Outstanding ☆

Northumberland, Tyne and Wear NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

St. Nicholas Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX4E2	St George's Park	Bluebell Court Kinnersley Ward Newton Ward	NE61 2NU
RX4Z3	Hopewood Park	Aldervale Clearbrook Bridgewell	SR2 0NB
RX461	Elm House	Elm House	NE8 1QE
RX438	Brooke House	Brooke House	DH5 8NB

Summary of findings

RX4E4	St Nicholas Hospital	Willow View	NE3 3XT

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?	Good ●
Are services caring?	Good ●
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 long stay rehabilitation mental health wards for working age adults at Northumberland, Tyne and Wear NHS Foundation Trust as **outstanding** because:

- Governance arrangements allowed ward managers to coordinate and manage performance using an electronic performance dashboard system. In addition, some wards were piloting additional electronic trackers that identified uncompleted tasks and improved discharge planning.
- The service inspired and motivated staff to succeed, encouraging professional development and a culture of staff self-belief and dedication. There were high levels of staff satisfaction. Staff were proud to work for the organisation and felt valued and supported. Staff provided feedback and ideas to improve the quality of care and treatment.
- There was a commitment to continuous improvement implementing safe innovative rehabilitation and recovery focused care across the wards. New working practices reflected best practice and wards reviewed these proactively. Each ward was either involved in a pilot, research or had introduced staff initiatives to improve the quality of the service.
- Patient's individual needs and preference were central to the planning and delivery of the rehabilitation and recovery pathway. Planning for discharge commenced on admission with patients actively involved in choosing their preferred discharge location. Wards maintained strong links with community mental health teams and local third sector organisations to ensure continuity of care. Elm House was unique in having close links with Gateshead local authority, providing a seamless transition back into the community.
- The service recognised that social inclusion was integral to the recovery process and was proactive in establishing links with third sector organisations to facilitate this. There were examples of innovative approaches to provide an integrated person centred pathway of care for people with complex needs. Clearbrook ward had developed links with local parishioners leading to jointly organised events taking place in the community. Staff recorded these events in a yearbook to remind patients of their progress. At St George's Park, two wards had established patient led mutual help meetings and developed their own local community.
- Staff were skilled in providing patients with evidence based psychosocial interventions. They used interventions based on The Royal College of Psychiatrist's model for inpatient rehabilitation to care for patients with complex needs. The multidisciplinary team considered all relevant factors and risk management at patient meetings and reviews to provide a framework to develop the most suitable treatment for a patient. This meant patients received care and treatment that suited their individual needs.
- Records showed and managers, staff and patients confirmed staffing levels were sufficient to meet the service needs. One to one interaction, activities, patient leave, and staff training went as planned. Vacancies were mostly due to progression or retirement, which meant there was high staff retention. Patients were familiar with staff covering shifts due to absences, as agency use was low.
- The service recognised that ongoing development of staff skills, competence, and knowledge led to high quality care. Staff were encouraged to undertake specialist recovery focused training.
- There was a commitment to involving carers and families in the treatment and care of the patient. Staff ensured carers and families were kept informed and had access to support throughout the duration of a patient's stay on the ward.

However,

- Entrance and exit to the wards at Hopewood Park was via a double door airlock controlled by staff. The level of control and security felt restrictive and was more appropriate to secure facilities than long stay rehabilitation wards.
- Staff had not monitored a patient receiving a high dose antipsychotic treatment in line with best practice guidance. We saw other patient records where monitoring had taken place.

Summary of findings

- At Hopewood Park, care plans did not always reflect the involvement of patients or include detailed and personalised information about the management of long-term physical health conditions. The service had introduced an ongoing initiative to improve the quality of care plans. The care plans on the short-term wards were detailed, holistic and recovery focused.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Managers, staff and patients told us there was sufficient staff available to allow escorted leave and ward activities to take place.
- Ward managers could adjust staffing levels as needed using staff that were already familiar with the wards.
- Patients had up to date risk assessments and management plans.
- Staff were skilled and confident in the use of de-escalation techniques.
- Compliance with mandatory training met trust target levels.
- Staff demonstrated good knowledge of safeguarding procedures and were proactive in raising concerns.

However,

- Entrance and exit to the wards at Hopewood hospital was via a double door air lock controlled by staff.
- Staff had not monitored a patient receiving a high dose antipsychotic treatment in line with best practice guidance.

Are services effective?

Good

We rated effective as good because:

- A full range of skilled staff and associated disciplines provided input into the care of patients.
- Staff used appropriate, evidence based psychosocial interventions.
- Staff supervision and appraisal rates were compliant with trust targets. This enabled ward managers to provide staff with appropriate support and meet development needs.
- Staff were encouraged to access specialist rehabilitation and recovery focused training.
- The multi-disciplinary team used in depth formulation as a framework for patient care and treatment and regularly reviewed the formulation and management.

However,

Summary of findings

- Care plans did not always reflect the involvement of patients or include detailed and personalised information about the management of long-term physical health conditions.

Are services caring?

Good 

We rated caring as good because:

- We observed positive and warm interactions between staff and patients.
- Staff ensured carers and families were kept informed and had access to support throughout the duration of a patient's stay.
- Staff provided family therapy to patients and their families to help build fractured relationships.
- Staff listened to patients preferences in respect of move on placements and sought to find appropriate accommodation that met the patients' needs.

Are services responsive to people's needs?

Outstanding 

We rated responsive as **outstanding** because:

- The wards recognised the importance of social inclusion to the recovery process and established strong links with local communities to facilitate this. Due to their unique environmental setting, Kinnersley ward and Bluebell Court established their own sense of neighbourhood and community through patient led mutual support meetings three times a week.
- Kinnersley ward and Bluebell Court were not part of the main hospital at St George's Park. They comprised houses, bungalows and flats situated in their own cul de sac and area of the hospital grounds. This layout supported and promoted patient independence.
- Clearbrook ward hosted joint events with local parishioners and the community centre. They produced a yearbook so their patients could reflect on all the events and activities that had occurred
- Occupational therapists, activities coordinators, support workers and the exercise therapy team all played a role in ensuring there was a meaningful, recovery focused activities programme throughout the week.

Summary of findings

- Overall, the average length of stay across the service was 343 days. This showed good coordination and links with community mental health teams, and positive discharge planning, leading to good throughput.
- Patients' individual needs and preferences were central to their discharge plans. The wards developed good relationships with third sector seeking to accommodate patient choice and continuity of care wherever possible.
- Ward managers had the autonomy to coordinate bed management and place patients in the setting that best meet their needs.

