were actively engaged in activities to monitor and improve patient outcomes.

We observed a care and treatment review meeting, which the patient and a range of professionals attended from the ward team and external representatives. The patient was supported by a speech and language therapist throughout the meeting.

There were excellent working relationships between staff on the wards and GPs.

The community transitions team had forged excellent relationships with staff from community treatment teams. This team had proactively supported staff within community providers to improve skills, confidence and competence in working with a particularly difficult patient group. This had resulted in positive risk taking which had seen success for patients in community placements and reduced readmission rates.

Ward staff had developed effective pre-discharge planning meetings. A wide range of external stakeholders attended these meetings including community care coordinators, commissioners, patient representatives including advocates and solicitors as well as staff from community placement providers.

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

Staff were required to complete training in the Mental Health Act. Compliance as at May 2016 for staff working on learning disability and autism wards was 89%. Wansbeck had achieved 100% compliance for Mental health Act training. Longhirst had the lowest level of compliance at 82%. At Craigavon, 92% of staff had completed Mental Health Act training.

At the time of the inspection, all patients on learning disability and autism wards were detained under the Mental Health Act. Staff supported patients to understand their rights under the Act upon admission on the wards and then monthly thereafter. Patients were asked to tell staff in their own words what their rights were. This ensured that patients had a clear understanding of the information being provided. Patient's care records were updated to reflect that rights had been explained to them and understood.

Capacity and consent to treatment forms were completed upon admission. Treatment forms were attached to medication charts in line with required practice.

Are services effective?

Outstanding



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.

Staff had access to support on the Mental Health Act and Code of Practice via a central Mental Health Act office within the trust.

We reviewed 43 care records and found that detention documentation had been completed correctly and was up to date.

All detained patients had an automatic referral to the Independent Mental Health Advocate. Patients told us they had an advocate and saw them regularly. We saw evidence in patient records that advocates had been involved in reviews and appeals.

Good practice in applying the Mental Capacity Act

Staff had completed training in the Mental Capacity Act. There was a 93% compliance rate for this training amongst staff on learning disability and autism wards. At Craigavon, 95% of staff had completed Mental Capacity Act Training. Most staff we spoke to knew the five principles of the Act.

The trust had policies on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to access these policies.

On learning disability and autism wards, we saw evidence that capacity assessments had been completed for patients where appropriate. Staff recorded capacity assessments on the electronic patient care record. For example, we saw one patient who had been assessed as lacking capacity to make decisions around transfer of care into a community service. Staff had involved family members in discussions around this issue and a best interest decision had been reached to proceed with the planned transfer package.

Are services caring?

Outstanding



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 73 patients and ten carers. Patients spoke very highly of the staff and the quality of care they received. They said staff were caring, respectful and supportive. Patients were keen to tell us about specific members of staff where they felt they had provided outstanding support and care.

Carers told us they felt that staff knew the patients very well. Staff communicated well with carers, and carers said they were kept well informed by ward staff. Carers felt involved in contributing to care plans and attended care programme approach meetings. Some carers spoke specifically about the excellent physical health care that was provided. One carer said that his son had lost a significant amount of weight and had been really well supported by staff to achieve this. This had resulted in a marked improvement in his physical health.

We observed excellent interactions between staff and patients. Staff demonstrated an advanced understanding and knowledge of patients. Patients felt that staff treated them with respect and were caring. Patient's communication skills were taken into account, and we saw copies of easy read and pictorial care plans. Staff had developed pictorial aids specifically for use with patients for de-brief after an incident or episode of seclusion.

Patient-led assessment of the care environment survey in 2015 had rated privacy, dignity and wellbeing for the trust at 92.3%. This was above the England average of 86%. Wards for learning disability and autism on the Northgate Hospital site were rated at 97.1% and at Rose Lodge, this was 89.9%. The score for Craigavon was 71.9%. The unit had developed an action plan to resolve the issues highlighted following the survey. All actions had been completed.

Carers said that staff provided them with support, which many found invaluable.

The involvement of people in the care that they receive

We observed a new patient being admitted onto one of the wards. Staff worked very effectively and in a caring way to make the patient feel at ease. New patients were allocated a 'buddy'. Patients who had been on the ward for longer

periods of time volunteered to take part in the buddy scheme to support new patients coming onto the ward. We saw really positive interactions between the patient 'buddy' and the newly admitted patient. A member of staff and the patient 'buddy' gave the new patient an orientation to the ward. Staff facilitated a call home so the patient could speak to his family to inform them he had arrived and was settled onto the ward.

We reviewed 43 care records. Patients completed 'My Shared Pathway', which was a collaborative care-planning tool. Staff supported patients to work through a series of pathway booklets on specific areas including patient's health, desired treatment outcomes, safety and risk and relationships.

