Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Wards for people with a learning disability or autism

Requires Improvement 

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Our rating of this service went down. We rated it as requires improvement because:

- There were not enough staff on Cheviot ward to make sure people always had the staff needed to keep them safe and meet their needs. People told us that when the services were short staffed, they could not do their planned activities and therapies.
- Staff did not receive the right training to ensure they had the skills and knowledge to meet people's needs. At the time of inspection training in learning disabilities, autism and alternative communication methods was not mandatory and a low proportion of staff had completed training in these areas. Three mandatory / essential clinical training courses and overall rates of supervision and appraisals fell below the trust target.
- For one person, staff applied restrictions which were not proportionate to the current level of risk including long term seclusion and access to personal belongings. There was no plan to end the restrictions.
- One person's care plan did not reflect an arrangement for communication with their multi-disciplinary team. Staff did not always have access to important information so that they could manage risks and meet the person's needs.
- People were not always being cared for in safe and therapeutic environments suitable for people with learning disabilities and/or autistic people and people with physical disabilities. On Lindisfarne, people in seclusion did not have privacy and dignity as other staff not involved in their care entered the seclusion area regularly. Seclusion rooms were not fit for purpose on three wards. On four wards, people did not have access to a nurse call alarm system. There were issues with regulating noise and temperature on some wards and three wards had accessibility issues due to stairs. The environmental risk assessment for Rose Lodge had not been reviewed regularly and environmental risk assessments did not detail specific locations of ligature anchor points. The trust was building new wards to improve medium secure environments.
- Staff did not always ensure that people's records contained evidence of their involvement in decisions about their care and treatment. Blanket restriction register did not contain all the restrictions in operation to ensure these were reviewed regularly.
- The use of restrictive interventions was high and there was a high proportion of prone restraint. There was limited evidence of lessons learnt from incidents shared and there was a delay in staff receiving a post-incident debrief on Acorn ward.
- The food ordering system was not person centred as people had to order their food two days in advance. People also told us mistakes happened with meals and this meant they did not always get their food choice.
- Carers told us that they wanted improved communication and involvement in their relative's care.
- There were issues with nursing assistants and registered nurses not feeling listened to and involved in multi-disciplinary team discussions and decisions made on Mitford Unit which the trust was trying to improve.

Our findings

- It was not always clear in some people with a learning disabilities' records the reason why they had been initially prescribed anti-psychotic medicines.

However:

- The service mostly met the principles of 'Right support, right care and right culture'.
- Staff managed discharge pathways as well as they could, but people stayed in hospital for longer than needed because it was difficult to find the right care and support in the community. This affected the services' ability to care for new people who needed the service.
- Staff embraced people's individuality and preferences on how they wished to live their lives. Some people staying in long-term segregation had regular access to leave to go out and had their own workshops for gardening, horticulture and vehicle repairs. Specialist assessments were completed to enable people to be safe and express their preferences.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. Staff had a positive and warm approach to people and their roles.
- People could do the things that they enjoyed than helped them to learn new things, skills and keep well. There were several health improvement initiatives to improve people's physical health.
- Staff and people participated in research, clinical audits, benchmarking and quality improvement initiatives.
- The service used systems and process to safely prescribe, administer, record and store medicines.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Leaders were visible and approachable and worked flexibly to understand the service, support staff and meet people's needs. Staff felt respected, supported and valued by managers and colleagues.

Background to inspection

Cumbria, Northumberland Tyne and Wear NHS Foundation trust provide mental health, learning disability and neurological care for people across the north of England. The trust also provides some national specialist services.

The trust provides nine wards that provide care to adults with learning disabilities and/or autistic people at Rose Lodge, Carleton Clinic and Northgate Hospital. These locations are registered to provide the following regulated activities:

- Assessment or medical treatment of persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Diagnostic and screening.

These wards comprised of:

- Rose Lodge – a learning disability and autism specialist assessment and treatment service for up to 10 people based in Hebburn in South Tyneside.
- Acorn – a learning disability assessment and treatment service for up to six people based at the Carleton Clinic in Carlisle.

At Northgate Hospital in Morpeth:

Our findings

Autism services:

- Mitford Bungalows is comprised of four bungalows. Three bungalows had one bedroom and one bungalow had two bedrooms. Overall, the service can care for up to five people.
- Mitford Unit is a specialist autism inpatient service for up to 15 people.

Low secure and rehabilitation services:

- Tweed comprises of a low secure ward for up to 15 people and a low secure rehabilitation ward for up to eight men with a learning disability.
- Tyne comprises of a mental health low secure care for up to 12 people and a hospital based rehabilitation in an environment suitable for up to 12 people. At the time of our inspection, Tyne hospital based rehabilitation was being used to care for two people. We only visited the hospital based rehabilitation service as part of this inspection.

Medium secure services were based within the Kenneth Day Unit. All three wards are for men with learning disabilities. We visited:

- Lindisfarne which could care for up to 10 people.
- Cheviot which could care for up to eight people.

There was another medium secure ward called Wansbeck which could care for up to six people. At the time of our inspection, the ward was closed to improve staffing levels across the services. This meant that we did not visit the ward as part of this inspection, however we reviewed data about the service and have included this in our report.

This was the first inspection of all these wards. Our last comprehensive inspection of this core services was prior to the opening of some wards and services being acquired from a different provider. In 2020, following a focussed inspection of some of the wards, we issued four requirement notices in relation to breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. These related to:

- Regulation 9 person centred care
- Regulation 12 safe care and treatment
- Regulation 13 safeguarding service users from abuse and improper treatment
- Regulation 17 good governance.

At this inspection, we found that these actions had been met.