Are services well-led?

Outstanding ☆

We rated well-led as **outstanding** because:

- Governance arrangements allowed managers to monitor and review performance using an electronic dashboard system. This enabled them to address deficits and make improvements. The service also piloted other electronic tracking systems enabling managers to monitor task management and community relationships, leading to further efficiencies.
- The service inspired and motivated staff to succeed. Staff were proud to work for the organisation and felt valued and supported in their work.
- The service was committed to continuous improvement. Wards implemented safe and innovative new working practices that reflected best practice across the wards, which they reviewed proactively.
- Each ward was either involved in a pilot, research or had introduced staff initiatives to improve the quality of the service.
- Staff felt empowered to contribute ideas for quality improvement and innovation.

Summary of findings

Information about the service

The long stay/rehabilitation service provided rehabilitation and recovery for working age adults with mental health problems. Occasionally the ward admitted patients over the age of 65 years if after assessment, placement was considered appropriate.

Brooke House was a 10-bed rehabilitation unit for people with complex mental health needs who required short-term intensive rehabilitation. The unit was a standalone building within the local community. It took male and female patients from the acute admission wards within the south area of Northumberland, Tyne and Wear NHS Foundation Trust. At the time of our inspection, there were ten patients allocated to the ward; of these eight were detained under the Mental Health Act. The main unit entrance door was locked on entry, for security reasons, but exit was unrestricted.

Elm House was a 14-bed community rehabilitation and recovery unit for working age adults, primarily from the Gateshead area. The building was a large three-storey house located at the top of a cul-de-sac in Bensham, Gateshead. Elm House provided care for individuals with complex mental health needs requiring longer-term rehabilitation. At the time of our inspection there were 13 patients allocated to the ward; of these eight were detained under the Mental Health Act 1983. The main unit entrance door was locked on entry, for security reasons, but exit was unrestricted.

St George's Park:

Kinnersley comprised a group of bungalows and houses located in its own cul-de-sac on the main hospital site. It consisted of over 20 buildings providing one, two and three bedroom houses or bungalows and a core six-bedded property. The ward provided a rehabilitation environment for males and females with complex long-term mental health problems. At the time of our inspection there were 16 patients allocated to Kinnersley; of these 15 were detained under the Mental Health Act 1983.

Bluebell Court was a group of flats and a bungalow positioned in its own area on the hospital site. It consisted of 15 individual flats on ground and first floor level surrounding a square, one bungalow and a communal building also used by staff. The ward provided a rehabilitation environment for males and females with complex mental health problems. At the time of our inspection there were 13 patients allocated to this location, of these 12 were detained under the Mental Health Act 1983.

Newton ward was an 18 bed high dependency unit (HDU) based at St George's Park. The ward provided intensive rehabilitation for males with severe mental health and complex needs over a short to medium term. At the time of our inspection there were 15 patients allocated to the ward all of whom were detained under the Mental Health Act 1983.

St Nicholas Hospital:

Willow View was a rehabilitation and recovery ward based at St Nicholas Hospital. It provided 17 in-patient beds for men and women with serious mental illness and complex needs who required intensive rehabilitation over the short to medium term. At the time of our inspection there were 13 patients allocated to the ward; of these 11 were detained under the Mental Health Act.

The main unit entrance door was locked on entry, for security reasons, but exit was unrestricted.

Hopewood Park:

Hopewood Park was a new build hospital, which opened in September 2014. Access and exit from the three long stay/ rehabilitation wards was controlled via an airlock.

Aldervale was an 18-bed high dependency ward with a focus on rehabilitation. It provided care and treatment for male patients aged 18 to 65 years of age. At the time of our inspection at the time of our inspection all patients were detained under the Mental Health Act 1983.

Clearbrook was an 18-bed high dependency ward with a focus on rehabilitation. It provided care and treatment for female patients aged 18 to 65 years of age. At the time of our inspection there were 18 patients allocated to the ward, of these, 17 were detained under the Mental Health Act.

Bridgewell was an 18-bedded ward that took patients across the age range with complex mental health needs

Summary of findings

requiring psychiatric continuing healthcare and long-term rehabilitation. A number of the patients required support with personal care and had mobility issues. At the time of our inspection there were 14 patients allocated to the ward; of these 13 were detained under the Mental Health Act. One patient was detained under the Deprivation of Liberty Safeguards.

We previously inspected St Georges Park, St Nicholas Hospital, Elm House and Brook House using the old inspection methodology and found them to be fully compliant. We had not previously inspected Hopewood Park.

We have carried out Mental Health Act (MHA) monitoring visits to all long stay/ rehabilitation wards. Following these visits, the trust provided an action statement telling us how they would improve adherence to the Mental Health Act and Mental Health Act Code of Practice in certain areas.

Our inspection team

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

Head of Inspection: Jenny Wilkes, Head of Hospital Inspection , Care Quality Commission

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

Jennifer Jones, Inspection Manager, Care Quality Commission

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

The team inspecting the long stay/rehabilitation mental health wards for working age adults comprised two inspectors, one consultant psychiatrist, two registered mental health nurses, and one social worker.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all nine of the wards at their various locations and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service and two carers
- spoke with the managers for each of the wards
- spoke with 41 other staff members; including doctors, nurses, occupational therapists, psychologists, pharmacists and support workers
- attended and observed one hand-over meetings, two multi-disciplinary meetings and a family therapy session.
- collected feedback from 30 patients using comment cards

Summary of findings

- looked at 39 treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During the inspection, we spoke with 19 patients who were using the service and two carers. All were very complimentary about the rehabilitation service.

Prior to the inspection, we gave patients the opportunity to provide feedback on the service via comment cards left on the wards. We received 30 comment cards relating to six of the wards. Sixteen comments were positive relating to friendly staff attitudes.

Nine comments cards contained both positive and negative feedback. The remaining cards were negative. Negative comments related to the environment, the smoking ban and staff attitudes.

Most patients told us they felt safe while on the ward. Ten patients mentioned the calm and settled atmosphere. All patients spoke positively about staff attitudes, saying staff were respectful and caring. Two thirds of patients told us they joined in with activities that suited them.

Carers expressed their satisfaction with the progress their relatives had made and praised the recovery and rehabilitation services. They felt confident that their relatives were safe on the ward.

Good practice

Clearbrook compiled a yearbook, reflecting on the joint events and activities patients from the ward had participated in with the local community. This encouraged a sense of social inclusion.