In all care records we reviewed, we found care plans to be patient centred. Patients were fully involved in the care planning process, and plans clearly documented patient wishes and views. Input from carers and family members was also evident. Patients confirmed that they had been involved in developing care plans and felt that staff listened to them and considered their views. Most patients felt positive about using the 'my shared pathway' booklets, although two patients felt that they did not have a clear vision of their discharge route out of medium secure services. Some patients did not have a copy of their care plan, but told us this was their choice and that they had been offered a copy.

Patients had individualised activity programmes, which were based on the therapeutic value of activities and the likes and dislikes of patients. Patients were happy that they had choice in deciding which activities to participate in. The activity facilities were excellent and provided an extensive range of activities both on the ward and off the ward. The diversity and quality of therapeutic activities was particularly impressive on the Northgate hospital site.

All patients had an independent mental health advocate. 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.

Patients attended regular meetings on all of the wards. This gave patients the opportunity in a formal way to raise any issues they had.

Are services responsive to people's needs?

Outstanding



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

Our findings

Access and discharge

The average bed occupancy rate for learning disability and autism wards was 86.6% between 1 November 2015 and 30 April 2016. Bed occupancy levels at Craigavon for the same period was 61%. The average length of stay for patients on learning disability and autism wards was 450 days. At Craigavon, the average length of stay was 2 days.

There had only been one out of area placement between 1 November 2015 and 30 April 2016. This had been a specialist, planned placement for a patient with autistic spectrum disorder.

There had been three delayed discharges on learning disability and autism wards between November 2015 and April 2016, one on Rose Lodge and two on Tweed. Two patients had been readmitted to Rose Lodge within 90 days of discharge during the same time period.

Staff on Alnwick had developed 'my discharge pathway', a new discharge planning tool. This was a visual tool in the shape of a house, depicting the building blocks that patients needed to complete to enable move-on to take place. Patients told us that they liked using this, as it gave them very clear areas to work on. For patients subject to Ministry of Justice conditions, this included completing relevant applications to the Ministry of Justice to secure conditional discharge. Staff told us this model supported community teams and aided the securing of community placements, as staff in the community understood the steps patients had completed whilst on the ward. A pre-discharge planning meeting instigated the discharge process. Ward staff coordinated these meetings, which were well attended by a range of external professionals including care managers, social workers, community care staff, commissioners and patient representatives including advocates and solicitors.

The trust, supported by clinical commissioning group commissioners, established a community transitions team. Staff in this team worked on low secure and locked rehabilitation wards on the Northgate hospital site. The team provided in-reach work onto Tweed, Tyne, Alnwick and Longhirst wards, to develop forensically informed community service specifications, care plans and transition plans for patients on a discharge pathway. The team facilitated risk management workshops for external

stakeholder groups, to support staff from community teams, support service providers and day service providers. During the initial period following discharge from hospital, the team provided advice and support to community teams on the treatment and management of patients. This not only supported community teams, but also provided reassurance to patients who continued to work with familiar staff from the ward in the initial stages of the community placement. The Responsible Clinician from the wards continued to undertake this role during the initial post-discharge period. This arrangement could remain in place for up to six months after discharge. This practice, coupled with the new discharge planning model had seen readmission rates reduce from 58% (2006 to 2010) to 8% (2011 to 2015).

The facilities promote recovery, comfort, dignity and confidentiality

The ward environments were clean and comfortable. Patients had access to rooms and equipment to support treatment and care. There was access to outside space on the wards, and patients had been involved in creating artwork and planting flowers in the gardens to personalise these areas.

We saw that patients had personalised their bedrooms and staff encouraged this. Patients could access their bedrooms at any time. On Longhirst, Tweed, Alnwick and Rose Lodge, patients had keys to their bedrooms. On the other wards, bedrooms could be locked by staff or left open, depending upon patient preferences. Most patients preferred to leave their bedroom doors unlocked so they could access these at any time. Patients on all wards had internet access. Access levels were graded based on risk. Patients on Longhirst, Rose Lodge, Ingram and Woodside could have their own mobile telephones. On all other wards, patients had access to a ward telephone, which they could use at any time. Patients could make calls on cordless ward telephones in the privacy of their own rooms. Patients had access to food and drink at any time of the day or night.

Patients, particularly those on the Northgate Hospital site, said the quality of the food was very poor. We received more negative comments about the standard of food than any other issue. Food for the wards at Northgate hospital was prepared off-site and then reheated by kitchen staff. Patients said the portions were not large enough, and that the food lacked flavour and was often not hot enough. One patient said a piece of fish they had been served recently

Are services responsive to people's needs?