In April and May 2022, we completed a focussed inspection of Rose Lodge and issued two requirement notices in relation to breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. These related to:

- Regulation 12 safe care and treatment
- Regulation 18 staffing

At this inspection, we found that the action in relation to physical health monitoring had been met.

What people who use the service say

Our findings

People using the service provided mostly positive feedback.

Most people told us that they liked the staff that supported them and thought that staff knew them and their needs well. Most people told us that they could do the things they enjoyed that helped them to learn new things and keep well.

However, people also told us that they could not always go out or do the activities they had planned when there was not enough staff. Some people told us that there were issues with mistakes being made with meals which meant sometimes people did not get their choice of food.

Carers provided variable feedback.

Most carers told us that they felt their relative was safe and received support from staff that knew them well. Some carers told us their relative was more settled emotionally since after entering the service. They felt were welcomed by staff into the service when they visited.

However, many carers told us that they wanted to have more contact with their relatives, be more involved in meetings and receive more information from staff about their relative's progress. Some carers told us that technology was a barrier to being able to attend the meetings they had been invited to.

Some carers told us there were delays in their relatives being able to move on from the service and that they did not think that all staff were sufficiently trained or experienced for their roles.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

Safe and clean care environments

Safety of the ward layout

- The trust mostly completed risk assessments of the care environments regularly. However, the assessments did not identify the specific locations and types of potential ligature anchor points on the wards. This meant that staff may not be aware of these risks and it was not clear whether all the action needed to reduce these had been taken to keep people safe. The environmental risk assessment for Rose Lodge was last completed in February 2021 and it should have been reviewed in February 2022.
- Staff observed ward areas to check people were safe. Many people had staff with them all the time in order to keep them safe and meet their needs.
- People were being cared for on wards that complied with eliminating mixed-sex accommodation guidance.
- People staying on Cheviot, Lindisfarne, Tyne and Tweed wards did not have access to a nurse call alarm system to call for help when needed. The trust informed us that people could wear a mobile alarm to wear if they wanted to. However, we found only one person had accepted this. Records did not contain evidence that staff had offered a

mobile alarm, discussed the benefits and risks of accepting or not accepting an alarm or assessed people's capacity in this area where appropriate. People staying on Mitford Unit did not have a nurse call alarm in their flat areas because they were only fitted in the communal areas. However, people staying on Mitford Unit always had staff with them. Staff had easy access to alarms.

Maintenance, cleanliness and infection control

- People were being cared for in wards that were clean and mostly well maintained. The last Patient Led Assessment of the Care Environments was completed in 2019. Cleanliness and condition, maintenance and appearance were scored above the national average for all locations except Rose Lodge which was slightly below the national average for condition, maintenance and appearance. Mitford Bungalows, Lindisfarne and Cheviot wards were worn and tired and needed redecoration. The trust told us that it was difficult to maintain Mitford Bungalows when people were staying there, and Lindisfarne and Cheviot wards would be replaced with new wards which were due to open in spring 2023.
- Staff used personal protective equipment (PPE) effectively and safely. Staff used clear masks to support communication with a deaf person staying in the service. This had made significant improvements in communication and reduced emotional reactions.

Seclusion rooms

- On three wards, the seclusion rooms were not fit for purpose. On Cheviot and Lindisfarne, the seclusion rooms had low ceilings that contained electrical wires overhead creating a safety hazard and staff could not see people clearly through the window panels because they were cloudy. On Tweed ward, there were ongoing issues with staff being able to maintain safe observation of people because the situation of the suite and the CCTV meant staff could only observe one or the other at a time.
- On the Mitford Unit, Rose Lodge and Acorn, staff ensured that if people were secluded, they were kept in a clean and safe environment, and their basic needs were met, including access to a toilet, food and water.
- Mitford Bungalows did not have a seclusion room.

Clinic rooms and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff maintained equipment and ensured that this was maintained in line with the manufacturers instructed and regularly cleaned.

Safe staffing

Nursing staff

- There were not enough nursing staff. The number of registered nurses needed to form the establishment level was 120 whole time equivalent. The service had 93 whole time equivalent substantive registered nurses. This meant that there were vacancies for 27 whole time equivalent nurses which was a 22% vacancy rate. On Acorn ward, although the ward had enough nurses, most of these were at a band five level and at this service had less experience.

Our findings

- On Cheviot ward, rotas showed that the service was not meeting the enhanced staffing levels required to ensure people were safe and their needs were met. This meant that the service was not always providing one to one staff or above ratio to people that needed this to keep them safe and to meet their needs.
- The service had enough nursing assistants. The number of nursing assistants needed to form the establishment level was 436 whole time equivalent. The service had 429 whole time equivalent nursing assistants. This meant that there were vacancies for six whole time equivalent nursing assistants which was a one percent vacancy rate.
- When necessary, managers deployed bank and agency staff to try to ensure that there were enough staff to cover vacancies and absences to keep people safe and to meet their needs. In the 12 months from March 2021 to April 2022, 11% of shifts were filled by bank and agency staff. Seven percent of shifts covered by bank staff (11,214 shifts) and 4% was covered by agency staff (5,557 shifts). Three percent of shifts were not filled (3822 shifts).
- The average sickness rate over the last 12 months was 9%. This included COVID-19 related absence.
- There was a low average turnover rate over the last 12 months at 2%.
- Some people and staff told us that leave, and activities were affected by staff shortages across the services. People felt frustrated at times that they could not do the things they wanted and had planned to do. They told us this had led to emotional distress. However, the data that was available showed that leave had been cancelled for resource reasons four times in the last 12 months. There was no data available in relation to cancelled activities.

Medical staff

- The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency.