Access to an electronic dashboard performance system enabled ward managers to manage performance on a daily basis and improved autonomy. Managers praised the tracker systems being piloted at Elm House, Brooke House, Willow View and Hopewood Park as these improved links with community care coordinators and led to discharge efficiencies.

The service developed a psychosocial interventions guide for use on all its high dependency units, which they recently evaluated. This outlined their work in developing a whole team approach to formulating the needs of patients who present with complex symptoms. The service had been invited to present their findings to two national conferences for professionals.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review the appropriateness of having controlled entry and exit via an airlock in a rehabilitation setting.
- The provider should ensure that staff monitor all patients receiving a high dose antipsychotic treatment in line with national guidance.
- The provider should ensure that all care plans reflect the involvement of patients and include detailed and personalised information about the management of long-term physical health conditions.

Northumberland, Tyne and Wear NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Kinnersley ward	St George's Park
Bluebell Court	St George's Park
Newton ward	St George's Park
Aldervale	Hopewood Park
Clearbrook	Hopewood Park
Bridgewell	Hopewood Park
Elm House	Elm House
Brooke House	Brooke House
Willow View	St Nicholas Hospital

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.

Mental Health Act training was part of the trust mandatory training programme. Staff were 90% compliant with this training.

Detailed findings

The wards had a good understanding of the Mental Health Act and code of practice. The trust had a Mental Health Act administration team, who advised and supported staff in the application of the Mental Health Act.

The system for recording patients' section 17 leave was in place. Detained patients received treatment authorised by the appropriate certificate. Copies of the certificates were kept with the patients' prescription cards. Staff clearly recorded capacity and consent to treatment in all patient records.

Staff regularly explained to patients their rights under section 132 and recorded their understanding in patient records.

Copies of the patients' detention papers and the reports by the approved mental health professionals were available and stored correctly.

Staff supported patients to access independent mental health advocates.

Notice boards across the service clearly displayed information about patients' legal status and rights under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 was mandatory. Overall, the service achieved a 95% compliance with this training.

Staff had a good understanding of the Mental Capacity Act and we saw examples of good practice.

Patients' records contained decision specific capacity assessments and showed that staff held best interest meetings where appropriate.

There was one deprivation of liberty safeguard in place. The majority of patients were detained under the Mental Health Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

The long stay /rehabilitation wards provided patients with a clean, comfortable, well-maintained environment. The service had carried out appropriate health and safety checks on equipment, such as checks on the fire extinguishers throughout the wards and appropriate electrical testing.

Ligature risk and environmental audits were in place and in date on all wards except for Hopewood Park. However, the trust was in the process of updating all its clinical environmental risk audits and we saw evidence of this across the other sites. Hopewood Park was built to a ligature risk free specification in 2014. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All bedroom furniture was anti-ligature with fixed bed bases and open style wardrobes. The risk register for Bridgewell identified handrails in the corridor as being a potential ligature risk. Staff managed this risk through patient observations and individual patient risk assessments.

Due to the layout of the remaining wards, there were blind spots where staff could not observe patients and where ligature risks existed. Each ward's risk register referenced ligature points and the mitigation to manage these risks. For example, Newton ward highlighted electrical cords from patients own electrical equipment/ phone chargers in bedrooms as potential ligature points. Staff controlled this risk by ensuring patients were individually risk assessed and risk management plans put in place. All staff were aware of the potential risk as they discussed this in daily reviews and patients had ongoing risk assessments.

Elm House and Brooke House, which were move on rehabilitation wards, had a room that they described as being ligature free. This was to accommodate patients if their condition deteriorated.

All mixed sex wards complied with Department of Health guidance on same sex accommodation. In each case, they achieved gender separation by accommodating male patients in a separate area to female patients. Female patients had access to a female only lounge.

Across the service, the clinic rooms were clean, tidy and well organised. Equipment for checking vital signs was present. There were adequate supplies of emergency equipment, oxygen and defibrillators, which staff checked regularly. The wards kept stocks of emergency medicines as per the trust resuscitation policy, and a system was in place to ensure they were fit for use. Ligature cutters were available and easily accessible. Drugs cupboards were well arranged and labelled. Medicine fridges were clean and in order and staff checked temperatures daily.

The service was clean throughout with good standards of hygiene and infection control. There were effective systems in place to reduce the risk and spread of infection. For example, there were hand gel dispensers on each ward and in individual flats, colour coded chopping boards in patients' kitchens and personal protective equipment readily available on wards.

Patient-led assessments of the care environment surveys are the national system for assessing the quality of the patient environment. These assessments were self-assessments undertaken by teams of NHS and private/ independent health care providers, and included at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services such as cleanliness. For 2015, the assessors rated the ward environments overall at 99%, which is above the England average of 98%. Elm House and St Nicholas Hospital both achieved 100%.

Several wards, including the high dependency wards, had nurse call system along corridors and in patient bedrooms. Where this was not in place, staff carried personal alarms. Patients who did not have access to nurse call systems or personal alarms could find staff in communal areas if they needed assistance.

Safe staffing

Staffing establishment levels were sufficient to allow essential ward activities to take place and for staff to attend training as needed. Ward managers reported that they had inherited the current staffing levels. The minimum staffing levels for each shift took into account the number of beds and needs of the patients. The trust reviewed staffing establishment levels at Kinnersley and Newton ward two

Good

Are services safe?

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

years ago. Ward managers were able to increase these levels based on their clinical judgement. For example, one ward had increased their staffing levels on eight occasions in three months to accommodate a patient requiring a high level of observation.

An analysis of the staffing levels for the three-month period ending 30 April 2016 showed that wards used mainly bank staff to cover any vacancy, leave or sickness on the wards. The bank staff comprised staff that already worked on the long stay/rehabilitation wards and were familiar with the patients. Overall, agency use across the service was low. Agency staff received a local induction before working on the wards.

Newton Ward had the highest qualified nurse vacancies across the service at 25% during this period. This was above the trust average of 14% and was due to staff progression. They had the highest use of agency staff across the service, using agency staff on 31 out of 273 shifts.

Brooke House had the highest nursing assistant vacancy rate of 22%. This was higher than the trust average of 9% and was due to staff retiring. Willow View had the highest number of shifts filled by bank staff, who covered 131 shifts during this period. This was because of staff vacancies and long-term sick leave.

In the 12 month period ending 30 April 2016, Bluebell Court had the highest number of vacancies overall with 14%, which was above the trust average of 3%. The ward had recently recruited to the vacancies and expected to have a full complement of nursing staff in September. The total percentage of staff leavers for the service overall was 5%. This was lower than the trust average and showed the service had the ability to retain staff, which led to settled wards.