Outstanding



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

was still frozen in the middle. We observed meal times on the wards and found the food to be of variable quality. Patients told us they had raised issues around their dissatisfaction with the food at their patient meetings, but nothing had been done. We saw minutes of patient meetings where a representative from the catering team had attended to discuss patient concerns about the food. One patient on Lindisfarne had requested specific food including low carbohydrate and high protein, as he was trying to get fitter. This request had been accommodated and he was getting the food he asked for.

Patient-led assessment of the care environment survey in 2015 had rated food quality for the trust overall at 88.8%. This was above the England average of 87.2%. Wards on the Northgate Hospital site scored 93.8% and 88.4% at Rose Lodge. There was no score recorded for Craigavon.

Patients raised concerns that staff were going to be made to wear uniforms. Patients said this would make them feel uncomfortable, particularly when on escorted leave into the community. There had been no consultation with patients about this issue. Staff we spoke to were not clear when uniforms were being introduced. Some staff said they would bring in a change of clothes to use when escorting patients on leave.

Patients on all the wards had access to an extensive activities programme. Occupational therapy staff worked with patients to develop individual schedules of activities. All activity plans were based on the therapeutic value of the activities.

Meeting the needs of all people who use the service

With the exception of the wards on the Kenneth Day Unit, all of the wards were located in single storey buildings. On Kenneth Day Unit, the nursing office, seclusion rooms, patient bedrooms and bathrooms were accessible via short flights of stairs. This meant that the unit was not able to meet the needs of patients with mobility problems. One patient on Cheviot ward was experiencing increasing mobility issues. Staff had responded appropriately to support this patient, and additional assessments of the patient's mobility had been undertaken. The patient was able to manage the stairs on the ward, but staff acknowledged that if his mobility declined further, then he might need to be transferred to an alternative unit.

All wards and the short break respite unit had carers' champions identified within the staff team. Carers' champions are members of staff who are enthusiastic about improving support and promoting service for carers. These staff, on behalf of the ward or service, offer advice to their colleagues about carers' issues and maintain links with local carers' support services.

Prior to admission onto learning disability and autism 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 and easy read. The trust had developed a carers' 'pocket pack', which was a small wallet containing information on local carers' support services, contact information of key staff on the ward and details of the carers' champion for the ward.

All patients had communication passports to ensure that the most effective form of communication was used to aid understanding. Some staff were trained in Makaton. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used alongside spoken words. We saw staff using the intensive interaction model with a patient. This creates a communication environment that is enjoyable and non-threatening to the individual on the autism spectrum, or with severe learning difficulties. The member of staff was close to the patient, giving eye contact, touch, copying the sound the patient made and it was clear this method of communication was effective. Staff used the disability distress assessment tool for patients who had difficulties in communicating. This enabled staff to identify distress cues in patients who because of cognitive impairment or physical illness had severely limited communication.

Staff knew patients and their families very well. Patients and carers told us that staff tried very hard to support carers to visit their loved ones in hospital. We heard of one family, who travelled from Scotland to visit a patient. Staff had accommodated the family's motorhome on the hospital site to enable longer visits to take place. Over time, this had developed to the patient spending time in the motorhome with his family, whilst being supported by ward staff.

Are services responsive to people's needs?

Outstanding



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

Staff adopted a very flexible approach to the delivery of treatment interventions based on the needs of patients. For example, psychology staff had delivered the sex offender treatment programme, which is traditionally delivered in a group setting, on a one to one basis for a patient who had not coped well with being part of a larger group.

Listening to and learning from concerns and complaints

Patients and carers told us they knew how to complain. Staff gave information on the complaints process within the welcome packs for patients and in carer's information 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.

Wards for learning disability and autism received 10 complaints between 1 November 2015 and 30 April 2016. Two of these complaints were upheld. One upheld complaint related to a breach of confidentiality by staff on Alnwick ward, and the second related to attitude of medical staff at Rose Lodge. No complaints had been referred to the ombudsman.

Learning disability and autism wards received three compliments between 1 May 2015 and 30 April 2016.

All wards held regular patient meetings. We saw copies of agendas and minutes of these meetings. Agenda items included health and safety, care and treatment reviews, nutrition and catering, issues and feedback. Patients could raise any issues they had about the ward or service at these meetings.

Staff and patients gave examples of how patient and carer feedback had brought about change in the service. These included providing internet access to patients and trialling use of mobile telephones on Longhirst ward.

Are services well-led?