Mandatory training

- At the time of our inspection, the training programme was not comprehensive because it did not meet the needs of people and staff in this service. Training on learning disabilities and autism was not mandatory and was inconsistent across the wards. At the factual accuracy stage, the trust confirmed it has made this training mandatory for staff.
- Staff had mostly completed and kept up to date with their mandatory training and essential clinical training.
- Overall staff had completed 91% of the various elements of training that the trust had set as mandatory and as essential clinical training. Three out of 24 courses fell below the trust target of 85%. These were safeguarding level three at 25%, Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards at 75% and clinical risk and suicide prevention training 81%. The trust had paused the requirement to meet the trust target for training during the COVID-19 pandemic. A recovery trajectory was in place to ensure that all training courses met the trust target by April 2023.

Assessing and managing risk to patients and staff

Assessment of patient risk

- People were risk assessed on admission and staff updated it regularly, including after any incident. However, none of the risk assessments reviewed contained evidence that people were involved in assessing and managing risks to themselves.
- Staff used a recognised risk assessment tool.

Our findings

Management of patient risk

- Staff were aware of and dealt with any specific risk issues. We identified examples of good practice in wound care on Mitford Unit.
- People were checked at least once every 60 minutes to make sure they were safe and well by staff.
- Staff followed good procedures for searching people and their bedrooms.
- The trust did not recognise all the restrictions applied to all patients' freedoms as blanket restrictions. The trust reported there were no blanket restrictions on Mitford Bungalows, Tyne, Tweed, Lindisfarne and Cheviot wards. Acorn, Rose Lodge and Mitford Unit had blanket restriction registers that did not reflect all the blanket restrictions in operation. However, we did not identify blanket restrictions in operation which were not justifiable, and these included those that would be expected for the types of wards provided.
- One person had significant restrictions applied to their freedom including, long term seclusion and no access to their belongings. Staff including an independent multi-disciplinary team told us this was due to potential risk and there was no plan to end seclusion until a transfer of care with no planned date occurred. Although there were some recent positive steps increasing time out of seclusion, there was a lack of positive risk taking and reduction in restrictions. This person's risk assessment had not been reviewed and updated since March 2022 and there was no evidence of incidents occurring since then to justify the continuing of all the restrictions imposed. Since the last Independent Care and Treatment Review, there had been limited changes made.
- People were being cared for in a smoke-free environment.

Use of restrictive interventions

- The wards in this service participated in the provider's reducing restrictive interventions strategy and approach. The trust followed a positive and safe approach and teams had access to a robust data dashboard called Talk 1st to target resources and interventions effectively. The trust was also involved in a number of initiatives internally and externally including, using the HOPE(S) model, piloting staff wearing body cameras the use of positive behavioural support plans. The HOPE(S) model is a clinical model developed from research and clinical practice that is aims to reduce the use of long-term segregation for people with a learning disability and autistic people.
- Although the trust had a strategy, it had not ensured that this was fully effective in reducing the use of restrictive interventions. The use of some restrictive interventions was high. Data from our previous inspections was not comparable to identify whether the use was reducing or increasing.
- There were 291 episodes of seclusion between April 2021 and March 2022. The wards with the highest use of seclusion were Mitford Unit (133 episodes) and Rose Lodge (75 episodes).
- There were 12 episodes of long-term segregation between April 2021 and March 2022. The wards with the highest use were Rose Lodge (five episodes) and Acorn (four episodes). At the time of our inspection, there were five ongoing episodes of long-term segregation.
- There were 2,381 incidents of the use of restraint between April 2021 and March 2022. These were the highest on Mitford Unit at 746 and Acorn at 419.
- There was a high use of prone restraint. There were 691 incidents of prone restraint used between April 2021 and March 2022. This equated to 29% of the overall number of restraints being in the prone position. The wards with the highest number of restraints in the prone position were Mitford Bungalows at 398 and Mitford Unit at 255. Mitford Bungalows had five people staying at the service and the rate of prone restraint represented 51% of the wards overall

restraints. The trust told us at the factual accuracy stage that when mechanical restraint was used, an incident of prone restraint was also reported. There was no clear dedicated strategy at trust level to reduce the use of prone restraint. This was not in line with national guidance which explains that prone restraint should only be used where there are cogent reasons for doing so because of the dangers of compression of the chest and airways. People with learning disabilities and autistic people have an increased risk of having physical health conditions that can make the use of prone restraint more unsafe.

- There were a total 46 incidents of the use of mechanical restraint used on six people between April 2021 and March 2022. The ward with the highest use of mechanical restraint was Mitford Unit at 45 incidents. Lindisfarne ward had one use of mechanical restraint. Following this period up to our inspection, the use of mechanical restraint increased for one patient to facilitate leave. The method of this restraint was metal handcuffs. The use of mechanical restraint was appropriately care planned for and the use was authorised in line with the trust's policy.
- There were 95 uses of rapid tranquilisation between April 2021 and March 2022. The wards with the highest use of rapid tranquilisation were Mitford Unit at 75 incidents followed by Rose Lodge at 10 incidents.
- Records reviewed showed that staff used seclusion appropriately and followed best practice.
- Incident reports did not specify what de-escalation attempts were used. In four of the incident reports reviewed for Acorn ward, this meant it was difficult to assess whether the correct techniques had been used and their effectiveness.

Safeguarding

- Staff were trained in safeguarding level one, knew how to make a safeguarding referral and who to inform if they had concerns.
- Following a focused inspection in March 2022, the trust had implemented safeguarding level three training for registered staff. Prior to this, local authority training had been completed by some staff. At the time of our inspection, 25% of eligible staff had completed safeguarding level three training.
- Staff followed safe procedures for children visitors.