Bridgewell, Bluebell, Clearbrook and Newton all had sickness levels above the trust average of 5% and the NHS average of 4%. However, sickness levels did not exceed 7% and were due to each ward having staff on long term sick. Newton ward had the highest number of staff leavers in the 12 months preceding the inspection with 6% of leavers although this was lower than the trust average of 8%.

Staff told us and patients confirmed that they received regular 1:1 time with their named nurse. This was a minimum of twice weekly across the service. Evidence showed escorted leave was only cancelled due to a clinical necessity and staff monitored and recorded when this happened. Staff and patients told us there was sufficient staff to ensure ward activities went ahead.

Those wards based at hospital sites had access to medical cover provided by hospital doctors. Nursing staff carried out physical health observations and interventions as needed. Staff encouraged patients at Elm House and Brooke House to register with local GP surgeries. Out of hours, the service contacted their nearest accident and emergency service.

The trust had a minimum compliance target of 85% for statutory and mandatory training, with the exception of information governance, which was 95%. Training data showed that the service was compliant with mandatory training achieving 94% compliance overall. There were 21 elements to mandatory training including: equality and diversity, fire, health and safety, infection prevention and control, medicines management training, safeguarding and managing violence and aggression.

Assessing and managing risk to patients and staff

We looked at 39 patient records during the inspection. Each record contained an up to date risk assessment and management plan. Staff discussed the risk status of each patient at the daily handover meetings and reviewed risk regularly. The trust used the functional analysis of care environments risk assessment tool, which looked at a set of risk indicators relevant to the patient. These included judgements of risk status in key areas (including violence, self-harm, risk of offending and self-neglect), service user and carer perspectives on risk and a risk management plan.

Newton high dependency ward was a locked ward. The ward displayed trust notices both inside and outside the front doors of the ward explaining the reasons why it operated as a locked facility. Informal patients should not be subject to any restrictions on leaving the ward although staff have a duty of care to the patient. Staff informed informal patients of their right to leave and request the doors are unlocked to facilitate this. At Hopewood Park, the main entrance to the wards was through an air lock, controlled by staff. An airlock strengthens security by providing an additional locked room that all staff, visitors and patients have to pass through to gain entrance or exit from a building. Signage displayed inside the ward told patients to ring the bell for staff assistance even though

there was no bell to ring. Staff told us the notice was old and needed removing. This level of control and security was more appropriate to a secure setting than a rehabilitation ward.

We did not identify any blanket restrictions on the other long stay/rehabilitation wards. Kinnersley ward had a patient with dementia related symptoms. The ward alarmed the back door of the patient's flat to alert staff of the patient's movements. The ward considered this the least restrictive intervention appropriate to the needs of the patient and obtained consent before implementing the alarm.

The service had 13 informal patients at the time of the inspection. Twelve of these patients were having treatment and care on 'open' wards. This meant they were free to leave the ward as they wished. The open wards had a controlled entrance for security reasons but an open exit for patients.

The trust had a policy for searching of patients. Staff did not routinely search patients. They carried out searches when they felt it to be necessary due to risk to self or others. Staff obtained consent from the patient and conducted the search in line with the Mental Health Act code of practice.

Staff received training in the prevention and management of violence and aggression achieving trust compliance rates for this mandatory training. Staff were skilled in the use of de-escalation techniques and gave examples of using distraction and low stimuli in the first instance. Nurses were able to give examples of positive risk taking through graded exposure. For example, encouraging patients on high observation levels or patients lacking in motivation to take section 17 leave, accompanied at first.

During the six-month period ending 30 April 2016, there were 92 incidents of restraints with 98% of these occurring on the high dependency/complex care units. Bridgewell ward located at Hopewood Park had 57 incidents of restraint involving six patients in total. Newton Ward had 20 incidents of restraint and had used prone restraint on seven occasions. This resulted in three incidents of rapid tranquilisation.

The high dependency/complex care wards at St George's Park and Hopewood Park had seclusion facilities. The seclusion rooms at Hopewood Park had no blind spots. The rooms were clean and suitably equipped with a mattress or a chair. Anti-ligature bedding was available if required. The rooms were fitted with temperature controls and close circuit television. Staff in the viewing area had access to alarms and phones and the ability to cut off the water supply. Clocks were visible to enable patients to see the time and each room had a window (fitted with an internal blind) allowing natural light into the room. There was a facility available for playing music and patients could communicate with staff using an intercom system. Each room had an ensuite toilet and shower, which staff could lock into either an open or a closed position.

We did notice some pooling of water in the ensuite facility in Bridgewell seclusion suite. We brought this to the attention of the ward manager to take appropriate action.

Seclusion records on all three wards met the requirements of the Mental Health Act code of practice. Staff also completed reviews of seclusion records in line with the Mental Health Act code of practice. There were no delays in documentation. We reviewed records on Aldervale and Clearbrook against progress notes and were satisfied seclusion was required and de-escalation tried first. We noted 15-minute observations detailed patient presentation and a record of offered food and drink. Seclusion appeared to end at the earliest opportunity. Seclusion care plans were in place although not used very often. On Aldervale, we saw evidence of a patient debrief post seclusion.

On Clearbrook, we observed a sanitary bin in the seclusion room, which demonstrated a commitment to patient privacy and dignity. There was a toilet roll resting on top of the bin, which raised issues around self-harm and infection prevention control. The trust has assured us they will review this issue as an action that the chair of the seclusion steering group will take forward. Clearbrook rarely used their seclusion room.

Overall, the high dependency /complex care wards used seclusion 69 times during the six months ending 30 April 2016. Newton ward had a seclusion care plan for a patient who had required the use of the seclusion facility on 32 times occasions during this period.

On Newton ward, the seclusion suite comprised a de-escalation room with access to a small open-air fenced area. There was a separate seclusion room with a staff observation area and seclusion room with separate en-suite facilities. The seclusion room was clean and furnished

Good

Are services safe?

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

appropriately. A monitor in the staff area allowed staff to view the seclusion room only. Staff had personal alarms and a unit radio to summon assistance if required. We viewed the seclusion documentation relating to Newton ward and found staff were completing this in line with the Mental Health Act code of practice.

Staff had a good understanding across the service of safeguarding and were able to explain the safeguarding procedure to us. There was evidence of appropriate safeguarding referrals to local safeguarding teams and attendance at multi-disciplinary meetings with the local authority.