Outstanding



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

Ward managers and other staff we spoke to were aware of the trust's vision and values. All staff felt a natural affinity to the values, and felt they were integral to the care that they delivered. Staff spoke passionately about the trust, and clearly felt valued and proud to work for the organisation. Staff spoke very highly about senior managers within the trust, from clinical nurse managers through to the chief executive. Staff felt that senior managers were very approachable, and all said they felt comfortable raising issues or concerns to more senior managers within the trust.

Due to the transforming care agenda, and the reduction of in-patient beds for learning disabilities, some staff were working on wards that they knew would be closing. Despite this, staff retained their enthusiasm and dedication for the wards on which they worked, retaining the interests of patients at the heart of what they did.

Staff told us that their supervision and appraisal processes reflected the trust values, and felt these were a 'golden thread' running throughout the service. We saw examples of completed appraisal documentation and could see that the trust values were actively considered and discussed as part of the appraisal process.

Good governance

Staff had access to a wide range of training to support them in developing their practice. Compliance with mandatory training was above trust targets. Staff had excellent opportunities to attend specialist training which was linked to improving delivery of care and outcomes for patients.

Staff received regular supervision in line with trust policy. Managers accommodated requests for additional supervision sessions from staff in addition to the required number of supervision sessions. Staff felt very well supported by their managers.

Each ward had a risk register. Staff discussed risks within team meetings and updated the risk register as new risks were identified or risks were removed. There was a good understanding of risk and the impact of these on staff and patients. Effective actions were in place to mitigate against identified risks.

Ward managers and service managers were provided with thorough analysis of incident data at service, ward and patient level. Staff used this data in a proactive and dynamic way, including at multi-disciplinary team meetings for the formulation of patient care plans.

Staff were involved in post incident reviews and debrief processes were effective and in place for both staff and patients. We saw evidence of learning from incidents being used to review and change practice.

There were robust meeting structures in place to ensure an effective two way flow of information. Ward managers held monthly team meetings and managers attended a monthly forensic management communication meeting. We saw that these meetings were structured around the five Care Quality Commission domains of safe, effective, caring, responsive and well-led.

Ward managers reported on a wide range of key performance indicators. The trust had an impressive performance dashboard, which clearly identified activity against targets. All staff had access to a personal performance electronic dashboard, which monitored compliance with training requirements.

Staff were involved in an extensive national and local clinical audit programme.

Staffing levels on the wards were appropriate to meet the needs of patients and provide safe and effective care. There was a robust multi-disciplinary team working on each ward, with staff from different professional background making equal contributions. There was a mutual respect between the different disciplines.

Ward managers had the autonomy to carry out their roles, but felt very well supported by more senior managers within the trust when necessary.

Leadership, morale and staff engagement

All staff we spoke to were clearly passionate about their work and working for the trust. Staff had a genuine sense that they had a positive impact upon outcomes for patients. Patients themselves told us many times that progress in their recovery had been made possible by the support of staff and the treatment they had received. Staff were dedicated and committed and felt a sense of pride in the wards in which they worked. Staff spoke very highly of ward managers and felt that leadership within the trust was strong and supportive.

Are services well-led?

Outstanding



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.

Sickness levels overall on learning disability and autism wards were below the trust average.

Each team worked within a multi-disciplinary framework and this was a truly equal partnership. The views of all disciplines was perceived as being equal, with no one profession having 'control' of decisions. We observed multi-disciplinary meetings and saw the mutual respect and value staff had for one another.

Many staff we spoke to had worked for the trust for a number of years. Staff had been given opportunities to develop their career pathways within the trust. One ward manager spoke with pride of the fact she had joined the trust after leaving school and had worked as a domestic assistant. She had stayed with the trust through her nurse training and had progressed within the organisation. The trust provided a leadership and development training programme.

Staff knew how to report concerns through the trust whistleblowing policy. Staff felt comfortable that they would be able to raise issues without fear of repercussions or reprisals.

Commitment to quality improvement and innovation

Staff were encouraged to continually review practice and identify ways to improve quality of care and patient

outcomes. Staff had developed an innovative discharge planning model for patients moving into community placements. This had resulted in a reduction in readmission rates.

There was excellent joint working between trust staff and external agencies. Community Transition Team staff facilitated risk management workshops to colleagues from community services. This supported the competence and confidence in community teams to work with challenging patients. Staff employed a collaborative approach to risk management. This included responsible clinicians from the trust continuing to maintain this role for a period of up to six months following discharge.

The trust had been the first in the country to deploy clinical psychologists as responsible clinicians. Psychologists from the trust had presented their experiences at national and international conferences to share learning with other providers.

Staff from the trust were encouraged to share effective practice with external stakeholders, and were regular presenters at the annual National Conference for Offenders with Learning Disabilities.