Staff access to essential information

- Staff used a combination of paper and electronic records.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Medicines management

- The service used systems and processes to mostly safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).
- People received their medicines from staff who prescribed, administered, recorded and stored their medicines safely. Medicines were stored securely in all units we looked at. Where paper prescribing documents were used, these were kept securely in the medicines room to ensure accessibility when administering medicines to patients. The trust had implemented an electronic prescribing system in most areas, which enabled medical staff to prescribe remotely

and efficiently. In the records we looked at we were assured medicines were being safely administered as prescribed, however we did find that the rationale for initially prescribing antipsychotic medicines for some people was not always clearly documented. The medicines records we reviewed showed people's behaviour was not controlled by excessive and inappropriate use of medicines.

- Staff told us medicines incidents were reported and lessons learnt were shared to improve practice.
- People received support from staff to make their own decisions about medicines wherever possible.
- Records we looked at showed discussions as part of a multidisciplinary team about prescribed medicines. Where possible patients were included in these discussions. Pharmacy teams provided a review of medicines and attended multidisciplinary team meetings when possible.
- Staff made sure people received information about medicines in a way they could understand. Easy read medicines leaflets were available on request from patients.
- Staff did not always follow processes to assess and provide the support people needed to take their medicines safely; for example, when assessing risks of people taking medicines themselves. Where people were self-administering medicines, risk assessments for this remained on paper and were not always present.
- Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. We saw evidence of review of medicines for each person we looked at; this was in the form of multi-disciplinary teams or as part of a pharmacy team review.
- Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services. In all records we looked at medicine's reconciliation had been completed by pharmacy staff. Data provided by the trust post inspection also supported our findings.
- Staff reviewed the effects of each person's medication on their physical health according to guidance from the National Institute for Health and Care Excellence.
- Physical health monitoring was taking place in line with guidance from the National Institute of Health and Care Excellence. The service employed a general practitioner who took the lead with this and records were updated on the clinical system. There was a good working relationship between the pharmacy team and the GP for review of medicines and this was being further developed with pharmacist led clinics for physical health monitoring.

Track record on safety

- The service had a good track record for safety. There was one serious incident reported between April 2021 and March 2022. This related to Tweed ward and involved a person leaving the hospital without authorised leave.

Reporting incidents and learning from when things go wrong

- The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents. We reviewed 11 incidents, these showed appropriate reporting and reviews completed by managers.
- There were examples where local learning from incidents was shared including following an incident on Tweed ward and where an after action review outcome was discussed on Cheviot following an incident on Lindisfarne ward.
- On Acorn ward, team meeting minutes showed there had been a delay in staff receiving a debrief following an incident for a number of months.

Our findings

Is the service effective?

Requires Improvement ↓↓

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

- People had a comprehensive assessment of their physical and mental health either on admission or soon after.
- People had care and support plans that were mostly personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. We reviewed 15 people's care plans and most met all these areas. However, for one person their care plan did not include information on the full level of restrictions applied to them. There was no plan to end long term seclusion or reduce restrictions despite no evidence of incidents occurring for at least two months. For another person, their care plan did not include information about their communication with their multi-disciplinary team to make sure appropriate safeguards were in place and that staff supporting the person had the information they needed to meet the needs of the person and keep them safe. We observed the impact of this on direct care.
- Staff mostly updated care plans when necessary. Twelve out of the 15 care plans reviewed had been updated regularly.

Best practice in treatment and care

- People had access to a range of suitable care and treatment interventions. These included medication, psychological therapies, occupational therapy including activities, training and the development of everyday living skills. The trust had also commissioned some external services to meet some people's individual needs where this could not be provided by the service. For example, bespoke trauma informed psychological therapies.
- People had access to physical health care, including specialists as required. Staff assessed and met people's needs for food and drink and for specialist nutrition and hydration.
- There were several health initiatives to improve people's physical health and wellbeing. Some of these were implemented to compensate for restrictions during the COVID-19 pandemic. These included but were not limited to a sports week, a healthy challenge group and conversation café on Wansbeck, a health first promotion on Tyne which included healthy food choices, education and exercise. People were given awards based on engagement in activities.
- People's progress during their stay was assessed using outcome measures. People reported any side effects of their medication to staff.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. As well as a clinical audit schedule and service evaluations completed, the service completed benchmarking assessments against relevant standards from the National Institute for Health and Care Excellence. The results of these showed that the service was partially meeting quality standards. Quality improvement initiatives were based mainly on delivering the positive and safe strategies to increase therapeutic environments and care, reduce the use of restrictive interventions and improve people's experiences of care.

Skilled staff to deliver care

Our findings

- Most teams included or had access to the full range of specialists required to meet the needs of people. Acorn and Rose Lodge had gaps in the multi-disciplinary teams and recruitment was taking place to fill these roles.
- Staff were experienced and qualified and managers provided new staff with an appropriate induction.
- At the time of our inspection, training in learning disabilities and autism was not mandatory for staff and access to specialist training was variable across the teams in this service. Although all wards specialised in the care of people with learning disabilities and/or autistic people, only Rose Lodge staff had completed training in learning disability awareness and only staff on Rose Lodge and Cheviot had completed autism awareness training. Autism core capabilities training was being rolled out to staff on Cheviot ward. Other wards had examples where some staff had completed training to enable them to develop further skills and knowledge to meet people's needs.
- The percentage of staff that received regular supervision was 73%. This was below the trust's target of 80% of staff receiving supervision once every month. The wards that fell below the trust's supervision target were Mitford Bungalows (78%), Mitford (62%), Tweed hospital based rehabilitation (60%), Rose Lodge (45%) and Acorn (42%). During the COVID-19 pandemic, the trust had paused the requirement for staff to complete supervision.
- The percentage of staff that had had an appraisal in the last 12 months was 58%. The trust had stepped down the requirement for appraisals during the COVID-19 pandemic. From April 2022, a plan for compliance was set to be met by March 2023. However, appraisal rates on Cheviot, Lindisfarne, Mitford Bungalows were higher at 79%, 81% and 95% respectively.
- Individual staff had completed a range of relevant courses to develop their skills and knowledge including but not limited to training that would improve the quality of people's care and in quality improvement initiatives.
- Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and interagency teamwork