We looked at the systems in place for medicines management across the long stay/rehabilitation wards at Hopewood hospital. We reviewed 21 prescription records and spoke with nursing staff that were responsible for medicines.

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

Prescription records were completed fully and accurately, and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act for most people.

One patient was receiving antipsychotic treatment above British National Formulary limits, which carried additional risks for the patient and was subject to extra physical health monitoring. Staff had not identified this on the Mental Health Act documents, patient care records, or prescription card. There was a policy in place to monitor high dose antipsychotic treatment. We saw other patients were monitored in line with trust policy. We brought this to the attention of the responsible clinician, who rectified the matter immediately.

'When required' prescriptions contained relevant information to enable staff to administer them safely. However, staff had not updated the care plan following changes to prescribed medication.

Some patients managed their own medications under the supervision of a nurse and staff discussed patients' progress at multi-disciplinary team meetings. However, for one person the risk assessment did not clearly describe the level of support required. We saw one patient had received rapid tranquilisation; there were detailed progress notes explaining the rationale for this. Staff had carried out the appropriate physical health monitoring in accordance with the trust policy and national guidance.

Staff closely monitored patients receiving medication such as clozapine and lithium. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines.

Ward staff told us about the comprehensive support provided by the pharmacy team, which included a visit by a clinical pharmacist regularly and attendance at multidisciplinary team meetings. An electronic medicines storage and management system was in use; this enabled the ward pharmacist to spend time giving advice to patients about the medicines they were taking when requested. There was also the facility for pharmacy staff to label medicines on the ward for patient discharge or periods of home leave.

Track record on safety

The long stay/rehabilitation wards reported two serious incidents for the year ending 31 December 2015. These were in the 'slips, trips, and falls' category and physical health. The ward manager reported the incidents through the trust reporting system for investigation in line with policy. Following the serious incident investigations, staff made changes to working practice:

- patients' footwear was included as part of the falls risk assessment
- staff made referrals to physiotherapy where appropriate
- staff worked on developing an interface with the general hospital
- staff received information and direction about oxygen management
- increased engagement with patients' families.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report using the online reporting system. We reviewed the incidents reported for the 12 months ending 30 April 2016. Overall, the service recorded 2490 incidents. Over half the incidents recorded related to aggression and violence or inappropriate patient behaviour. Other incidents recorded included medication,

Good

Are services safe?

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

absconding, accidents, equipment problems and information governance among other categories. The service had two incidents recorded as causing major harm during this period. Staff involved in the incidents received a debrief using a supportive approach. This involved a discussion of what happened and what staff could have done differently. Ward managers cascaded any learning from these incidents through team meetings and email action points. This included discussion and learning from other incidents via the trust central alert system.

Ward managers were aware of the importance of being open and transparent with patients and their families and apologising if things went wrong. One ward manager was able to tell us how they followed the trust policy on duty of candour following a communication failure around a patients discharge. Staff interviewed identified the need for transparency in their work.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We looked at 37 patient care records across the service. The ten care plans we reviewed on the high dependency wards lacked detail and evidence of patient involvement. Despite this, we observed care that was person centred and recovery focused. The trust recognised the need to improve the quality of care plans. They were currently targeting this as an action across the service. Ward managers acknowledged improvement was ongoing. We found that some wards had been more successful than others at improving care plan quality. For example, at Bluebell Court, Brooke House, Elm House, Kinnersley and Willow View, we found, up to date, well personalised, holistic and recovery oriented care plans.

The inspection of medication management at Hopewood Park revealed a variation in the quality of care plans relating to long-term physical health conditions. On one ward, we saw an example of a comprehensive care plan for a patient with chronic obstructive pulmonary disease, which contained detailed and personalised information about their management. However, on the same ward for another patient with the same condition there was no care plan in place. Nurses on the ward had recently received specialist training in oxygen management so were able to provide the right care should the need arise. On another ward, we saw basic information included in the care plan for a patient with diabetes. There was a more detailed discussion around diet and exercise included in their one to one meetings with care staff.

Patients with physical health problems received appropriate monitoring, for example physical observations and blood tests, in accordance with national guidance. A phlebotomy and physical health team of nurses visited the wards regularly. We saw staff provided support to a patient who chose to access physical healthcare through a local GP.

All information needed to deliver care was readily available when needed and stored securely either in electronic format or in lockable files for paper format.

Best practice in treatment and care

The service had processes in place to provide care and treatment that followed best practice and National Institute for Health and Care Excellence guidance. For example, staff followed National Institute for Health and Care Excellence guidelines on prevention and management of psychosis and schizophrenia in adults and bipolar disorder in adults.

There was a range of psychological therapies across the service personalised to meet the individual needs of patients. The wards provided evidence based psychosocial interventions and family therapy using a multi-disciplinary approach. This included liaison with outside agencies, carers and families. Patients on Bridgewell ward regarded as treatment resistant had limited psychological input in comparison to other wards. However, some patients' rehabilitation had benefited from psychological interventions and they had progressed to more recovery-focused wards.

The service recovery model was a whole systems approach to recovery, including social inclusion, promoting independence, autonomy and hope. The trust were currently reviewing the operational policy for the stepped care service - move on/relapse prevention.

Patients received a full physical assessment on admission. All patient records we reviewed showed the patient had ongoing physical health monitoring. At stand-alone units, staff encouraged patients to establish local links and register with local GPs. Patients at St George's hospital had access to the onsite treatment centre for physical health needs. Hopewood Park appointed physical health nursing leads and staff received training in phlebotomy and electrocardiogram monitoring. The wards transferred patients to the general hospital if they required specialist medical input for a physical health condition.

Staff used a variety of evidence-based tools to assess and record severity and outcomes, which were undertaken on admission and then at regular intervals. Tools included the recovery star, the short Warwick-Edinburgh mental well being scale and the clinical global impression rating scale.

The service undertook various clinical audits, in which staff participated. For example, Mental Health Act audits, physical health audits, medication reconciliation and electronic documentation audits. At Hopewood Park, clinicians were involved in an ongoing audit on anti-psychotic prescribing in rehabilitation settings. This was at the data collection stage. At St George's Park, the wards

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undertook two lithium and clozapine audits a year. Brooke House were currently looking at improvements in dental care for patients and staff were at the planning stage for this audit.