- Staff mostly held regular and effective multi-disciplinary team meetings. Registered nurses and nursing assistants on Mitford Unit did not routinely attend multi-disciplinary team meetings to review people's care. They felt that they provided most of the direct care and did not feel their views were valued and decisions were made about people's care without involving them. The trust had also received this feedback through staff pulse surveys and closed culture interviews. In response, it had reintroduced more multi-disciplinary meetings and team days to encourage cohesive team working. We observed a debrief involving staff at all levels following an incident.
- Staff shared information about people at handover meetings within the team. We observed two handover meetings, the handover meeting on the Mitford Unit was comprehensive whereas the handover on Tweed ward lacked specific detail about events that had occurred and mood descriptions which were vague.
- Mitford Bungalows had limited space for staff, and they told us that this meant that it was less common for members of the wider multi-disciplinary team to spend time outside of planned sessions. The trust told us that its estates team were reviewing space utilisation following our feedback.
- The ward teams had effective working relationships with teams outside the organisation. There were various roles across the wards that dedicated time to communicating and working with teams outside of the organisation including commissioners. We also saw visiting community care co-ordinators from outside of the area.

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

- Staff had a good understanding of the Mental Health Act, its code of practice and the guiding principles. However, only 75% of staff had completed training in the Mental Health Act which was below the trust target of 85%.

Our findings

- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act through a central Mental Health Act office and administrators. The trust had relevant policies and procedures that reflected the most recent guidance and staff could access these easily.
- People had their rights under the Mental Health Act explained regularly in a way they could understand and had easy access to independent mental health advocates.
- People's records contained copies of detention papers, consent to treatment documentation and Section 17 leave forms (permission to leave hospital) which were up to date and reflected their care and treatment. Staff ensured people were able to take Section 17 leave when this had been granted.

Good practice in applying the Mental Capacity Act

- Staff had a good understanding of the Mental Capacity Act and its five statutory principles. However, only 75% of staff had completed training in the Mental Capacity Act which was below the trust target of 85%.
- Staff made deprivation of liberty safeguard applications when required. These are to protect people without capacity to make decisions about their own care. There was one deprivation of liberty safeguards application made in the last 12 months for Tweed ward.
- The trust had a policy on the Mental Capacity Act which included deprivation of liberty safeguards. Staff had easy access to the policy and to advice on the Mental Capacity Act.
- People were given every possible assistance to make a specific decision for themselves. Mental capacity assessments were completed appropriately by staff. Where people lacked capacity to make specific decisions, staff made decisions in their best interests in line with best practice. People's records contained examples of capacity assessments and best interest decisions. These related to decisions about health, medication and accommodation.

Is the service caring?

Good  

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

- People were consistently supported positively and warmly by staff that knew them and their individual needs well. Staff were kind and compassionate and they were committed and enthusiastic about their work with people.
- People, including those staying in long-term segregation, were supported to be individuals and express their preferences on how they wished to live their lives without judgement. People's individuality was embraced including how they wished to dress, the things that interested them and the hobbies they liked to do. Positive examples of this included people staying in long-term segregation had regular leave to go out and had their own workshops for gardening, horticulture and vehicle repairs.
- People's personal, cultural, social and religious needs were respected. We saw positive examples where people's individuality was supported well and where specialist assessments were completed so that people could express their cultural preferences when eating and drinking.
- People told us that staff supported them to understand and manage their care and treatment, do things that they enjoyed and to plan for their future.

Our findings

- People preferred to be supported by regular staff that knew them and their needs well rather than bank or agency staff that they were not as familiar with.
- However, there were concerns about one person's privacy and dignity not being maintained and people told us that they did not always get the food they ordered.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient people to the ward and to the service. Video tours were also available for some wards so that people and their carers could see where they would be staying.
- People's care plans did not contain evidence to reflect how they had been involved or their views. People had access to copies of their care plans and some people attended multi-disciplinary meetings about their care.
- People had easy access to advocates. Staff had co-produced a self-advocacy course for people with a learning disability and autistic people staying in the Northgate Hospital services.
- People could give feedback on their care through one to one sessions, patient meetings and a patient and carer survey. Lindisfarne and Wansbeck wards had sufficient responses to analyse. People and carers from Lindisfarne rated their care 8.88 out of 10 and people and carers from Wansbeck rated their care 6.88 out of 10.
- People were supported to understand their care and be involved in discussions and decisions about their care and treatment. However, there was limited training for staff in alternative communication methods which meant that communication between staff and people may not be as effective.

Involvement of carers

- Many carers told us that they wanted to receive more contact from their relative, receive more communication and be more involved in meetings to discuss their relative's progress. Some carers felt that technology was a barrier in attending the meetings they had been invited to. Mitford Unit had a monthly family and carers newsletter which provided key updates on the service including any changes, photos and biographies of new staff and activities that people had taken part in.
- Staff enabled carers and families to give feedback through a patient and carer survey. The results of the survey could not be broken down to distinguish between people and carers responses. People and carers from Lindisfarne rated their care 8.88 out of 10 and people and carers from Wansbeck rated their care 6.88 out of 10.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Bed management

Our findings

- Staff made sure that they considered the impact of people coming into the service on the people who were staying in the service. This meant that although some wards limited the number people they cared for to make sure they could provide a safe and high-quality service. The average overall bed occupancy rate for this service was 71%. Wards with the highest average occupancy rate were Mitford Bungalows which was 100%, Mitford Unit at 87% and Rose lodge at 81%. Acorn had the lowest occupancy rate at 38%.
- There were 23 people staying in the services that were from outside of the local area. Nineteen out of the 23 people were staying out of their local area because there are insufficient services locally where they live and/or that can meet their needs. Nine of these people were staying on the Mitford Unit and Mitford Bungalows which are national specialist autism services. A further four people on admission were admitted to a ward in their local area but were now staying out of area because services were transferred as part of a merge of providers. This meant that it was more difficult for people to maintain their connections to their home local communities and made it more difficult when preparing for leaving hospital. There were examples where it was more difficult for hospital and community staff to work during transition and less opportunity for people to visit and spend time in the places they were moving to after their discharge.
- People always had their place in the service when they returned from leave and generally were not moved unless it was justified on clinical grounds and was in the interests of the person. However, prior to our inspection the trust had closed Wansbeck ward and transferred people between Lindisfarne and Cheviot wards to try to improve staffing across the medium secure services.
- The trust provided a range of services so if someone required more intensive care, they had the ability to provide this if needed.

Discharge and transfers of care

- People's discharge was planned and managed as well as staff could. Staff liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. However, due to a lack of suitable accommodation and adult social care services in the community, staff were not always able to ensure that people did not stay in hospital for longer than needed. In the last 12 months, there were 28 people that had a delayed discharge for this reason. Another person was waiting for hospital-based care outside of the trust's services.
- The higher need for some services and delays in the ability to discharge people into the community meant that in some cases people were waiting to step down into lower intensity services. Some people transitioned from the Mitford Unit to Mitford Bungalows and then into the community. However, delayed discharges from Mitford Bungalows into the community were impacting upon this pathway. Staff told us one person staying in secure services could be waiting for a place at the Mitford Unit for up to two years.
- There were also a small number of people that were staying in long-term segregation because being cared for away from other people was the most suitable option to meet their needs. While these people were waiting for the right care and support to be built in the community, they were staying in hospital for longer than needed and they were being segregated from other people. Although this was not in line with the principles of Right Care, Right Support and Right Culture, their quality of life was of a good standard and in the longer term this was in each person's best interests to ensure their future was sustainable in the community.

Facilities that promote comfort, dignity and privacy

- People had their own bedrooms and were not expected to sleep in bays or dormitories. Most people had their own ensuite bathrooms or their own bathrooms. People staying on Cheviot, Lindisfarne and Tweed shared bathrooms. Each person had somewhere they could keep their belongings safe.

Our findings

- The design, layouts and furnishings of the wards to support people's treatment, privacy and dignity varied. The Mitford Unit was purpose built for autistic people and had a calm, sensory sensitive and quiet environment with sufficient facilities and space to support care and treatment. Although Mitford Bungalows required re-decoration, the layout provided people with their own space and was amenable to providing person centred care.
- Other wards had different challenges due to their design and layouts. Most wards has suitable environment temperatures. The heating on all the wards at Northgate Hospital was controlled by a central system. Tweed and Tyne wards were very warm. On Tweed, the ward was still warm even though windows were open because the heating was on. On Tyne, the air conditioning was broken. The trust informed us following our inspection that the air conditioning on Tyne had been fixed.
- Most wards had noise-reducing features. However, the environments on Acorn and Rose Lodge had no noise-reducing furnishings and this meant that there was a high level of noise reverberation through the environments from doors banging, people including staff and activities. On Rose Lodge, wind also whistled through windows creating noise. On Tyne ward, there were issues with doors slamming creating noise. The trust told us at the factual accuracy stage that it had ordered noise reducing acoustic panels for Rose Lodge to reduce environment noise.
- Three wards had limited communal spaces and facilities to support activities and therapies. These were Cheviot, Lindisfarne and Tweed. During our inspection, Cheviot ward was noisy due to the number of people and staff on the ward. This meant that a room designated to be quiet was noisy. When meetings took place on the ward, this impacted upon on the ability to do ward activities and therapies. Rose Lodge and Acorn ward did not have sensory rooms. The activity room on Rose Lodge was on the staff corridor and this meant it was only accessible with staff present.
- On Lindisfarne, there was a sluice room and a laundry room in the seclusion room staff area. This meant that anyone using the sluice room or laundry could see any person in the seclusion room and bathroom and the CCTV monitors openly. This did not protect people's privacy and dignity. This also meant that people staying on Lindisfarne could not do their own laundry impacting on their independence also. This had been raised previously and not action had been taken to make any changes to protect people's privacy and dignity. The noise of the laundry also disturbed people staying in the seclusion room.
- There were some plans to make estates improvements for some wards. The trust was building new facilities expected to open in summer 2023 on the Northgate Hospital site that would replace Cheviot, Lindisfarne and Wansbeck wards. The service provided on Acorn ward were temporary and there was no timescale for this ward to close. The trust was in discussion with commissioners about how to make improvements to the Rose Lodge estate. However, there was no plan for any changes in the low secure services Tyne and Tweed.
- People could meet visitors and make phone calls in private. People had access to outside space.
- People had to order their choice of food two days in advance. Staff told us that this was often difficult especially for people with a learning disability or autism. Some people told us that there were issue mistakes being made with meals which meant that people did not get their choice of food sometimes.