Skilled staff to deliver care

A full range of healthcare professionals provided input to the service and supported patients. This meant there was a sufficient skills mix among staff to meet patients' needs. All staff had access to regular supervision with St George's Park, Elm House and Brooke House achieving over 100% compliance rate of monthly supervision. Records showed that when supervision did not take place, staff were either on leave, long-term sick or working a night shift.

Compliance with performance appraisals was high across the service. As at 30 April 2016, they achieved a 92% compliance rate for non-medical staff and 95% for medical staff. This meant that ward managers were able to support staff with their professional development to provide quality care and treatment for patients.

Each ward held regular staff team meetings. We looked at the minutes from several meetings held during the last three months. Minutes showed standard items on the agenda included quality and performance, recruitment, risk registers, policy updates, staff wellbeing and safeguarding.

The service encouraged and supported staff to undertake specialist training that would enhance the skills within the team and lead to professional development. Staff had access to a range of training and qualifications that were rehabilitation and recovery oriented. For example, behavioural family therapy, belief in recovery, cognitive behavioural interventions, mindfulness and wellness recovery action plans among others. The service expected all band two workers to undertake a care certificate diploma.

The service did not currently have any staff being performance managed.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team held weekly meetings at each location. The service used in depth formulation during these meetings with regular reviews of formulation and management. Formulation looks at all relevant factors and risk management to provide a framework to develop the most suitable treatment for a patient. Patients met with their responsible clinician at least fortnightly to discuss their treatment and care and attended a care programme approach review every three months. A care coordinator link represented individual community mental health teams at these meetings.

We observed a multi-disciplinary team meeting at St George's Park. The patient did not attend the meeting as they found the reviews challenging. Instead, the consultant met with the patient the previous day to gain their view. Staff invited the patient's carer/relative to attend the meeting, which they did after the multi-disciplinary discussion. The multi-disciplinary team used formulation to structure the meeting, looking at the problem, precipitating factors, perpetuating factors, protective factors and predisposing factors. There was a clear agenda and the team discussion was caring and well informed.

The short stay/move on wards had good links with community mental health teams and the community rehabilitation service. At Willow View and Elm House, the ward managers were able to monitor community mental health team involvement with patients using an electronic tracker. This monitored how often a care co-ordinator had seen their patient and alerted staff when this did not happen fortnightly.

Nursing handovers occurred before each shift change. We observed a nurses handover. Staff discussed issues such as physical health care, risk management, safeguarding issues, current presentation and discharge planning for each individual patient. Staff handed over new patient details thoroughly. This ensured that staff coming on duty were up to date with all aspects of patient care and treatment.

Elm House held a daily review meeting informed by an electronic daily tracker that acted as a live document. This computer dashboard tracker was a pilot for the Newcastle and Gateshead area. It enabled the ward to pick up any changes in patient presentation and see when identified actions were complete. This in turn influenced patient length of stay making the ward more efficient.

Elm House was unique in having close links with Gateshead local authority attending fortnightly health and social care interface meetings. This helped further build good relationships with external organisations, for example, local authority safeguarding teams and general practitioners.

Are services effective?

Good

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

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

Mental Health Act training formed part of the trust mandatory training programme. Staff were up to date with their training and met with trust compliance targets. We reviewed care and treatment of patients detained under the Mental Health Act and found the wards adhered to the Act and Mental Health Act code of practice. All wards had access to a Mental Health Act administrator based in a central team. Staff knew whom to contact for administrative and legal advice to support the operation of the Mental Health Act.

At the time of the inspection, the service had 117 patients detained under the Mental Health Act. We reviewed patients' current leave forms and found that staff completed section 17 leave forms with clear conditions. The responsible clinician completed a risk assessment within ward rounds and nurses undertook a risk assessment pre leave occurring. Patients were aware of how much leave they could take and used it. However, staff did not formally record the patient perspective of how leave had gone.

Overall, records showed that detained patients received treatment with the proper authorisation of medication for mental disorder. We saw that patients' medication charts had copies of these certificates attached as appropriate. Staff adhered to the Mental Health Act rules around consent to treatment and capacity, and clearly recorded this in all patient records. At Hopewood, there was some confusion about the authorisation of emergency medication under section 62 of the Mental Health Act and the use of the existing certificate for medication. We discussed this with the responsible clinician.

Copies of the patients' detention papers and the reports by the approved mental health professionals were available and stored correctly. All records had a detention care plan but they were not always correct. For example, one record referred to the wrong certificate when treating a patient under section 62 (emergency powers). We noted the recording of second opinion appointed doctor decisions with patients was variable. There was a delayed second opinion appointed doctor request that the Mental Health Act office eventually picked up following their audit procedure.

Patients had access to independent mental health advocates. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. All patients we spoke with confirmed staff supported them to contact the independent mental health advocates should they require advocacy support. Both units displayed information on the advocacy service on their Mental Health Act notice board.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was mandatory for all relevant staff. Figures supplied by the trust showed that overall the service was compliant with trust targets for Mental Capacity Act training.

Staff we spoke with had a good understanding of the Mental Capacity Act and its principles. Staff understood the processes to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act. They took practicable steps to enable patients to make decisions about their care and treatment wherever possible.

We saw appropriate examples of capacity assessments and best interest decisions in patient records. Staff recorded when they assessed patients as having possible impaired capacity, for example on a decision-specific basis. The service made decisions in patients' best interests when they lacked capacity, recognising the importance of the person's wishes, feelings, culture and history.

At the time of our visit, one ward had a Deprivation of Liberty Safeguard application. A Deprivation of Liberty Safeguard application becomes necessary when a patient, who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely. Applications have to show that this is in the patient's best interests and the least restrictive option.

There was information for patients and relatives on the Mental Capacity Act and Deprivation of Liberty Safeguards on the wards.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed a caring and compassionate team, who promoted service user independence and recovery. There were positive and warm interactions across the service between staff and patients. Staff participated in activities, engaging and treating patients with dignity and respect. They provided care and support in a calm, kind, friendly and patient manner.

Patients and carers made positive comments about the quality of the care and treatment provided. The patients we spoke with were complimentary about staff attitude and engagement.

We observed various meetings where staff discussed patients' needs with dignity and respect.

We received 30 comment cards relating to six of the wards. At St George's Park, we received four positive comments stating that staff were friendly, caring, understanding and helpful. One mixed comment criticised food and uncomfortable furnishings. At Elm House and Brooke House, we received eight positive comments about patient experiences and four mixed comments relating to the location of Brooke House. At Hopewood Park, we received four positive comments about the environment, four mixed comments about the environment and three negative comments relating to staff attitude and the ban on smoking.

The involvement of people in the care that they receive

Each ward had informative welcome packs given to patients on admission to help orient them to the ward and explain the care and treatment provided.

Patients felt that they were involved in their care. During the inspection, we looked at 37 care plans, of these 27 showed meaningful patient involvement. For example, at Brooke House, care plans included a patient's points of view about not giving up smoking. In addition, wellness recovery action plans incorporated the patients' perspective of how to manage their illness. Patients' views were also included in their recovery pathway and discharge planning records, which showed patients fully involved in selecting future placements.

We saw that families and carers were involved in patient care, attending review meetings and family therapy sessions. Bridgewell ward had a carer's champion who updated, supported and involved patients' relatives and carers. They maintained links with monthly carers' groups across the area.

Each ward held regular community meetings. The community meetings gave patients the opportunity to comment on the running of the ward including the environment, activities and catering amongst other things. We looked at the minutes from recent meetings. We saw examples where patients had requested specific activities or raised issues. Staff responded to these requests and made changes where possible.

Patients were also able to give feedback to the trust using points of view cards and the patient advice liaison service. Patients at Brooke House were involved in a pilot scheme whereby they contributed to staffs' yearly appraisals. This pilot was ongoing.

Patients had regular access to independent mental health advocates for patients detained under the Mental Health Act. Staff informed patients about the availability of the independent mental health advocates and enabled them to understand what assistance the independent mental health advocate could provide. Patients we spoke with were aware of the independent mental health advocacy service and five patients said they actively engaged with the service.

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 service had a clear rehabilitation and recovery focused pathway for accommodating patients on long stay, medium stay or move on /step down wards. Ward managers had the autonomy to coordinate bed management. They attended fortnightly referral meetings to discuss admissions, placements in respect of clinical need and patient mix, and discharges across the service. Patients received a graduated induction to the wards wherever possible to reduce patient anxiety.

The average bed occupancy across the service for the six-month period ending 30 April 2016 was 91%. This was higher than the royal college of psychiatrist recommended bed occupancy rate of 85%. However, patients always had a bed available to them on return from leave and patients only moved wards for a clinical need.

The service was actively trying to repatriate those patients placed out of area in the past. The average length of stay for current patients for the 12-month period ending 30 April 2016 was 343 days. This did not include any time spent previously on other wards in the trust during the same inpatient spell. Long stay wards had an expected average length of stay of between six to 24 months. For move on wards, this was six to 18 months.

Staff routinely planned for a patient's discharge from the point of admission. Staff involved patients in discharge planning, taking into account their preferences with regard to accommodation and location. The move on/short stay wards had good throughput. Elm House had seen an improvement in their discharge rates over the last 18 months. This was due to electronic tracker systems that helped reduce delays in coordination and calculated daily average length of stay. Willow View had discharged 14 patients in the 12 months prior to inspection. They offered their patients continuity of care providing up to six therapy sessions post discharge to support their transition back to the community.

There was currently one delayed discharge of three weeks due to a patient changing their mind about independent living at the last minute. This led to a request for supported living instead, which the ward had just succeeded in securing. During the six-month period ending 30 April 2016, the service re-admitted two patients within 90 days following discharge from a trust inpatient bed.

The facilities promote recovery, comfort, dignity and confidentiality

Individual wards had sufficient space for activities and care. Across the service, there was a range of rooms and equipment to support the rehabilitation and recovery of patients. For example, there were clinic rooms to examine patients, games rooms, art rooms and faith rooms. We noted a calm and settled atmosphere on each ward we visited.

Bridgewell ward at Hopewood Park was due to move location in March 2016. This had not happened yet as the new location had fewer beds than the existing location. Due to the complex needs of the patients, the ward was struggling to find placements in suitable supported environments. However, they maintained good links with several establishments and were hopeful of securing appropriate accommodation for patients who would be ready for discharge in the months ahead. This would then allow the proposed move to go ahead.

Rooms were comfortable, clean and spacious. We saw some patients had chosen to personalise their bedrooms. The bedrooms provided a lockable storage space for patients to keep possessions safe.

Kinnersley and Bluebell ward comprised houses or flats, which promoted independent living. Patients had access to a clubhouse for activities and leisure. The short stay/move on wards were open wards and had a very homely feel to them. In comparison to the Newton high dependency ward, Hopewood Park had a very clinical and security conscious feel to it.

There was access to a telephone to make a private phone call on each of the wards. Patients had the option of having a key to their room if appropriate following risk assessment. Patients had access to bedrooms and external garden areas during the day. Patients we spoke to had mixed feelings about the food provided by the service. All patients were able to have hot drinks and snacks at all times.

Occupational therapists and activity co-ordinators were included in the staff mix for each ward. Managers, staff, carers and patients all told us that activities were well

Are services responsive to people's needs?

Outstanding ☆

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

planned and delivered. The service provided an activities programme seven days a week including evenings. Patients had access to external activities such as fishing groups, swimming, gym, and gardening club allotments. Brooke House had developed and introduced activity toolboxes, which allowed patients to select either group or individual sessions. These included a variety of activities for example, board games, crafts, table tennis, cooking and music among others. At Elm House, three support workers acted as activity champions to support and engage with patient activities.

The service had access to the trust's exercise therapy team, who we saw actively engaging with patients during the inspection. We noted that planned activities included a range of physical exercise such as dance and walking clubs.

Meeting the needs of all people who use the service

Patient's individual needs and preference were central to the planning and delivery of the rehabilitation and recovery pathway. Overall, the service provided choice and ensured continuity of care. This was in part due to the autonomy the ward managers had in ensuring they admitted patients to the ward best suited to meet their needs.

Some wards provided better facilities than others did for accommodating patients with mobility issues. The weekly managers meeting ensured patients went to the wards that could meet individual needs the best. Wards had some rooms designed and adapted to enable access by wheelchair users.

At the time of our inspection, patients on wards were able to attend multi-faith services around the trust. They also had access to a multi faith box, which included a bible, the Koran and a prayer mat. Staff gave us examples of how they provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. For example, Elm House had developed links with a local faith leader to ensure that staff and patients had an understanding of cultural needs to support the patient. The ward managers were knowledgeable about equality and diversity issues and knew how they could accommodate individual patients' needs within the service.

All wards had well organised display boards. They included information leaflets about treatments, local services, advocacy, support groups, patients' rights and how to complain. If required, staff could obtain this information in different languages. The service had previously used interpreters for patients whose first language was not English.

The service was able to meet patients' individual dietary requirements for health and culture, requesting specialist diets for patients who needed them. This included meals for patients who required vegan, vegetarian or coeliac diets, as well as kosher or halal meat if required. Staff supported those patients who were self-catering, helping with planning and budgeting, shopping, preparation and cooking of food to meet their individual dietary requirements.

The service provided meaningful activities and aimed to promoting social inclusion and equality. On Clearbrook ward, the occupational therapist had developed and established a partnership with the local church and community centre to provide an integrated person centred pathway of care for people with complex needs. They held many joint events, for example, contributions to the local church fairs, rambling events, film nights and remembrance day service. The patients also participated in the annual race for life event. The occupational therapist captured these events in a yearbook for patients to see. This innovative approach enabled Aldervale and Bridgewell wards to join in appropriate activities. For example, volunteering work at the local dog rescue centre.

St George's Park was a more rural location. In order to facilitate links with the community, the wards had access to a trust car. Patients used this transport to attend physical health related appointments, community groups, family contact visits, home leave and as part of supporting shopping to assist with self-catering care plans and other social and individual activities within the community setting. Records showed that overall 25% of patients on the wards accessed the vehicle daily in the three months leading up to the inspection. In addition and due to the unique layout of Kinnersley and Bluebell wards, patients developed their own local community. They held patient led mutual help meetings three times a week to support and value one another. For example, a patient might help another with the preparation of a meal.

The short stay/move on wards had excellent relationships with the community mainly due to their locations. They developed links with local organisations providing a creative forum for mental health patients and facilitating

Are services responsive to people's needs?

Outstanding ☆

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

group work and skill sharing opportunities. Occupational therapists were proactive in understanding the needs of individual patients and provided meaningful activities that met these needs.

Listening to and learning from concerns and complaints

The service received five formal complaints in the 12 months ending 30 April 2016. Ward managers investigated complaints using the set procedure and timeframes contained in the trust policy. Following investigation, the service fully upheld one complaint. The service also partially upheld two complaints following investigation. Managers ensured lessons learned from complaint outcomes were included as actions in staff personal development plans.

There was information on how to complain displayed on notice boards and in the welcome packs staff gave patients. The welcome pack explained how to make complaints and the support available from the patient advice and liaison services. The patients we spoke to said they would complain directly to staff in the first instance.

Staff we spoke with knew the complaints procedure and felt able to manage informal and formal complaints. Ward managers shared learning arising from complaints with staff at the business meetings. Staff received individual feedback during supervision and discussed how to handle things differently in the future.

The service received eight compliments during the last 12 months (1 May 2015 – 30 April 2016).

This figure does not take into account the compliment cards each ward received directly.

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

The trust vision was 'to improve the wellbeing of everyone we serve through delivering services that match the best in the world'. The trust values were based on three domains: caring and compassionate, respectful and honest, and transparent.

Staff we spoke with knew the trust's vision and values and felt they were essential to the care and treatment they delivered. Staff supervision and appraisals incorporated trust values. It was evident from interactions with patients that staff were clearly committed to providing high quality care and took pride in their achievements. Staff told us they felt supported and valued by the trust.

Staff knew who the senior managers within the trust were and commented positively on their visibility on the wards and their approachability. They felt able to raise issues or concerns with senior managers.

Good governance

The trust had a good governance structure in place to oversee the running of the service with effective local leadership in place on each ward. The service ensured systems and processes were effective.

We found that staff were compliant with trust targets for mandatory training, supervision and appraisals. Regular bank staff filled staffing shortfalls caused by vacancies and absences. Staff reported incidents appropriately and received feedback and lessons learned at team meetings or during individual supervision.

Managers were able to monitor key performance indicators to measure performance using an electronic performance dashboard system.

The ward managers had the autonomy and sufficient authority to run their wards. They worked collaboratively to ensure they admitted patients to the ward best suited to meet their needs and had responsibility for bed management.

The trust operated a centralised values based recruitment system. New staff praised the interview process and the comprehensive induction they received making favourable comparisons to previous experiences.

Each ward had their own risk register, which staff identified and updated during team meetings

Leadership, morale and staff engagement

Morale was high; all staff we spoke with were enthusiastic about their work and felt well supported by their colleagues. Staff were dedicated and there was a sense of 'can do' and commitment to the trust. They spoke highly of their manager and multi-disciplinary team.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation.

There was a commitment to personal development that led to a culture of staff self-belief and dedication. Staff provided feedback and ideas to improve the quality of care and treatment. For example, activity toolboxes and a team wellness tool kit for staff.

Commitment to quality improvement and innovation

The service was committed to improving and innovating rehabilitation and recovery focused care across the wards. There was recognition of the importance of social integration in improving treatment outcomes. This led to the service actively engaging with outside organisations to improve treatment outcomes.

Innovations and new working practices reflected best practice and wards reviewed practices proactively. For example, the service reviewed their commitment to formulation development in March 2016 to establish the progress made and look at ways of improving formulation.

Bluebell Court, Newton ward and Aldervale had achieved the Royal College of Psychiatrists' accreditation for inpatient mental health services programme with excellence. Accreditation for inpatient mental health services programme was a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Kinnersley ward, Willow View and Elm House had recently enrolled in the programme.

Elm House was the first of the rehab wards to achieve a 'STAR' ward status in March 2016. This award involved benchmarking a ward against 75 standards to improved daily experiences and treatment outcomes for mental health inpatients.

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.

Each ward was either involved in a pilot, research or had introduced staff initiatives to improve the quality of the service:

- Kinnersley ward introduced patient led mutual respect meetings and were developing staff and patient individual profiles to break down barriers and build relationships.
- Bluebell Court was implementing the 'safewards' model, which aims to have a positive outcome for managing conflict and containment.
- Newton ward were currently developing secondment opportunities with the trust's dual diagnosis team
- Willow View was involved in a research study with Newcastle University about psychosis and language.
- Aldervale was running a dual diagnosis pilot. This involved the use of a drug and alcohol screening assessment tool and relationship with mental health.
- Clearbrook was part of the initial pilot to reduce restrictive practices on the ward and improve the quality of care plans. The trust has since extended this scheme to other inpatient wards.
- Bridgewell was involved in a pharmacy pilot using a pharmacy automation system to support prevention of medication errors and provide documentation for regulatory compliance. They were awaiting pharmacy feedback.
- Brooke House was exploring a pilot on oral hygiene as they had noticed many patients neglected this area of physical health.
- Elm House had introduced a team wellness toolkit for staff.