Patients' engagement with the wider community

- People had access to education and activities of their choice. Where possible people accessed community activities that were meaningful and recovery oriented.
- People took part in their chosen social and leisure activities on a regular basis. Staff were creative where people were unable to do activities of their choice due to restrictions during the COVID-19 pandemic.
- People received person-centred support with self-care and everyday living skills. Where appropriate people could prepare their own meals and do their own laundry.

Our findings

- Although some carers wanted more contact with their relatives, staff supported people to maintain contact with their families and carers using a range of methods. On Mitford Unit, carers received a newsletter with information about the service including activities their relative had been doing.

Meeting the needs of all people who use the service

- Not all wards were fully accessible for people with disabilities. Cheviot, Lindsfarne and Acorn wards were on multiple levels with steps. Cheviot and Lindisfarne did not have lifts. However, Acorn ward had a lift for people with disabilities to use and all other wards were accessible for people with disabilities.
- The information provided to people was not always available in easy read formats across all the wards. There was use of easy read materials on most wards except for Mitford and Mitford Bungalows. These wards had limited use of easy read material to support people to understand and be involved in their care.
- There was limited training on alternative methods of communication. Although the service had speech and language therapists, staff providing most of direct care to people had not received training in alternative communication methods. One member of staff had recently completed Makaton training and it was planned they could start to deliver this to staff and staff at Rose Lodge had received communication training. No other staff members had completed any formal training in communication methods. One person on Mitford Unit used Makaton as their method of communication and none of the staff supporting them had completed Makaton training.
- People had access to information on local services, treatments, advocacy and how to make a complaint. People had access to appropriate spiritual support.
- People had a choice of food to meet their dietary requirements including for religious and cultural needs.

Listening to and learning from concerns and complaints

- People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Information was displayed on how to make a complaint and was available in an easy read format. In the 12 months between March 2021 and April 2022, there were 12 complaints. None of these complaints were upheld, nine were partially upheld and three were not upheld. No complaints were referred to the parliamentary health service ombudsman.
- The themes of complaints about the service related to communication with carers, approach of staff, care pathway issues and people's emotional reactions.
- The service treated concerns and complaints seriously and investigated them. However, there were no examples of how lessons were learnt from the results and how this was shared with the whole team and wider service.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Our findings

- Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. They were visible and approachable to people and staff. Ward managers worked outside of office hours to ensure they understood their services, how to support staff, meet people's needs and assess the culture of the service.
- Leadership development opportunities were available through different management and leadership programmes.

Vision and strategy

- Staff knew and understood the provider's vision and values and how to apply them in the work of their team. They demonstrated these in practice and were positive and enthusiastic about their role.
- The trust had a clear vision for the direction for some of the services that demonstrated ambition and a desire for people to achieve the best outcomes possible. The trust had an estates programme to improve medium secure care services at the Northgate Hospital location. This would replace Cheviot, Wansbeck and Lindisfarne wards with new purpose-built services that will meet best practice standards. The trust recognised that Acorn ward and Rose Lodge required improvements to the estates in order to be fit for the purpose that they were being used for. Acorn ward had opened following a requirement to use Edenwood, another ward in Cumbria, for an alternative use. It was expected that Acorn ward would close but there was no date set.
- Although the provider invested in staff by providing training opportunities, there lacked a strategy to ensure that all staff working in this service received a comprehensive training package to meet the needs of people with learning disabilities and autistic people.

Culture

- Staff mostly felt respected, supported and valued. On all wards staff felt supported and valued by their managers and colleagues. On the Mitford Unit, registered nurses and nursing assistants did not feel valued in multi-disciplinary meetings. However, work was ongoing to try and improve staff involvement in multi-disciplinary team discussions and communication.
- Staff felt positive and proud about working for the trust and their teams and they felt they could raise concerns without fear of retribution. They understood the whistleblowing policy and knew who the freedom to speak up guardian was.
- Staff could access additional training and could request this through the supervision and appraisal processes to continue in their professional development. This enabled staff to develop in their own roles and to progress.

Governance

- Governance systems and processes had not ensured that the effectiveness of the reducing restrictive interventions strategy was being sufficiently monitored. There was a high level of use of restrictive interventions which had not been recognised in all services despite there being an intelligent system that provided a wealth of data. There was a lack of positive risk taking to reduce restrictions and long-term seclusion for one patient and independent multidisciplinary team reviews did not challenge this. There were gaps in the monitoring of cancelled activities and issues with blanket restriction registers not reflecting blanket restrictions in operation. This meant that restrictions in operation may not be reviewed regularly to ensure they remained appropriate. There were also issues with Cheviot ward not meeting the enhanced staffing levels. Multiple wards had environmental issues that had not been addressed. On Acorn ward, incident reports did not always contain detail about de-escalation techniques attempted.

Our findings

- However, there were effective systems and processes to assess and share information so that staff understood how their service was performing. Plans were mostly in place to address any areas of risk and performance. This included a recovery plan for improving mandatory and essential clinical training, supervision and appraisal compliance and estates work to improve medium secure care environments.
- There was a clear framework of meetings from ward level so that essential information could be shared upwards and downwards effectively.
- Staff did clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care.
- The management of records and recordings of surveillance ensured they were protected and stored safely.

Management of risk, issues and performance

- On most wards, staff maintained and had access to the risk register at ward level. At the time of inspection all wards apart from Cheviot and Acorn had a risk register. The trust provided evidence following inspection that risk registers had been implemented for these wards. Risk registers mostly matched staff concerns but did not reflect all the concerns that identified during our inspection. This included, the use of restrictive interventions particularly the rates of the use of prone and mechanical restraint and rapid tranquilisation, the environmental issues on Acorn and Rose Lodge and the issues on Lindisfarne in relation to the privacy and dignity of people staying in seclusion. This meant that there were not always sufficient plans in place to manage and mitigate these risks. At the factual accuracy stage, the trust provided evidence that risk registers had been implemented for Cheviot and Acorn wards.
- The trust were managing the beds as well as they possible and were assertive in relation to the discharge pathways.
- The services had suitable plans for emergencies including, outbreaks and adverse weather.
- There were no cost improvement measures taking place.

Information management

- Systems used to collect data from wards were intelligent and not overburdensome for staff. Information entered on systems enabled analysis which could be used effectively to make changes to improve the safety and quality of care.
- Staff had access to the equipment and information technology to do their work. Systems were accessible to staff and worked well. Information governance systems included confidentiality of patient records.
- Managers had access to information to support them with their management role. They had access to live dashboards and reports to enable them to understand the performance of their service, staffing and patient care.
- Staff made notifications to external bodies when required.

Engagement

- Staff, people and carers had access to up-to date information about the work of the provider and the services they used. This was through the intranet, communications to staff and newsletters. Carers had access to forums and surveys.
- People and carers had opportunities to give feedback on the service they received through surveys.
- People were beginning to be involved in decisions made about changes to the service. A positive example of this was people from the medium secure services being involved in the naming of the new enhanced care services.

Our findings

- The service worked well in partnership with advocacy organisations and with commissioners including the host commissioners which helped to give people using the service a voice and enabled external monitoring of the services.

Learning, continuous improvement and innovation

- People and staff had opportunities to participate in research. There had been research completed into a range of areas looking into the people's experience of COVID-19, prescribing practices, autism in adulthood, models of secure care for people with learning disabilities, personality disorder diagnosis in people with intellectual disabilities and harnessing clinical psychology to improve wellbeing.
- Cheviot, Lindisfarne, Wansbeck (medium secure) and Tweed (low secure) wards participated in the quality network for forensic mental health services and had last been peer reviewed in November 2021. None of the other wards had received accreditation from a relevant scheme. The trust was implementing the HOPE(S) model.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with five legal requirements.

- The service must ensure that people have access to a nurse call alarm system. (Regulation 12 (2) (a) (b)).
- The service must ensure that the use of prone restraint is reduced. (Regulation 12 (1) (2)(b)).
- The service must ensure there are sufficient suitably qualified, competent, skilled and experienced staff deployed. Staff must have received appropriate training to enable them to have the skills and knowledge to meet the needs of people with learning disabilities and/or autistic people. (Regulation 18 (1) (2)(a)).
- The service must ensure that that restrictions imposed on people's freedoms and access to belongings are only in place when these are necessary and proportionate. (Regulation 13 (4) (b)).
- The service must ensure that people's care is designed to ensure their needs are met. (Regulation 9 (2) (b)).
- The service must ensure that that the seclusion room on Lindisfarne ward and surrounding facilities ensure the privacy and dignity of people. (Regulation 10 (1) (2) (a)).
- The service must ensure that the premises are fit for purpose and suitable for the purpose that they are being used. (Regulation 15 (1) (c)).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that comprehensive environmental risk assessments are completed regular and that these ensured that staff know the location of potential ligature anchor points.
- The service should reduce the number of vacancies for registered nurses.
- The service should ensure that records are maintained for all wards in relation to the cancellation of activities.
- The service should ensure that people's involvement in their care is recorded.
- The service should ensure that there is an effective strategy that reduces the use of restrictive interventions in the service.
- The service should ensure that incidents reports are completed with all the relevant information.
- The service should ensure that staff receive timely debriefs following incidents.
- The service should ensure that staff receive regular supervision and an annual appraisal.
- The service should ensure that carer satisfaction of communication and involvement is improved.

Our findings

- The service should continue to manage beds and be assertive in managing the discharge pathway so that people do not say in hospital for longer than needed.
- The service should review the system for ordering food to ensure that this is suitable for people in the service.
- The service should ensure that information is available in easy to read formats for people.
- The service should ensure that all mandatory courses meet the trust's target for compliance.
- The service should ensure that the rationale for prescribing anti-psychotic medication is recorded.

Our inspection team

Our inspection team comprised one lead inspector, one inspection manager, three team inspectors, one assistant inspector and two medicines inspectors from CQC. The team also had four specialist advisors; two registered nurses, one occupational therapist and a psychologist. An expert by experience supported our inspection remotely due to their availability.

This inspection followed our methodology for inspecting services for people with learning disabilities and autistic people and the Quality of Life Tool. Key members of the team had specialist experience in learning disabilities and autism.

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

During our inspection, we:

- Toured the care environments and observed how staff were caring for people.
- Received feedback from 14 people in the service and 20 carers.
- Interviewed 77 staff including: pharmacists, the chief pharmacist, pharmacy technicians, ward managers, a deputy ward manager, a case manager, a nurse consultant, registered nurses, clinical leads, a consultant clinical psychologist, a clinical lead occupational therapist, speech and language therapists, occupational therapists, psychologists, a specialty doctor, consultant psychiatrists, lead senior house officer doctor, nursing assistants, an assistant practitioner, a nurse specialist, an operational ward manager.
- Reviewed 17 people's care and treatment records
- Reviewed 13 seclusion records
- Reviewed 11 incidents
- Observed 12 meetings including handovers, a daily meeting, a cognitive stimulation therapy session, discharge planning meetings, an art therapy session, multi-disciplinary team meetings and a formulation meeting.
- Reviewed a range of policies and procedures and documents relating to the running of the service.
- We also received feedback from three host commissioners and three advocates.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment