# Northumberland Tyne and Wear NHS Foundation Trust

## Evidence appendix

St Nicholas Hospital
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Tyne and Wear
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

## Facts and data about this trust

The trust had 14 locations registered with the CQC (on 23 February 2018).

| Registered location | Code | Local authority |
|---|---|---|
| **Brooke House** | RX438 | Sunderland |
| **Campus of Ageing and Vitality** | RX4E6 | Newcastle upon Tyne |
| **Easter Field Court Residential Care Home** | RX422 | Northumberland |
| **Elm House** | RX461 | Gateshead |
| **Ferndene** | RX4CA | Northumberland |
| **Hopewood Park** | RX4Z3 | Sunderland |
| **Monkwearmouth Hospital** | RX4K2 | Sunderland |
| **Northgate Hospital** | RX467 | Northumberland |
| **Queen Elizabeth Hospital** | RX442 | Gateshead |
| **Rose Lodge** | RX4Y0 | South Tyneside |
| **Royal Victoria Infirmary** | RX4E5 | Newcastle upon Tyne |
| **St George's Park** | RX4E2 | Northumberland |
| **St Nicholas Hospital** | RX4E4 | Newcastle upon Tyne |
| **Walkergate Park** | RX4W4 | Newcastle upon Tyne |

| | |
|---|---|
| **Total number of inpatient beds** | **804** |
| **Total number of inpatient wards** | 57 |
| **Total number of day case beds** | 0 |
| **Total number of children's beds (MH setting)** | 56 |
| **Total number of children's beds (CHS setting)** | 0 |
| **Total number of outpatient clinics a week** | 43 |
| **Total number of community clinics a week** | 8283 |

# Is this organisation well-led?

## Leadership

The trust board was well established, providing the appropriate range of skills, knowledge and experience to fulfil its role. The board had six executive directors including the chief executive, who had taken up post in 2014. The executive directors had extensive experience in NHS management at an executive level. There were seven non-executive directors including the chair, who was appointed in December 2017 and took up post in February 2018. The non-executive directors brought experience and knowledge from the fields of finance and business, local and central government and clinical practice in strategic roles. Board members had opportunities to attend regular development sessions and 'away days'.

The board demonstrated a comprehensive understanding of the challenges faced by the trust and the strategies and plans which were in place to address these. The board maintained strong oversight of the progress being made against the trust strategies and plans.

Staff within the trust spoke highly of managers and senior leaders. Staff side representatives spoke positively about the relationship they had with the senior leadership team and felt involved in key meetings and decision making processes.

Fit and proper person checks were in place. There were robust systems in place to ensure board members (executive and non-executive) were fit to perform their roles. The necessary checks were completed prior to and during employment.

The trust board and leadership team displayed integrity on an ongoing basis. High priority was placed on doing the right things for patients, staff and the organisation as a whole. There were clear and robust governance structures and arrangements in place, and we observed constructive challenge taking place within trust board meetings and committee meetings. There were six sub-committees of the board, each chaired by a non-executive director. A public and private board meeting was observed, as well as a quality and performance committee, audit committee and mental health legislation committee meeting.

The trust had commissioned an external well led review in 2015, the action plan for which was completed and had been signed off by the trust board. Another external review was scheduled for September 2018, which was in line with the requirement of NHS Improvement to undertake external reviews every three years.

The trust had undergone an organisational restructure in October 2017, creating a locality based operational delivery model. Delivery of the trust's portfolio of service took place across three locality care groups (North, Central and South), each managing four clinical business units:

- Access clinical business unit – providing a portfolio of services including crisis teams, street triage and Section 136 services, community substance misuse services, liaison services, criminal justice/court diversion services.
- Community clinical business unit – providing primary care services, improving access to psychological therapies services, community mental health services, day care services.
- Inpatient clinical business unit – providing mainstream mental health inpatient beds

The fourth clinical business unit in each locality care group was a specialist service clinical business unit. In the North locality, the specialist clinical business unit was children and young people inpatient mental health beds, in the Central locality the specialist clinical business unit was

secure services for learning disability and autism, in the South locality the specialist clinical business unit was neurological services and specialist mental health services.

In addition to the three locality care groups, there was a safer care group, which brought together previously separate corporate functions of:

- Patient Safety – including health and safety; security; incident, complaints and claims management
- Infection Prevention and Control & Tissue Viability
- Safeguarding
- Medical Devices
- Physical Health and Health Improvement
- Corporate Nursing Development
- Emergency Preparedness, Resilience & Response
- Positive and Safe Care

The safer care group had a group nurse director and group medical director, supported by two associate directors and a treatment effectiveness and governance manager.

The new organisational structure provided an operational delivery structure that allowed devolved decision making. This structure enabled care groups to be clinically led and professionally managed.

To support this operational delivery structure, the trust had invested in and developed a collective leadership model. Each locality care group had a multi-disciplinary senior management structure consisting of a triumvirate of group director, group nurse director and group medical director. Clinical business units had a collective leadership structure which comprised of an associate director, associate nursing director, associate medical director, associate allied health professional director and associate psychological services director. The trust developed professional and collective leadership programmes, as well as a general leadership development programme for all grades and roles. This was aimed at any staff looking to develop leadership skills, to support the trust's ambition to develop leadership capacity and capability. Each locality care group had their own dedicated managers for workforce and organisational development, commissioning and quality assurance, business development, service improvement and operational support.

The chair, chief executive and non-executive directors described the process for talent management, opportunities for progression within the organisation and succession planning arrangements for senior leadership posts. Within the new organisational structure, a deputy chief operating officer role had been created, along with a deputy director positive and safe and a deputy director for academy development. The move to a collective leadership model enabled greater leadership development opportunities for existing and aspiring managers within the trust. Staff at all grades had the opportunity to complete the Aspiring Leadership programme, which was external to the trust. Care group directors and associate directors had created opportunities for staff from lower levels of management to deputise and created learning opportunities for these staff.

There was a programme of board visits to services. The senior leadership team described how valuable and important these visits were to augment performance information received into the

board. Board members used these visits as a valuable opportunity to hear from staff and patients directly about their experience of working for and using the services provided by the trust.

The trust had a named lead for safeguarding children, and group directors shared the adult safeguarding responsibilities.

Leaders at all levels of the organisation demonstrated a comprehensive understanding of key priorities and challenges, both internal and external to the trust, and took appropriate action to address these. The move to a locality based structure had resulted in care group directors having greater autonomy and devolved decision making powers. Care group directors were visible within their localities, with a programme of visiting services and teams. Senior leaders at both clinical business unit and care group levels had a comprehensive understanding of the key priorities and challenges, both internal and external to the trust. The move to an operational locality structure had resulted in closer relationships being developed between senior managers and external partners. This included regular dialogue with clinical commissioning groups, local authorities and other providers of local services.

The executive board had 16.6% black and minority ethnic (BME) members and 33% women.

The non-executive board had no BME members and 42.9% women.

| | BME % | Women % |
|---|---|---|
| **Executive** | 16.6% | 33.0% |
| **Non-executive** | 0.0% | 42.9% |
| **Total** | 8.3% | 38.5% |

## Vision and strategy

The trust had developed a new five year strategy; Caring, Discovering, Growing: Together (2017-2022). This had been developed using a co-production approach, and through extensive engagement in conjunction with staff, governors, board members, people who used services and their families and carers.

The trust vision was: ‘To be a leader in the delivery of high quality care and a champion for those we serve’. This was underpinned by six strategic ambitions which were;

1. Working together with service users and carers, we will provide excellent care, supporting people on their personal journey to wellbeing
2. With people, communities and partners, together we will promote prevention, early intervention and resilience
3. Working with partners there will be “no health without mental health” and services will be “joined up”
4. The trust’s mental health and disability services will be sustainable and deliver real value to the people who use them
5. The trust will be a centre of excellence for mental health and disability
6. The trust will be regarded as a great place to work

The trust vision was underpinned by a framework of three values:

- Caring and compassionate
- Respectful
- Honest and transparent

Trust values were embedded within staff appraisals and in the values based recruitment process. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. The trust embedded its vision, values and strategy in corporate information received by staff. The trust vision and values were visible on the trust's intranet site, on their website and in information displayed throughout the trust.

The trust had established quality goals in 2009, developed through consultation with patients, staff and partner organisations. The purpose of the quality goals was to identify three key areas which would support the trust in achieving its vision and providing an overarching framework for the trust strategy. These quality goals had been reviewed and updated as part of the refreshed trust strategy and were:

- Quality goal one – keeping you safe
- Quality goal two – working with you, your carers and your family to support your journey
- Quality goal three – ensuring the right services are in the right place at the right time to meet all your health and wellbeing needs.

The trust identified annual quality priorities to support the achievement of the quality goals, again these were developed in partnership with service users, carers, staff and external partners.

The trust had adopted a truly collaborative approach to enable staff, patients, carers and external partners to contribute to discussions about the development of the strategy and changes to services. Consultation had taken place prior to the organisational restructure and engagement events had been held to seek the views of key stakeholders and also to ensure that patients and carers were kept informed of progress.

The trust strategy and quality goals were robust and realistic, clearly defining what success would look like and how this would be measured. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The trust had an active involvement in local sustainability and transformation plans. The chief executive of the trust was the chair and senior responsible officer of the Cumbria and North East STP Mental Health Steering Group and the deputy chief executive of the trust was the deputy senior responsible officer and vice chair.

The trust had planned services to take into account the needs of the local population. Care group directors had built strong relationships with commissioners, local authorities and other local providers in their respective localities. Local population data was used effectively to inform and shape service delivery which meant that locality care groups had the autonomy to meet the needs of the populations they served.

Commissioners and other stakeholders described a strong and effective leadership within the trust, working collaboratively to resolve system-wide issues. Commissioners regularly carried out quality assurance visits to services and had unrestricted access to staff and people who used services.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

The trust had a strategy for meeting the physical healthcare needs of patients. There was a robust governance structure around physical healthcare issues, including a physical health and wellbeing group which reported into the quality and performance committee. Three assurance groups for food and nutrition, falls and resuscitation and medical emergencies reported into the physical health and wellbeing group. Staff from the trust's dietetics service had been involved in the development of a public health funded initiative. The 'Weight in Mind' initiative supported people with mental health difficulties and learning disabilities to manage their weight through dietary intake and lifestyle choices. Part of this initiative included a website for service users and health professionals to provide resources to support people to make healthy lifestyle choices. During inspection of core services, we saw that patient's physical healthcare needs were robustly assessed and responded to in an appropriate and timely manner.

## Culture

Staff were universally positive about the trust. Staff felt well supported by managers within services, and spoke very highly of senior leaders. The chief executive was well known and held in high regard by staff across the trust.

Members of the board, including executive and non-executive directors carried out a programme of service visits. These routine visits meant that senior leaders were visible and well known throughout the trust. Care group directors regularly spent time in services within their respective clinical business units.

Commissioners reported an open and transparent culture within the trust, and carried out quality assurance visits, where they had unrestricted access to staff and patients in services.

The trust recognised and promoted staff success through an annual staff awards programme. Nominations for the staff awards scheme had increased year on year and the awards were held in high regard by staff with a sense of pride in being nominated for awards.

Staff we spoke with in the four services we inspected and in trust-wide focus groups told us they felt listened to, supported and valued. Staff had a strong sense of pride in working for the trust.

The trust had won the Health Services Journal Provider Trust of the Year in 2017, and had been shortlisted in the Chief Executive of the Year category.

Many staff had worked for the trust for long periods of time, and felt they had been given opportunities to develop their careers within the trust. In 2017 the trust won an Investor in Apprenticeship award from North East Apprenticeship Ambassador Network, having demonstrated the highest standards of excellence in employing apprenticeships (71% gained a job with the trust and a further 20% gained employment elsewhere)..

In the 2017 NHS Staff Survey the trust had better results than other similar trusts in 25 key areas:

| Key finding | Trust score | Similar trust's average |
|---|---|---|
| **KF11: % Appraised in the last 12 months** | 92% | 89% |
| **KF12: Quality of appraisals** | 3.25 | 3.15 |
| **KF13: Quality of non-mandatory training, learning or development** | 4.07 | 4.06 |
| **KF20. Percentage of staff experiencing discrimination at work in the last 12 months** | 10% | 14% |

| Key finding | Trust score | Similar trust's average |
|---|---|---|
| **KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion** | 93% | 87% |
| **KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month** | 96% | 92% |
| **KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents** | 3.85 | 3.71 |
| **KF31. Staff confidence and security in reporting unsafe clinical practice** | 3.85 | 3.67 |
| **KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months** | 34% | 41% |
| **KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves** | 52% | 55% |
| **KF19. Organisation and management interest in and action on health and wellbeing** | 3.90 | 3.71 |
| **KF15. Percentage of staff satisfied with the opportunities for flexible working patterns** | 65% | 59% |
| **KF16. Percentage of staff working extra hours** | 67% | 72% |
| **KF1. Staff recommendation of the organisation as a place to work or receive treatment** | 3.87 | 3.67 |
| **KF8. Staff satisfaction with level of responsibility and involvement** | 3.93 | 3.87 |
| **KF9. Effective team working** | 3.92 | 3.85 |
| **KF14.Staff satisfaction with resourcing and support** | 3.54 | 3.36 |
| **KF5. Recognition and value of staff by managers and the organisation** | 3.69 | 3.56 |
| **KF6. Percentage of staff reporting good communication between senior management and staff** | 40% | 35% |
| **KF10. Support from immediate managers** | 3.97 | 3.88 |
| **KF2. Staff satisfaction with the quality of work and care they are able to Deliver** | 4.02 | 3.85 |
| **KF32. Effective use of patient / service user feedback** | 3.78 | 3.70 |
| **KF24. Percentage of staff / colleagues reporting most recent experience of violence** | 94% | 93% |
| **KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months** | 17% | 22% |
| **KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse** | 70% | 60% |

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in one key area.

| Key finding | Trust score | Similar trust's average |
|---|---|---|
| **KF22. %experiencing discrimination at work in the last 12 months** | 25% | 21% |

Each locality care group within the trust had a meeting focussed on workforce issues, where issues arising from the staff survey had been discussed. Managers had taken issues highlighted from the staff survey to staff Speak Easy events to give staff the opportunity to discuss in more detail. The trust had developed a more robust support programme for international recruits, which extended beyond induction phase.

The trust worked appropriately with trade unions. Trade union representatives spoke of an open and positive relationship with senior managers within the trust. Trade union representatives gave examples of how they had been involved in changes across the trust, including the organisational restructure. Trade union representatives felt they needed to be more closely involved in meetings at locality care group level.

Managers addressed poor staff performance where needed. The trust had appropriate policies and procedures in place in relation to managing staff performance. The quality and performance committee of the trust board received regular reports on disciplinary and grievance cases across the trust. Managers gave examples of where they had addressed poor performance with staff from different roles. The disciplinary policy and procedure was available to all staff via the trust intranet, and provided a clear structure of the disciplinary procedure. Of the four disciplinary records we reviewed, three had failed to meet the timescales outlined in the trust policy. In all records, we found delays in the time taken to issue formal written correspondence regarding the outcome of disciplinary investigations. However all of the investigations reviewed were thorough, with actions and outcomes appropriately recorded. Trade union representatives felt that greater levels of pastoral care for staff going through disciplinary procedures would be beneficial. In the cases we reviewed we found the trust were supportive and fair throughout the process and took into account mitigating circumstances of staff when decision making.

Following the publication of the Francis report in February 2015, all NHS trusts were required to appoint a freedom to speak up guardian within 2016/17. The Francis review was established in response to evidence that NHS organisations did not react appropriately to concerns raised by staff, including maltreatment of staff speaking out. The trust appointed a freedom to speak up guardian in December 2015. Their role was to foster a culture of safety and learning in which staff could raise concerns. The freedom to speak up guardian was a part time position, working one day per week and was supported by a network of 34 freedom to speak up champions. A deputy guardian meant that the role was maintained during periods of leave. The freedom to speak up guardian attended regional and national networks and events to support them in the delivery of their role. The freedom to speak up guardian had regular meetings with the chief executive and felt comfortable meeting with the chief executive to raise any specific concerns outside of these structured meetings. There were robust governance and reporting arrangements for the guardian. They attended monthly meetings with the director of workforce and organisational development and had regular meetings with the executive directors and a non-executive director. The freedom to speak up guardian attended a quarterly oversight group, chaired by a group nurse director. This oversight group was also attended by the deputy director of workforce and organisational development and the trust's equality and diversity lead and the freedom to speak up guardian deputy. The freedom to speak up guardian was a member of the equality and diversity group. Bi-annual reports from the guardian were presented to the trust board, with exceptional matters being escalated more quickly if required. The biggest challenge faced by the freedom to speak up guardian was capacity and discussions were underway to extend the working hours to an additional two days per month.

Staff were aware of the role of the freedom to speak up guardian. Staff were able to raise concerns without fear of retribution and knew how to use the trust whistle blowing process. There was an open and honest culture and a positive environment for learning from incidents and complaints. The trust took appropriate learning and action as a result of concerns raised. We reviewed six grievance records and found these to be comprehensive. All included comprehensive information into the investigation and outcome. In all records reviewed, there was a delay in the

issuing of written notification of the final outcome of the grievance hearing. Learning from investigations was shared at the learning and improvement group which met monthly and was attended by representatives from all care groups.

Teams had positive relationships and staff spoke of a culture of mutual respect and support between different disciplines.

The trust applied duty of candour appropriately. The trust had a practice guidance note; 'Being Open' supporting the incident policy. This set down clearly the requirement to be open and transparent with patients and family members in providing a true an accurate acknowledgement of the facts and offering a meaningful apology where required. We reviewed five serious incidents investigations which evidenced the trust applied duty of candour appropriately and followed the 'Being Open' practice guidance note.

The chief executive and the chair of the board were seen as role models for equality and diversity. There was an equality and diversity lead for the trust, who felt well supported by the executive team in his role. The executive director of workforce and organisational development held the organisational responsibility for equality and diversity. The collective leadership model meant that all care group directors had responsibility for equality and diversity within their own localities. Care group directors were supported by the dedicated equality and diversity lead to develop localised EDS2 gradings and priorities for action for the 2018 submission. Previous EDS2 submissions were trust-wide rather than locality-based. All executive directors and the board received equality and diversity training and further training in respect of EDS2 within localities.

The trust did not have a dedicated equality strategy, instead using the EDS2 action plans to monitor improvements. The board had since realised that a dedicated equality strategy would provide greater focus and act as a more effective vehicle for strategic planning. The trust was therefore in the process of formulating and agreeing a new equality strategy for 2018-2022.

It is a legal requirement to publish a report at least every four years stating what action has been taken to meet the Public Sector Equality Duty. The associated organisational equality objectives must be reviewed and published annually. The trust incorporated its equality and diversity report into the annual Quality Report. Whilst this met the legal requirement to publish the information, there was no reference to this document or link to it on the trust's equality web-page. We raised this with the trust who took immediate action and produced the equality and diversity report as a standalone document, which was easily found on the equality web-page.

Equality and diversity training was mandatory for all staff, with compliance rates of 94% at the time of the inspection. Additional training in lesbian, gay, transgender and bisexual awareness had been developed by the chair of the LGBT staff network and had started to be rolled-out within the trust.

The chair of the Mental Health staff network had put together a proposal for training up to 100 mental health first aid champions. This proposal was under consideration.

Chaplaincy services were available for staff. The chaplaincy team comprised a Muslim faith leader and a representative from the Humanists UK as well as eight Christian faith leaders. There were self-help leaflets in public areas, including one entitled "Spirituality and Mental Health: Help is at Hand".

The Trust reported compliance with the requirements for Two Ticks Accreditation, now Disability Confident Standard, and the Mindful Employer Charter, and had aspirations to achieve the Stonewall Equality Index standards.

Staff networks were in place promoting the diversity of staff. This included well-established LGBT and BAME networks. The disability network was less well developed. The trust had launched an online LGBT forum to open up opportunities for staff to participate if they could not attend network meetings in person.

The trust provided the information in the table below in staffing prior to the inspection.

**Definition**

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 31 Dec 2017 | 3970 | N/A |
| Total number of substantive staff leavers | 1 Jan 17 – 31 Dec 17 | 252.1 | N/A |
| Average WTE* leavers over 12 months (%) | 1 Jan 17 – 31 Dec 17 | 10% | N/A |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | At 31 Dec 2017 | 200.4 | N/A |
| Total vacancies overall (%) | At 31 Dec 2017 | 5.0% | N/A |
| Total permanent staff sickness overall (%) | Most recent month (December 2017) | 6.7% | 5% |
| | 1 Jan 17 – 31 Dec 17 | 15.9% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 Dec 2017 | 1844.37 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 Dec 2017 | 1379.01 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 Dec 2017 | 152.1 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 Dec 2017 | 67.0 | N/A |
| Qualified nurse vacancy rate | At 31 Dec 2017 | 8.2% | N/A |
| Nursing assistant vacancy rate | At 31 Dec 2017 | 4.9% | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 Jan 17 – 31 Dec 17 | 6843 (2.7%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 Jan 17 – 31 Dec 17 | 5 (>0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 Jan 17 – 31 Dec 17 | 567 (0.2%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 32064 (12.4%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 7043 (2.7%) | N/A |
| Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 2449 (9.8%) | N/A |

| | | | |
|---|---|---|---|
| Shifts NOT filled by agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 0 (0%) | N/A |

*WholeTime Equivalent

The trust acknowledged the challenges in relation to recruitment of staff. As of December 2017, there was an overall vacancy rate of 5% within the trust. There was an active and creative recruitment campaign for both medical and nursing staff. The trust had developed strong links with local universities, and had been working in partnership with one university to support the development of a new medical school for the region. There was an active international recruitment campaign, with new medical recruits coming from India.

The trust had a sickness rate of 6.7% as at December 2017, which was above the trust target of 5%. One of the trust's strategic ambitions was that the trust would be regarded as a great place to work. Sickness absence was closely monitored at team, ward, clinical business unit and care group levels. The quality and performance committee received regular reports which included sickness absence levels.

Staff had access to support through occupational therapy. Managers were required to maintain regular contact with staff on longer term sick and conduct return to work interviews. Sickness 'clinics' were delivered in care groups to proactively manage sickness absence. The trust was developing additional training for managers in relation to managing absence.

Staff had access to a suite of mandatory training and as at 31 December 2017, the training compliance for trust wide services was 90% against the trust target of 85%. Overall, all core services achieved the trust mandatory training target of 85%.

Staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. Appraisal compliance was discussed in meetings at clinical business group and locality care group level, as well as being routinely reported to the board. Staff at all levels had access to a performance dashboard, which gave managers oversight of their team's compliance with training and appraisals and staff accessed an individual dashboard data.

The trust's target rate for appraisal compliance was 85%. As at 31 December 2017, the overall appraisal rate was 82%. Three of the 17 teams achieved the trust's appraisal target. The thirteen core services failing to achieve the trust target are listed below in red.

| Core Service | Total number of staff requiring an appraisal | Total number of staff who have had an appraisal | % of staff who have had an appraisal |
|---|---|---|---|
| **MH - Wards for older people with mental health problems** | 251 | 239 | **95%** |
| **MH - Forensic inpatient** | 100 | 95 | **95%** |
| **MH - Wards for people with learning disabilities or autism** | 469 | 419 | **89%** |
| **MH - Child and adolescent mental health wards** | 246 | 208 | **85%** |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 237 | 200 | **84%** |
| **Medical Care** | 152 | 127 | **84%** |
| **MH - Mental health crisis services and health-based places of safety** | 277 | 231 | **83%** |

| Core Service | Total number of staff requiring an appraisal | Total number of staff who have had an appraisal | % of staff who have had an appraisal |
|---|---|---|---|
| **Other** | 380 | 315 | **83%** |
| **CHS - Adults Community** | 71 | 57 | **80%** |
| **MH - Community mental health services for people with a learning disability or autism** | 166 | 131 | **79%** |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 280 | 222 | **79%** |
| **MH - Community based mental health services for older people** | 227 | 179 | **79%** |
| **MH - Specialist community mental health services for children and young people** | 339 | 265 | **78%** |
| **Outpatients** | 9 | 7 | **78%** |
| **MH - Community based mental health services for adults of working age** | 633 | 477 | **75%** |
| **Substance Misuse** | 85 | 56 | **66%** |
| **Grand Total** | **3922** | **3228** | 82% |

The trust did not provide a target rate for clinical supervision although the trust wide rate was 90% as between 1 January and 31 December 2017. Seven of the 16 teams (44%) were equal or higher to the trust average of 90%. Each core service's compliance rate can be seen below.

**Caveat:** there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

| Core Service | Formal supervision sessions each identified member of staff had in the period | Formal supervision sessions each identified member of staff should have received | Clinical supervision rate (%) |
|---|---|---|---|
| **MH - Wards for people with learning disabilities or autism** | 3154 | 3458 | 110% |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 2477 | 2440 | 99% |
| **MH - Wards for older people with mental health problems** | 3078 | 2915 | 95% |
| **MH - Mental health crisis services and health-based places of safety** | 2097 | 1993 | 95% |
| **Other** | 1982 | 1861 | 94% |
| **MH - Community based mental health services for older people** | 1632 | 1522 | 93% |
| **CHS - Adults Community** | 65 | 60 | 92% |

| Core Service | Formal supervision sessions each identified member of staff had in the period | Formal supervision sessions each identified member of staff should have received | Clinical supervision rate (%) |
|---|---|---|---|
| **Medical Care** | 1485 | 1319 | 89% |
| **MH - Specialist community mental health services for children and young people.** | 1581 | 1387 | 88% |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 2,302 | 1,997 | 87% |
| **MH - Child and adolescent mental health wards** | 2,340 | 1,954 | 84% |
| **MH - Community based mental health services for adults of working age** | 4573 | 3802 | 83% |
| **MH - Forensic inpatient** | 1078 | 871 | 81% |
| **MH - Community mental health services for people with a learning disability or autism** | 1156 | 858 | 74% |
| **Outpatients** | 78 | 57 | 73% |
| **Substance Misuse** | 652 | 435 | 67% |
| **Grand Total** | **29957** | **26917** | **90%** |

Staff had access to group supervision as well as individual supervision sessions.

## Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures, with the most recent review taking place in June 2017.

The trust had commissioned an external well led review in 2015 and had completed all actions which were signed off by the board. In line with the NHS Improvement requirement to carry out an external well lead review every three years, another review had been scheduled for September 2018.

The trust had an effective governance framework in place. The trust board of executive and non-executive directors met on a monthly basis with both private and public meetings. There were six sub-committees of the trust board; the charity committee, resource and business advisory committee, quality and performance committee, remuneration committee, audit committee and mental health legislation committee. We attended a public and private board meeting and a number of committee meetings including; quality and performance committee, audit committee and mental health legislation committee. Discussions were challenging and supportive. We reviewed minutes and papers for other committee meetings. The trust papers for board meetings and other committees were of a high standard and contained appropriate information. Each committee of the board had a number of sub-groups to ensure work was being carried out and progress made against delivery of the trust strategy.

Non-executive and executive directors were clear about their areas of responsibility. Executive directors attended specific committees relevant to their allocated portfolio. Non-executive directors chaired committees relevant to their areas of expertise and knowledge. Executive and non-executive directors held a shared sense of responsibility for delivering the trust strategy.

The trust had a council of governors who met every two months. We observed a council of governors meeting.

Operational management groups were in place which provided a robust reporting framework. A clear framework set out the structure of ward/service team, division and senior trust meetings, to ensure connectivity between the board and team level. Since our last inspection, the trust had undergone an organisational restructure. There was a robust reporting structure in place to ensure an effective and efficient flow of information from care group to executive management team and through to the board and relevant sub-committees. Each locality (North, Central, South) had a service development group, sustainability and workforce group, quality standards group and a locality management group. These reported into relevant corporate decision team meetings (workforce, quality and risk), as well as the weekly business delivery group.

Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. The business delivery group was a weekly meeting, attended by care group directors and the senior leadership team. The first part of this meeting focused on safety related issues, including a review of all serious incidents, complaints, safeguarding incidents and complex cases. The second part of the meeting focused on issues relating to workforce, quality assurance, system pressures, finance and other relevant matters. These meetings ensured that information was shared between senior managers across localities.

Care group directors, executive directors and associate directors across the trust described this new operational meeting structure as being effective, giving excellent opportunities to escalate and cascade relevant information across and between teams and management levels within the trust.

The trust had developed an accountability framework, which clearly defined the parameters of devolved decision making powers. Staff at all levels of the organisation understood their roles and responsibilities, and what issues to escalate to a more senior level.

We reviewed minutes from all meetings within this structure and found a robust flow of information being reported and actioned between the groups.

Appropriate governance arrangements were in place in relation to medicines management. The medicines optimisation strategy set out the six core ambitions regarding medicines optimisation linked to the trusts vision and overall strategy. Clear lines of reporting were in place with governance arrangements embedded within the trusts structures and lines of accountability. Appraisals and peer supervision were mapped to the strategy. Key priorities and risks had been identified on the risk register and the medicines management committee regularly reviewed these ensuring action plans were implemented. Learning actions from medicines incidents and audits were shared and reviewed.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust had an executive and non-executive Mental Health Act lead. This ensured the Mental Health Act was given appropriate oversight at board level. A Mental Health Act legislation committee reported directly to the board on Mental Health Act work streams, issues and risks. The trust reported on the use of the Mental Health Act quarterly and included a range of datasets. The trust reported that there were no breaches of the 24 hour time allowed for patients in the section 136 suite in the six months prior to inspection.

The trust had identified some breaches linked to the Mental Health Act and acted on these. Following identification of an issue, learning took place and changes made to systems as required. The trust had only recently started to collect data and monitor the use of section 62. The trust recognised this as an area for improvement. There were robust processes for developing and ratifying Mental Health Act related policies, all of which were up to date and in line with the Code of Practice 2015. When there was a change to Mental Health Act legislation or updates to case law, staff were informed. The trust did this by the use of the staff intranet. The mental health legislation clinical development manager was responsible for policies and procedures linked to the Mental Health Act. These policies went to the Mental Health Act steering group and committee and then the board. The trust board ratified all policies. The trust monitored Mental Health Act data within quality standards groups, the Mental Health Act steering committee fed directly into the Mental Health legislation committee.

There was representation from partners on Mental Health Act working groups, including approved mental health professionals, local authorities, independent mental health advocates, police and ambulance services. Staff from the locality care groups had developed links with respective local authorities. The trust had multi-agency policies and protocols, which were developed in partnership with other organisations to ensure collaborative working. The trust had entered into service level agreements with a number of organisations to support Mental Health Act administration and clinical functions when detained patients were in need of physical care. This included the majority of local acute trusts.

Local authorities provided the approved mental health professional service. The trust did not employ anyone currently practising as an approved mental health professional. The trust had a register of section12 doctors who could detain patients. Approved mental health professionals and the trust confirmed there was an up-to-date list of section 12 approved doctors.

Approved mental health professionals told us there were concerns about the availability of section 12 doctors to attend Mental Health Act assessments. Approved mental health professionals said section 12 doctor availability and bed availability were the biggest issues. There were concerns expressed about community team waiting lists and pathway issues. Approved mental health professionals reported this affected the patient experience.

The trust used patient feedback to change practice. One example was a change in the model used within care planning to promote a quicker discharge.

The Mental Health Act administration team had robust systems and processes in place to monitor compliance with the Mental Health Act and Code of Practice 2015. The trust sufficiently resourced the Mental Health Act administration team and members of the team felt supported in their roles. Mental Health Act administration staff told us there were frequent internal and external audits of systems. The trust was part of the national Mental Health benchmarking network. There was a scrutiny checklist available for ward staff. Ward staff used this at the time a detained patient was accepted onto the ward. Mental Health Act administration staff checked detention. The Mental Health Act administration team prioritised checking detention documents.

There was a restrictive interventions reduction programme in place. The trust had established “Talk First” as a strategy and practice groups and reflection supported this at ward level.

Reducing restrictive practice was included in Mental Health Act training and training by nursing staff. Mental Health Act legislation team members provided advice about Mental Capacity Act (2005) and restrictive practice to the wards. The trust stated all wards had action plans about reducing restrictive practices. The trust told us they had authorised two blanket restrictions across the trust. This linked to the smoking ban and locked ward entrances and exits. In addition, there

were blanket restrictions agreed in some trust sites regarding access to outdoor space and access to bedroom door keys. These were due to the locations facilities. During our inspection of acute admission wards and psychiatric intensive care units, we found blanket restrictions in place. The executive lead for the Mental Health Act told us that decisions regarding restrictions were made at a local level and delegated to local clinical business units. The trust recognised this was an area for improvement and planned a more robust approach to monitoring and reviewing restrictions.

The trust had policies for complaints and incidents, which outlined staff responsibilities, procedures, timescales for responding and for investigations and escalation processes. The trust had effective systems in place to manage and respond to complaints.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

| | In Days | Current Performance |
|---|---|---|
| **What is your internal target for responding to* complaints?** | 5 | 100% |
| **What is your target for completing a complaint?** | 15 | 100% (currently 91%) |
| **If you have a slightly longer target for complex complaints please indicate what that is here** | 35 | 100% (currently 91%) |

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

| | Total | Date range |
|---|---|---|
| **Number of complaints resolved without formal process*** in the last 12 months** | Unknown as these are managed locally and only formal complaints are recorded centrally | Not provided |
| **Number of complaints referred to the ombudsmen (PHSO) in the last 12 months** | Currently there are seven open complaints which have been referred to the PHSO and are being investigated. Four of these were opened in 2017. | Not provided |

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

We reviewed a random sample of six formal complaints that had been investigated and closed. All complaints had been investigated appropriately and resolved where applicable in line with trust policy. The investigator had maintained contact with the complainant in addition to writing to them to formally confirm the outcome of the investigation. This included any actions the trust had taken or intended to take in response to the outcome of the complaint.

This trust received 396 compliments during the last 12 months from 1 January to 31 December 2017. Community-based mental health services for older people and community-based mental health services for adults of working age both had the highest number of compliments, each accounting for 16% of the total compliments recorded by the trust.

The trust was working with third party providers effectively to promote good patient care. There were extensive examples of the trust working with external partners in the interest of good patient care. Joint working initiatives included:

- The trust had worked collaboratively with other mental health and acute care providers, police, ambulance service, experts by experience and local charities to develop a training programme on dealing with mental health crisis. The initiative was developed by

professionals in the North East who worked closely with people who had experience of mental health service to create simulated crisis scenarios and how to respond to these.

- Street triage – a partnership with police officers and mental health nurses to provide early intervention to individuals coming into contact with the police to provide mental health assessment and signposting/referral to appropriate services. The initiative reduced the number of preventable detentions under Section 136 of the Mental Health Act.
- Blue room – a partnership with Newcastle University which developed an immersive virtual reality to help autistic children overcome their phobias.

The trust provided psychiatric liaison services into four acute hospitals. Contractual arrangements for the delivery of these services were in place, which had been commissioned via respective clinical commissioning groups.

## Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The trust had a robust clinical and managerial infrastructure in place to support incident management. The safer care group, established in October 2017 as part of the organisational restructure, facilitated the reporting, investigation and communication of all incident activity both internal and external to the trust.

There was a culture of open reporting, with staff encouraged to report all incidents. The trust used an electronic system for reporting incidents which any member of staff could access. The trust had an incident management policy, which clearly detailed staff responsibilities in responding to and reporting incidents of various types, investigation processes and dissemination of lessons learned from incidents. The trust had adopted the principles of the National Patient Safety Agency's 'Seven Steps to Patient Safety' and embedded these in day to day practice. Staff were aware of the policy and their roles and responsibilities in relation to reporting incidents.

The trust had a dedicated team of investigating officers, who carried out all serious incident investigations. The team sat within the safer care group, and was independent of clinical services, to ensure impartiality and transparency when conducting investigations.

All serious incidents, complaints and safeguarding incidents were reported to the weekly business delivery group, who ensured that appropriate actions were in place to investigate and resolve.

A serious incident review panel met weekly to review in detail serious incident reports, recommendations and action plans to test, share and challenge learning. The outcome of all serious incident investigations were reported weekly to the business delivery group.

The trust had established a monthly learning and development group, to share lessons learned and good practice. The trust had a wide range of mechanisms to disseminate learning from incidents including:

- seven minute briefings to cascade concise learning points to staff
- Central Alert System to communicate information quickly to staff
- 'Safer Care' bulletin, issued monthly

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 January and 31 December 2017 the trust reported 95 serious incidents. The most common type of incident was 'apparent/actual/suspected self-inflicted harm meeting SI criteria' with

80 incidents. Of these, 49 occurred in community-based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS.

| Core service/ SIRI type | Abuse/alleged abuse of adult patient by third party | Accident | Apparent/actual/suspected homicide | Apparent/actual/suspected self-inflicted harm | Commissioning incident | Confidential information leak/information governance breach | Disruptive/ aggressive/ violent behaviour | Failure to obtain appropriate bed for child who needed it | Slips/trips/falls | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **MH - Community-based mental health services for adults of working age** | | | 1 | 49 | 1 | | 2 | | | 53 |
| **MH - Mental health crisis services and health-based places of safety** | | | | 12 | | | | | | 12 |
| **Substance Misuse** | | | | 7 | | | | | | 7 |
| **MH - Child and adolescent mental health wards** | | | | | | | | 6 | | 6 |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 1 | 1 | | 2 | | | | | | 4 |
| **CHS - Adults Community** | | | | 2 | | | | | | 3 |
| **Other** | | | | 4 | | 1 | | | | 5 |
| **MH - Community based mental health services for older people** | | | | 2 | | | | | | 2 |
| **MH - Wards for older people with mental health problems** | | | | | | | | | 2 | 2 |
| **MH - Specialist community mental health services for children and young people** | | | | 1 | | | | | | 1 |
| **Outpatients** | | | | 1 | | | | | | 1 |
| **Total** | **1** | **1** | **1** | **80** | **1** | **1** | **2** | **6** | **2** | **95** |

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 January to 31 December 2017 were categorised as ‘self-harming behaviour’, ‘disruptive/aggressive behaviours’ and ‘patient accident’. These three categories accounted for 70.6% of all incidents reported. There were 71 deaths reported.

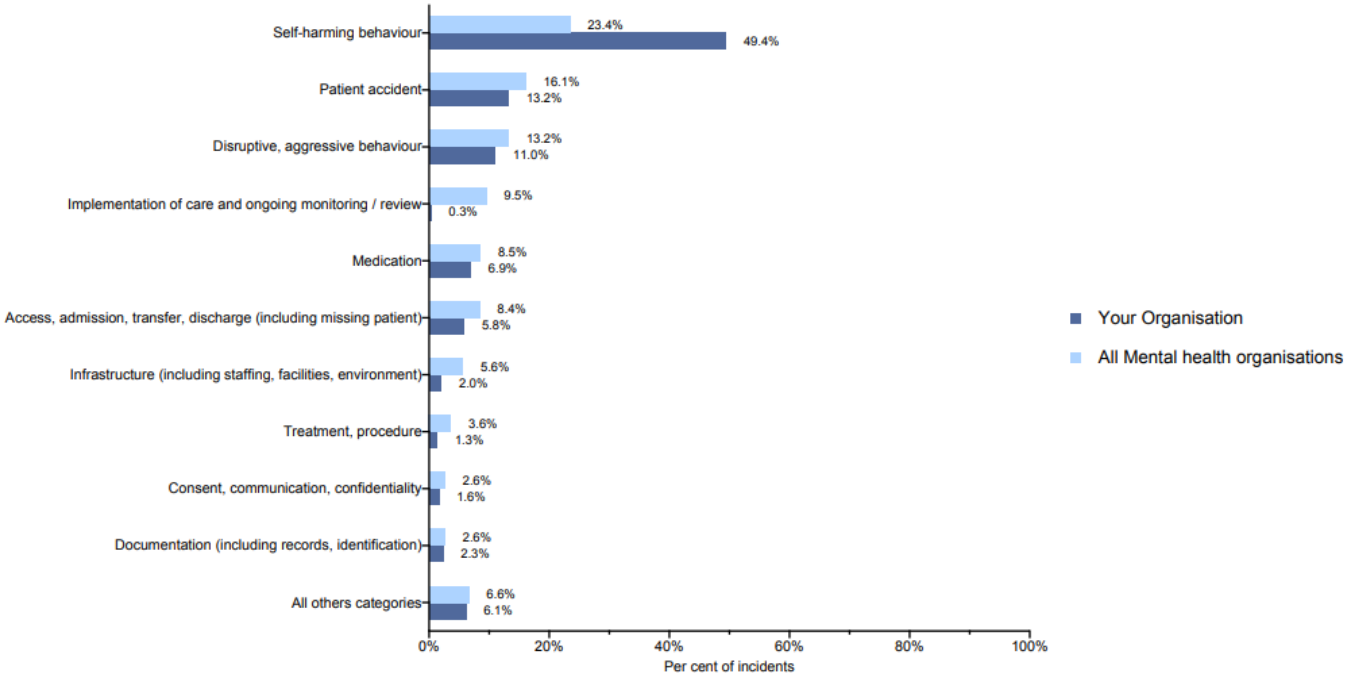
There were a further 92 notifications not categorised or grouped as 'Internal Comprehensive'.

Of the total incidents, 92.4% reported were classed as no harm (56.4%) or low harm (36%).

| Incident type | No harm | Low harm | Moderate | Severe | Death | Total |
|---|---|---|---|---|---|---|
| **Self-harming behaviour** | 2359 | 2218 | 535 | 26 | | **5138** |
| **Patient accident** | 980 | 716 | 100 | 8 | | **1804** |
| **Disruptive, aggressive behaviour (includes patient-to-patient)** | 868 | 298 | 10 | 2 | | **1178** |
| **Medication** | 678 | 165 | 19 | 3 | | **865** |
| **Access, admission, transfer, discharge (including missing patient)** | 377 | 379 | 3 | | | **759** |
| **Infection Control Incident** | 225 | 155 | 49 | 1 | 1 | **431** |
| **Infrastructure (including staffing, facilities, environment)** | 308 | 46 | 15 | | | **369** |
| **Documentation (including electronic & paper records, identification and drug charts)** | 199 | 35 | 2 | | | **236** |
| **Patient abuse (by staff / third party)** | 176 | 30 | 4 | 2 | | **212** |
| **Treatment, procedure** | 138 | 40 | 10 | 1 | | **189** |
| **Consent, communication, confidentiality** | 81 | 34 | | | | **115** |
| **Other** | 12 | 9 | 4 | 1 | 70 | **96** |
| **Implementation of care and ongoing monitoring / review** | 49 | 6 | 3 | | | **58** |
| **Medical device / equipment** | 20 | 8 | 4 | | | **32** |
| **Clinical assessment (including diagnosis, scans, tests, assessments)** | 14 | 3 | 1 | | | **18** |
| **Grand Total** | **6484** | **4142** | **759** | **44** | **72** | **11501** |

According to the latest six-monthly National Patient Safety Agency Organisational Report (1 October 2016 to 31 March 2017), the trust was in the middle 50% of reporters nationally for similar trusts.

Self-harming behaviour accounted for a higher proportion of the total number of incidents reported compared to similar trusts.




Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Risks were monitored and managed via the board assurance framework and corporate risk register. Structures and systems were in place to support the delivery of integrated risk management across the trust, which supported devolved decision making and management of risk. Risk management training had been provided to staff including new associate director roles. Each ward, care group and clinical business unit held their own risk register which were reviewed through care group meetings as well as the corporate decisions team risk meeting. Staff maintained ward level risk registers and were able to effectively escalate concerns as needed. Risks on the registers matched the concerns of staff.

The trust risk management policy included a risk appetite framework which highlighted the amount of risk the board was willing to accept in order to achieve the trust's strategic ambitions. Risk appetite is the level of risk deemed acceptable or unacceptable based on the specific risk category. For example, the trust had a moderate risk appetite for clinical innovation that did not compromise quality of care, a high risk appetite for partnerships which may support people who used the services, a low risk appetite for risk that may compromise quality effectiveness, and a very low risk appetite for risk that may compromise safety.

The trust board were sighted on the most significant risks and mitigating actions were clear. The board assurance framework was reviewed at each board meeting. Committees of the board considered the risks pertaining to their areas of responsibility and reviewed the corporate and care group highest risks to ensure effective controls were in place. Any risks exceeding the trust risk appetite were reported to the board. Action plans were in place to address any gaps in control measures, with oversight maintained by the board and relevant committees. Executive and non-executive directors demonstrated a detailed knowledge of the board assurance framework and strategic risks. There was robust audit programme linked to the board assurance framework which provided leaders with the required level of assurance.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. They demonstrated a thorough understanding of performance frameworks and were aware of the areas where the trust was underperforming. For example, all executive and non-executive directors and care group directors reflected upon the waiting times for access to community specialist mental health services for children and young people.

The trust provided a document detailing their highest profile risks. Each of these had a current risk score of 16 or higher.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| Opened | ID | Description | Risk level (initial) | Risk score (current) | Risk level (target) | Link to BAF strategic objective no. | Last review date |
|---|---|---|---|---|---|---|---|
| **May 17** | SA3.2 | That we do not influence the development of new care delivery models (ACO, MCP, ACS, STP) leading to increasing fragmentation of MH service delivery. | 20 | 16 | 9 | Ob: 3 | Dec 17 |
| **May 09** | SA04 | That we have significant loss of income through competition, choice and national policy, including the possibility of losing large services & localities. | 16 | 20 | 10 | Ob:4 | Dec 17 |
| **May 17** | SA5 | Failure to develop NTW Academy resulting in the lack of enhanced future nursing supply. | 20 | 20 | 12 | Ob:5 | Dec 17 |

The trust had no external reviews commenced or published in the last 12 months between 1 January and 31 December 2017.

The trust had robust plans in place for emergencies and other unexpected or expected events. There were detailed business continuity plans including a major incident plan and associated policies to ensure services could respond effectively in the event of an emergency situation or major incident which could impact on service delivery. These plans had been deployed effectively during a period of severe weather which had caused severe disruption to road and transport links.

The trust had a financial strategy which included detailed plans for delivery of services and financial objectives to March 2019. All budgets, including financial delivery plans, were signed off by budget holders before approval by the trust board. There were robust governance arrangements in place to monitor budgets and progress against financial delivery plans. Financial delivery plans were developed through operational groups and reviewed through the business delivery group, group operational management groups, executive management team, corporate decisions team and the trust board. These plans were also reviewed by the resource and business assurance committee. Where cost improvements were taking place, the trust had effective systems in place to ensure they did not compromise patient care. Financial delivery plans were each subject to a quality impact assessment, providing assurances that patient safety was not compromised as a result of financial efficiencies.

NHS Improvement's single oversight framework segmented the trust into category one for finance and use of resources, which meant the trust was assigned maximum autonomy. The trust was operating in a challenging financial environment, compounded by a financial recovery programme of just over £2 million from one of the clinical commissioning groups. The trust was in negotiations with commissioners and NHS England to identify how this efficiency could be realised through service redesign. The trust was forecast to achieve the financial plan and control total for 2017/18.

The trust was forecasting to deliver agency spend within its £8.6m ceiling and targeted medical agency reduction. The reduction in agency spend was attributable to general and international recruitment as well as upskilling the workforce to take on new roles.

| | Historical data | | Projections | |
|---|---|---|---|---|
| **Financial Metrics** | **Previous financial year (2 years ago) (April 2015 - March 2016)** | **Last financial year (April 2016 - March 2017)** | **This financial year (April 2017 - March 2018)** | **Next financial year (April 2018 - March 2019)** |
| **Income** | £306.2m | £316.5m | £312.6m | £305.8m |
| **Surplus** | £4.2m (£9.7m including impairment reversals) | £9.2m (£16.6m deficit including impairments) | £7.1m | £7.1m |
| **Full costs** | £302.0m (£296.5m including impairments) | £307.3m (£333.1m including impairments) | £305.5m | £298.7m |
| **Budget** | £2.0m | £6.5m | £7.1m | £7.1m |

The trust participated in 136 national and local clinical audits as part of their clinical audit programme in the last 12 months.

## Information Management

The Information Governance Toolkit is an online system which allows organisations to assess themselves against information governance policies and standards. NHS organisations have to complete this each year. Information governance is the system an organisation uses to ensure that information is handled safely. The trust reported performance against the toolkit through the Caldicott health informatics group, the quality and performance committee and the corporate

decisions team. The trust met the required standard of level two across all key standards in the toolkit.

The board received holistic information on service quality and sustainability. The quality of information and data presented to the board and its sub-committees was of a very high standard. Data was complemented by the programme of board visits to services which provided the board with a comprehensive understanding of service quality. Board members were aware of the trust's performance, including finance, through the use of key performance indicators and a range of other quality metrics, which fed into the board assurance framework. Members of the board expressed a high level of confidence in the quality of the data presented. Information was in an accessible format, timely, accurate and identified areas for improvement. Where issues were identified, deep dives were undertaken to provide further assurance on the data and actions taken. The trust had robust quality governance systems in place, from ward to board level. Managers and senior leaders monitored quality through care group quality standards meetings, corporate decisions team, the quality and performance committee and the trust board.

The trust had a data quality improvement plan to ensure continuous improvement in performance information which included an audit programme for all performance and quality indicators.

The trust had developed a highly effective dashboard for performance data that provided information at trust, care group, clinical business unit and ward level. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Staff could interrogate the data to provide real time information on incidents which could be broken down to individual patient level if required. This meant that staff could use data in a meaningful and responsive way. For example, we saw how data was used to inform the rostering of staff on child and adolescent mental health wards to reduce incidents of violence and aggression and as a result, reducing levels of restraint for patients. The trust's use of data to influence the delivery of care to improve patient outcomes was impressive.

In line with best practice, the trust had separate and distinct senior information risk owner and Caldicott guardian. The senior information risk owner is accountable for how an organisation manages information and provides a focal point for managing risks and incidents. The Caldicott guardian is an advisory role which acts as the conscience of an organisation. They are concerned with the management of patient information. The Caldicott guardian was the executive medical director; the senior information risk owner was the executive director for commissioning and quality assurance.

The trust had robust information governance systems in place, including confidentiality of patient records. The trust maintained an information assets register. The Caldicott and health informatics group retained oversight of the informatics strategy and provided the quality and performance committee and board with evidence of compliance against the strategy. Each information asset, including electronic patient information systems, was assigned an information asset owner. All information assets had been subject to risk assessment and had business continuity plans in place. The information governance incident management group was a sub-group of the Caldicott and health informatics group. This group reviewed all incidents which related to information governance and identified any emerging themes from reported incidents.

The clinical records improvement group was established to oversee any required changes to the electronic patient records system and maintain an effective change control process. This meant that there were robust arrangements in place to define and manage changes to electronic patient records.

Staff had access to a range of IT systems, including desk-top computers, laptops and mobile technology. These systems worked well and helped to improve the quality of care.

Leaders submitted notifications to external bodies as required. The trust was proactive in working with commissioners and regulators and had mature and open discussions where issues arose.

## Engagement

The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. Service user and carer experience was a trust quality priority. The trust's strategy, vision and values underpinned a culture which was truly patient centred. There was a programme of visits to services by board members, care group directors and governors which meant that patients and staff were able to meet with them and give direct feedback. A service user or carer was invited to each board meeting to give a personal insight into their experience of being involved with services provided by the trust. All executive and non-executive directors told us they found this one of the most powerful and insightful items on the board agenda. The trust had a genuine commitment to the involvement of patients and carers at all levels. Patients and carers had been heavily involved in the design and development of a purpose built autism unit. The Mitford Unit opened in 2016, and won the Building Better Healthcare award for the best mental health development in 2017. The unit was highly commended in the European Healthcare Design Awards 2017.

The trust was committed to creating opportunities for people who had experience of mental health issues and using mental health services. The trust employed 32 people as peer support workers, who were deployed in a range of services across the trust to support people using services. There were also 46 volunteers with lived experience of using mental health services working across the trust.

Following the last comprehensive inspection of the trust by CQC in 2016, the trust was found to be in breach of regulation 9 of the Health and Social Care Act. This was because patients on older people's wards were not actively involved in the development of their care plans. In response, care plan training had been delivered to all qualified nurses in inpatient older people's services. Senior clinicians had facilitated care plan clinics to share best practice and evidence based interventions. Lead nurses developed caseload reflective supervision with staff, which incorporated person centred care planning. At the core service inspection for wards for older people in advance of the trust well led review, we found the quality care plans had significantly improved and were person centred.

The trust had secured funding from a National NHS Leadership Academy innovation fund to facilitate a service user and carer leadership programme, which was in its third year. A peer support worker had been seconded into the patient and carer engagement team to support the development of the programme.

The trust had agreed three long term quality goals, on the domains of safety, service user and carer experience and clinical effectiveness. The trust set annual quality priorities to achieve the quality goals. The quality priorities were developed in consultation with key stakeholders including service users, carers, staff, governors and commissioners. The Council of Governors and the service user and carer reference group jointly facilitated an engagement session in November 2017 with stakeholders to share progress against the 2017/18 quality priorities, and agree quality priorities for 2018/19. The trust also carried out a survey to solicit wider views from those who were unable to attend the session.

The trust strived to ensure that family members and carers of people who used services were supported and enabled to contribute to decisions about their care. The trust had implemented the triangle of care, which laid out six key principles of working with carers. The trust delivered carer awareness training to inpatient and community staff and had refreshed this training during 2017/18. A rapid improvement process workshop had been carried out across the trust to review the approach to engagement with carers. All services within the trust had action plans to fully implement and embed the triangle of care principles, progress against which was monitored and reviewed at carer champion forums.

In 2016, the trust launched its own charity; the SHINE fund. These charitable funds have supported the development of a number of Recovery Colleges across the trust's geographical footprint. Recovery Colleges provide service users with support from people with lived experience of mental health issues and services. There were four Recovery Colleges at various stages of development.

Ward staff had access to feedback from patients and carers and used this to make service improvements. Feedback from patients and carers was broken down to core service and ward level, which enabled staff to respond in individualised ways. The trust had a robust process in place to seek the views of people who used services and their carers. The trust gathered feedback using the friends and families test and 'points of you' survey. Key themes and findings from this survey activity were reported quarterly to the board. Between January to March 2018, 1742 service users and carers provided feedback via the Points of You survey. This included the friends and family test question which asked people to rate the likelihood they would recommend the service received to friends or family. In January to March 2018, 89% of respondents to the survey said they would recommend the service. This had increased from a recommendation rate of 86% for the period October to December 2017. Between April 2017 and March 2018, 6872 patients and family members or carers had provided feedback to the trust. Overall, 83% of the comments received between January to March 2018 were positive and linked to staff attitudes, service quality and care and treatment provided. The board received a detailed analysis of the findings from both the friends and family test and points of you survey, broken down to core service level. Data was presented to indicate whether results had improved or got worse than the previous quarter. The trust used a different survey for the gender dysphoria service, which was a nationally developed tool. The board also received an overview of ratings for the trust from the NHS Choices, Care Opinion and Healthwatch websites.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Overall, the trust scored lower than the England average for five out of six months for people recommending the trust as a place to receive treatment. In addition, a higher percentage said they would not recommend the trust when compared to the England average each month.

| | Trust wide responses | | | | England averages | |
|---|---|---|---|---|---|---|
| | Total eligible | Total responses | % that would recommend | % that would not recommend | England average recommend | England average not recommend |
| **July 17** | 25810 | 446 | 86.3% | 6.3% | 89% | 4% |
| **Aug 17** | 25052 | 593 | 86.8% | 6.4% | 88% | 5% |
| **Sept 17** | 26089 | 580 | 84.0% | 9.0% | 89% | 4% |
| **Oct 17** | 26652 | 608 | 85.2% | 6.3% | 86% | 6% |
| **Nov 17** | 27180 | 569 | 85.9% | 6.9% | 87% | 5% |

| | Trust wide responses | | | | England averages | |
|---|---|---|---|---|---|---|
| **Dec 17** | 23962 | 370 | 88.0% | 6.0% | 88% | 4% |

The trust had a structured and systematic approach to staff engagement. Staff were able to attend regular 'Speak Easy' events which gave them the opportunity to share what was working well and make suggestions for improvements. These sessions were attended by two executive directors along with other members of the senior management team.

The trust had an established programme of Schwartz Rounds. These were smaller sessions, which provided a structured forum where staff came together to discuss the emotional and social aspects of delivering care. These were facilitated every two to three months and were attended by between 45 to 90 staff at each session.

In 2017 the trust won an award from the North East branch of the Chartered Institute of Personnel and Development for their work in employee engagement.

The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The percentage of staff that would recommend this trust as a place to work in Q2 17/18 decreased when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care in Q2 17/18 also decreased when compared to the same time last year. There is no reliable data to enable comparison with other individual trusts or all trusts in England.



Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

The board received quarter four 2017/18 friends and families test data, which indicated that 70% of respondents would recommend the trust as a place to work. This was an increase of 6% from the same period in 2016/17. In quarter four 2017/18, 76% of staff would recommend the trust for care or treatment, and increase of 2% for the same period in 2016/17.

The trust sought to actively engage with and support staff in a range of equality groups. A number of staff networks were in place, including LGBT and BAME. In addition to these meetings, the trust had recently set up an online forum for LGBT staff who may be unable to attend the meetings.

There were effective communication systems in place, including trust intranet and newsletters to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Service information leaflets and self-help guides for patients and carers were available in a range of formats including easy read, web-based and most recently available in British Sign Language format. Patients and staff had access to the 'choice in medications' website, which provided information on medication used in mental health services.

The trust's patient information centre received Information Standard quality mark and all patient and carer leaflets were produced under the scheme. Two of the self-help guides were highly commended at the British Medical Association's Patient Information Awards 2017. (Anxiety – easy read information and Depression and low mood – a guide for partners).

The council of governors included appointed and elected governors. On appointment, governors received an induction and training to support them in the fulfilment of their role. We spoke with Governors in a focus group as part of our inspection activity. Governors told us they had received extensive training to support them in their roles and had a good understanding of their responsibilities. Governors felt actively involved in the operation of the trust and were confident in challenging executive and non-executive directors. Governors had opportunities to visit services to further build their knowledge and understanding of the trust.

The trust was actively engaged in collaborative work with external partners and was heavily involved in developing sustainability and transformation plans. The chief executive of the trust was the chair and senior responsible officer of the Cumbria and North East STP Mental Health Steering Group and the deputy chief executive of the trust was the deputy senior responsible officer and vice chair.

The trust had planned services to take into account the needs of the local population. Following the organisational restructure in October 2017 to a locality care group model, care group directors and associate directors felt they were much more engaged with relevant external stakeholders. Locality care directors had more capacity to develop stronger relationships with clinical commissioning groups, local authorities and third sector organisations in their localities. Local population data was used effectively to inform and shape service delivery which meant that locality care groups had the autonomy to meet the needs of the populations they served.

External stakeholders said they received open and transparent feedback on performance from the trust. We spoke with clinical commissioners who were positive about their relationships with the trust and said there were strong relationships with the trust at appropriate levels of seniority.

## Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. These included:

- The trust had been selected by NHS England to be one of seven 'Global Digital Exemplar' trusts and was receiving additional funding for three years to develop and innovate digital solutions to improve patient experience.
- The trust was working in collaboration with Newcastle University on trial for new treatment for bipolar disorder. The trust had been successful in securing funding of just under £2 million to run the study, recruiting patients from around 40 NHS trusts across the UK.
- Staff from the trust's Complex Neurodevelopment Disorder Service had been awarded National Institute for Health Research health technology assessment grant of over £1.5 million. This would enable the trust to carry out a study in managing repetitive behaviours to support parents of young people with autism to manage challenging, restricted repetitive behaviours.
- The trust was participating in a study for people with psychosis, using immersive virtual reality to treat psychosis, funded by a £4 million grant from the National Institute of Health Research.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff and teams were recognised for their achievements, including;

- Four services had been selected for inclusion in the 'Guide to Positive Practice in Mental Health', a national resource for mental health care.
- The team from the child and adolescent mental health inpatient services had been the first team in the country to win a CAMHeleon award. CAMHeleon is an organisation which provides resources and celebrates best practice in child and adolescent mental health

wards, offering positive experiences whilst they are in hospital. The team won the award for using creative and colourful ideas to develop a suite of resources to improve and enrich the experiences of young people in the service.
- A police liaison worker was a finalist in the National Police Twitter Awards category of Best Informative Police Account (Non-Police).

The trust had an effective approach to participate in national audits and accreditation schemes and shared learning. During 2017/18, the trust had completed eight national clinical audits covered services that the trust provided and 97 local clinical audits. The trust participated in 100% of required national clinical audits. We found highly effective systems in place to cascade actions and learning from clinical audits, which supported the trust's commitment to continuous improvement.

The trust board were committed to investing in research and development. The trust was very active in the field of clinical research and was involved in 75 clinical research studies during 2017/18. During the same period, 50 clinical staff participated in ethics committee approved research. The trust was the third most active mental health and disability trust in the country, based on the number of active research studies.

There were organisational systems to support improvement and innovation work. Staff had received training in improvement methodologies and used standard tools and methods. The trust had been delivering lean methodology training since 2009. The trust delivered 15 programmes of certified leader training per year. The objective of the training was to support delivery of transformed services by leading, directing, and governing implementation of a system of continuous improvement. It aims to create a different way of thinking across the organisation.

The trust adopted rapid process improvement workshops. These workshops took place over five days to review specific issues, within post workshop reviews taking place at 30, 60 and 90 days. Workshops are usually driven by a member of the executive team, to raise the profile and indicate to staff the importance of this work. The trust had used this process to reduce the use of bank and agency staff, and also to review and improve the trust's approach to engaging with carers.

Investigating officers had received training in a range of investigation methodologies including root cause analysis and human factor training.

There were systems in place to review compliance with National Institute for Health and Care Excellence guidance. During 2017/18 the trust completed 18 guidance assessments, five of which had actions put in place to ensure compliant was met.

Following the publication of the report by Mazars (an independent organisation tasked by NHS England to investigate all deaths of service users who received mental health or learning disability services at Southern Health NHS Foundation Trust), an alliance of mental health trusts from Yorkshire, Cumbria and the North East was formed, known as the Northern Alliance. The Alliance was supported by Mazars. The trust was an active participant in the Northern Alliance, developing and implementing a common approach to mortality across the region in line with best practice. The trust also participated in the Learning Disabilities Mortality Review programme, commissioned by NHS England, to ensure that all deaths of patients with a learning disability are reviewed and any learning is used to improve health and social care services for people with a learning disability.

There were effective systems in place to identify and learn from unexpected deaths. The trust had a robust governance structure in place to review and respond to deaths. The safer care group maintained oversight of all serious incidents, including deaths, and carried out investigations, analysed data to identify themes and trends and produced reports. All deaths were reviewed at the weekly business delivery group, attended by senior managers and clinicians. There was a weekly serious incident and mortality review panel, which was a multidisciplinary meeting, chaired by a senior clinician. The review panel identified key areas of learning and developed a learning plan

for dissemination across the trust. A monthly learning and improvement group, consisting of broad membership of representatives across the trust, reviewed learning and themes and reviewed the effectiveness of how learning had been embedded across the trust. The trust board received a quarterly safer care report which included an annual review of all deaths.

Learning from deaths was discussed by staff at all levels through team meetings, learning groups and individual supervision. Information on learning was cascaded to all staff through seven minute bulletins, monthly safer care bulletins and the central alert system. The board also received regular vignettes, which provided the background, context and the situation leading up to a death, the learning gained following investigation and actions carried out as a result.

The trust ensured learning from deaths and other serious incidents was embedded in practice in a variety of ways. This included an audit programme to assess the extent to which learning and actions was being delivered within services and teams, reviewing and updating trust policies, updating relevant training programmes for staff to reflect learning.

The trust's performance dashboard included data on deaths, including a clinical data dashboard which allowed clinicians to 'drill down' to underlying data. The trust produced an analysis of all deaths recorded between 2010 and 2016, including natural cause deaths.

The records of five deaths that we reviewed showed accurate recording of the details of the death, staff being offered support, liaison with other agencies, thorough investigations with appropriate recommendations, actions and timescales. It was evident that families or carers had been supported and involved, including in the development of the terms of reference for the investigation.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. Examples of individual team recognition included the street triage team, which was an initiative bringing together officers from the police force with mental health nurses. The aim of the initiative was to reduce the demand on front line resources within both organisations. The initiative was commended by the local police and crime commissioner.

Staff were aware of their contribution to cost improvement objectives. Financial delivery plans were in place at care group level, as part of the devolved decision making model. Staff had an understanding of the financial challenges facing the trust and were encouraged to identify and support measures to drive down costs.

Staff used data to drive improvement. The trust's performance dashboard was sophisticated and provided data at trust, care group, clinical business unit and ward level. Staff could drill down to patient level data if required. This had enabled staff to effectively review incident data as part of the trust's 'Talk First' programme, which had resulted in significant reductions in restrictive interventions. For example, between 2016/17 and 2017/18, the use of prone restraint had reduced by 13%, the use of mechanical restraint had reduced by 67%, and use of seclusion had reduced by 14%. For the same reporting period, reported incidents of self-harm had reduced by 23%. This was due to the fact that staff were effectively using real time incident data to change how services were delivered to more robustly support patients.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation and the relevant dates.

| Scheme Name | | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|---|
| Accreditation for Inpatient Mental Health Services (AIMS) | AIMS - WA (Working Age Units) | Collingwood Court, Campus for Ageing and Vitality Accredited to March 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Embleton Ward, St George's Park Accredited to April 2018 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Fellside Ward, Tranwell Unit Accredited to July 2018 (Excellent) | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Lamesley Ward, Tranwell Unit Accredited to June 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Longview Ward, Hopewood Park Accredited to June 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Lowry Ward, Campus for Ageing and Vitality Accredited to September 2018 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Shoredrift, Hopewood Park Accredited to June 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Springrise, Hopewood Park Accredited to January 2018 (Excellent) | | Acute wards for adults of working age and psychiatric intensive care units |
| | | Warkworth, St George's Park Accredited to February 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | AIMS - PICU (Psychiatric Intensive Care Units) | Beckfield, Hopewood Park Accredited to March 2019 | | Acute wards for adults of working age and psychiatric intensive care units |
| | AIMS - AT (Assessment and triage wards) | | | |
| | AIMS - OP (Wards for older people) | Mowbray Ward, Monkwearmouth Hospital Accredited until 21 March 2020 | Hauxley Ward Final Report submitted awaiting outcome | Wards for older people with mental health problems |
| | | Roker Ward, Monkwearmouth Accredited until July 2020 | Woodhorn Ward Final Report submitted awaiting outcome | Wards for older people with mental health problems |

| Scheme Name | | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|---|
| | | Akenside, Campus for Ageing and Vitality Accredited until May 2020 | Castleside Ward Participating | Wards for older people with mental health problems |
| | AIMS - Rehab (Rehabilitation wards) | Aldervale, Hopewood Park Accredited until April 2019 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Bluebell Court, St George's Park Accredited as excellent until February 2018 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Clearbrook, Hopewood Park Accredited as excellent until September 2018 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Willow View, St Nicholas Hospital Accredited until January 2019 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Elm House, Gateshead Accredited until April 2019 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Kinnersley, St George's Park Accredited until July 2020 | | Long stay / rehabilitation mental health wards for working age adults |
| | | Newton Ward, St George's Park Accredited until April 2020 | | Long stay / rehabilitation mental health wards for working age adults |
| Quality Networks | Quality Network for Inpatient Learning Disability Services (QNLD) | The majority of In-patient Learning Disability Services in the Trust are Forensic Learning Disability services which are covered by the Quality Network for Forensic Services | | Wards for people with learning disabilities or autism |
| | Quality Network for Inpatient CAMHS (QNIC) | Fraser, Ferndene Annual peer reviews | | Child and adolescent mental health wards |
| | | Redburn, Ferndene Annual peer reviews | | Child and adolescent mental health wards |
| | | Riding, Ferndene Annual peer reviews | | Child and adolescent mental health wards |
| | | Alnwood, St Nicholas Hospital | | Child and adolescent mental health wards |

| Scheme Name | | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|---|
| | | Annual peer reviews | | |
| | | Stephenson, Ferndene Annual peer reviews | | Child and adolescent mental health wards |
| | Quality Network for Community CAMHS (QNCC) | Newcastle CYPS Accredited until 2019 | | Specialist community mental health services for children and young people |
| | | Northumberland CYPS Accredited until 2020 | | Specialist community mental health services for children and young people |
| | | South of Tyne and Wear CYPS Accredited until 2020 | | Specialist community mental health services for children and young people |
| | | North Tyneside CYPS Member | | Specialist community mental health services for children and young people |
| | Quality Network for Perinatal Mental Health Services (QNPMH) | Beadnell Ward, St George's Park Accredited awaiting certificate | | Other |
| | Quality Network for Eating Disorders (QED) | Ward 31a, Royal Victoria Infirmary Accredited to March 2019 | | Other |
| | Quality Network for Forensic Mental Health Services | Northgate Hospital Quality Visit - November 2017 | | MH - Forensic inpatient |
| | | St Nicholas Hospital Full Inspection - December 2017 | | MH - Forensic inpatient |
| ECT Accreditation Scheme (ECTAS) | | Hadrian Clinic, Newcastle Accredited to February 2021 | | N/A |
| | | Morpeth Unit, St George's Hospital Morpeth Accredited until September 2020 | | N/A |
| Psychiatric Liaison Accreditation Network (PLAN) | | Self Harm and Liaison Psychiatry Service (RVI Newcastle) Accredited until December 2018 | | MH - Community-based mental health services for adults of working age. |

| Scheme Name | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|
| | Northumberland Liaison Psychiatry and Self Harm Team (Wansbeck General Hospital) Accredited until February 2018 (in review stage - cycle 2) | | MH - Community-based mental health services for adults of working age. |
| | Psychiatric Liaison Team (Sunderland Royal Hospital) Accredited as excellent until February 2018 (in review stage - cycle 2) | | MH - Community-based mental health services for adults of working age. |
| Memory Services National Accreditation Programme (MSNAP) | | Monkwearmouth Memory Protection Service Deferral of decision to July 2018 | MH - Community-based mental health services for older people |
| Home Treatment Accreditation Scheme (HTAS) | Crisis Assessment and Home Based Treatment Service - Newcastle Accredited until June 2019 | | MH - Community-based mental health services for adults of working age. |
| | Sunderland Crisis Team Accredited to June 2020 | | MH - Community-based mental health services for adults of working age. |
| | South Tyneside Crisis Team Accredited until June 2020 | | MH - Community-based mental health services for adults of working age. |
| | Gateshead Crisis Team Accredited until June 2020 | | MH - Community-based mental health services for adults of working age. |
| | Northumberland Crisis Team Accredited until June 2020 | | MH - Community-based mental health services for adults of working age. |
| Accreditation for Psychological Therapies Services (APPTS) | Sunderland and South Tyneside Psychological Service - Adult Pathway Accredited in May 2017 | | Other |
| | Sunderland Psychological Wellbeing Service (IAPT) Accredited in June 2015 | | Other |

| Scheme Name | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|
| Star Wards | Rose Lodge, Sunderland<br>Full Monty | Lindisfarne, Northgate Hospital<br>Application submitted | Wards for people with learning disabilities or autism |
| | | Wansbeck, Northgate Hospital<br>Application submitted | Wards for people with learning disabilities or autism |
| | | Cheviot, Northgate Hospital<br>Application submitted | Wards for people with learning disabilities or autism |
| | | Tweed, Northgate Hospital<br>Application submitted | Wards for people with learning disabilities or autism |
| | | Tyne, Northgate Hospital<br>Application submitted | Wards for people with learning disabilities or autism |
| | Springrise, Hopewood Park<br>Full Monty | Embleton, St George's Park<br>Awaiting decision | Acute wards for adults of working age and psychiatric intensive care units |
| | Beckfield, Hopewood Park<br>Full Monty | Alnmouth, St George's Park<br>Benchmarking documentation completed | Acute wards for adults of working age and psychiatric intensive care units |
| | Longview, Hopewood Park<br>Full Monty | Fellside Ward, Tranwell Unit<br>Benchmarking complete, application ready to submit | Acute wards for adults of working age and psychiatric intensive care units |
| | Shoredrift, Hopewood Park | Lamesley Ward, Tranwell Unit<br>Benchmarking complete, application ready to submit | Acute wards for adults of working age and psychiatric intensive care units |
| | Collingwood Court, Campus for Ageing and Vitality<br>Full Monty | | Acute wards for adults of working age and psychiatric intensive care units |
| | Lowry Ward, Campus for Ageing and Vitality<br>Full Monty | | Acute wards for adults of working age and psychiatric intensive care units |
| | Bridgewell, Hopewood Park | | Long stay / rehabilitation mental health wards for working age adults |
| | Aldervale, Hopewood Park | | Long stay / rehabilitation mental health wards for working age adults |
| | Clearbrook, Hopewood Park<br>Full Monty | | Long stay / rehabilitation mental health wards for working age adults |
| | Newton Ward, St George's Park | | Long stay / rehabilitation mental |

| Scheme Name | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|
| | | | health wards for working age adults |
| | Kinnersley, St George's Park Full Monty | | Long stay / rehabilitation mental health wards for working age adults |
| | Willow View, St Nicholas Hospital Full Monty | | Long stay / rehabilitation mental health wards for working age adults |
| | Elm House, Gateshead Full Monty | | Long stay / rehabilitation mental health wards for working age adults |
| | Bede, St Nicholas Hospital Full Monty | | MH - Forensic Inpatient |
| | Aidan, St Nicholas Hospital Full Monty | | MH - Forensic Inpatient |
| | Oswin, St Nicholas Hospital Full Monty | | MH - Forensic Inpatient |
| | Cuthbert, St Nicholas Hospital Full Monty | | MH - Forensic Inpatient |
| | Mowbray Ward, Monkwearmouth | Hauxley Ward, St George's Park Benchmarking documentation completed | Wards for older people with mental health problems |
| | Roker Ward, Monkwearmouth Full Monty | Woodhorn Ward, St George's Park Benchmarking documentation completed | Wards for older people with mental health problems |
| | Cleadon, Monkwearmouth Full Monty | | Wards for older people with mental health problems |
| | Marsden, Monkwearmouth | | Wards for older people with mental health problems |
| | Castleside, Campus for Ageing and Vitality Full Monty | | Wards for older people with mental health problems |
| | Akenside, Campus for Ageing and Vitality Full Monty | | Wards for older people with mental health problems |
| | Stephenson, Ferndene Full Monty | | Child and Adolescent Mental Health Wards |
| | Riding, Ferndene Full Monty | | Child and Adolescent Mental Health Wards |

| Scheme Name | Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved). | Are there any further services, labs, units or wards that are engaged with the scheme but have not yet achieved accreditation? | Core service |
|---|---|---|---|
| | Ward 3, Walkergate Park | | AC - Medical care (including older people's care) |
| | Ward 2, Walkergate Park | | AC - Medical care (including older people's care) |
| Investors in People | 2016 - 2019 | | N/A |
| Better Health at Work | Continuing Excellence | | N/A |
| The General Pharmaceutical Council pharmacy | Pharmacy dispensary “good” (top 12 %) | | N/A |

# Mental health services

## Acute wards for adults of working age and psychiatric intensive care units

### Facts and data about this service

Northumberland, Tyne and Wear NHS Foundation Trust has ten acute wards for adults of working age and one psychiatric intensive care unit which provide services to a population of approximately 1.4 million people living in Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. The eleven wards are based at four hospital locations: The Campus for Ageing and Vitality, Hopewood Park, Queen Elizabeth Hospital and St. George’s Park.  The wards and locations are listed below:

| Location site name | Ward name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| St George's Park | Alnmouth | 19 | Female |
| St George's Park | Embleton | 19 | Male |
| St George's Park | Warkworth | 19 | Male |
| Campus for Ageing and Vitality | Collingwood | 16 | Male |
| Queen Elizabeth Hospital | Fellside | 20 | Male |
| Queen Elizabeth Hospital | Lamesley | 18 | Female |
| Campus for Ageing and Vitality | Lowry | 16 | Female |
| Hopewood Park | Beckfield | 14 | Mixed |

| | | | |
|---|---|---|---|
| Hopewood Park | Longview | 18 | Female |
| Hopewood Park | Shoredrift | 18 | Male |
| Hopewood Park | Springrise | 18 | Male |

The locations have been registered since 2010 and provide the following regulated activities relevant to the service:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury

# Is the service safe?

## Safe and clean care environments

### Safety of the ward layout

All wards had an annual comprehensive environmental risk assessment. Identified environmental risks were added to ward risk registers which were reviewed regularly. All wards had an up to date fire risk assessment.

The trust had undertaken recent (from 1 April 2017 onwards) ligature risk assessments on wards at three locations.

All of the wards presented a high level of ligature risk due to acute and psychiatric intensive care unit admissions. None of the wards presented a lower risk.

On most wards staff mitigated the risk of ligature anchor points adequately. These included replacing missing and non-security screws from bedroom fittings and ceiling mounted shower heads clamped in place to prevent movement and potential ligature points. A ligature point is anything that could be used to attach a cord, rope or other material, for the purpose of hanging or strangulation. All ongoing risk was managed clinically on an individual basis, including the doors which remained a ligature risk. However, on Fellside and Lamesley we identified ligature anchor points in the ward kitchens which had not been assessed on the ward's ligature risk assessment. We raised this with the clinical nurse manager on the day of inspection. Following the inspection the trust undertook a specific risk assessment of the ward kitchens.

Lines of sight were enhanced through the use of mirrors to eliminate potential blind spots.

The wards complied with national guidance on eliminating mixed sex accommodation. All wards except Beckfield were single sex wards. On Beckfield all bedrooms were ensuite. There was a designated corridor for female bedrooms. The ward had a lounge area for females only. Over the 12 month period from 1 January 2017 to 31 December 2017 there were no mixed sex accommodation breaches within this core service.

Nurse call alarms were available in patient bedrooms and communal areas on four of the 11 wards. These four wards (Beckfield, Longview, Spingrise and Shoredrift) were at the Hopewood Park location.

### Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. Patients told us that the wards were always clean and several patients praised the domestic staff. Cleaning schedules were up to date and domestic staff had a clear understanding of how to clean the wards.

The occupational therapy facilities at the Campus for Ageing and Vitality, accessed by patients on Collingwood and Lowry wards, were not maintained appropriately and posed a potential risk. Equipment to support activities was not stored appropriately which meant that patients could access items which could be used to cause harm. We raised this during the inspection and staff took action to address these issues.

Staff adhered to infection control principles including handwashing. Handwashing facilities were available in all clinic rooms. Hand gels were available at ward entrances for visitors. The trust undertook regular infection control audits.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017), the location(s) scored higher than the similar trusts for three of the four aspects overall and similar to other trusts for one.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Hopewood Park** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety | 100% | 97.3% | 81.1% | 90.7% |
| **St Georges Hospital, Morpeth** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/Rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety<br>Wards for older people with mental health problems | 98.2% | 93.3% | 89.8% | 88.8% |
| **Camus for Ageing & Vitality** | Acute wards for adults of working age and psychiatric intensive care units<br>Wards for older people with mental health problems | 99.1% | 85.2% | 89.2% | 72.7% |
| **Trust overall** | | **99.3%** | **95.8%** | **88.1%** | **85.8%** |
| **England average (Mental health and learning disabilities)** | | **98.0%** | **95.2%** | **84.8%** | **86.3%** |

## Seclusion room

Seclusion rooms were available to use if necessary for patients on all wards. All seclusion rooms allowed clear observation and two-way communication, and had toilet facilities and a clock to orientate patients to the time of day.

Lowry ward shared the seclusion room facilities of Collingwood ward which was on the floor below. This meant that staff and patients used the lift or stairs to transfer between floors to access seclusion. This process involved the use of several staff members engaged in restraint. Staff had a clear understanding of how to support this process including how to clear the areas between the ward and seclusion room to promote the privacy and dignity of patients, however the trust did not have a clear protocol for staff to follow to ensure that this process was carried out safely

### Clinic room and equipment

All wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly. Longview, Shoredrift and Springrise wards had separate clinic rooms for medicines and for physical health checks.

Staff maintained the clinic room equipment well and kept it clean on all wards. However, on Shoredrift ward we found that the weekly cleaning records for medical equipment had not been completed in over a month.

## Safe staffing

### Nursing staff

Managers had calculated the number and grade of nurses and healthcare assistants required. All wards had a three shift pattern. All wards had two qualified nurses on duty during the day and one qualified nurse on duty at night. There was always at least one qualified nurse on each ward at all times.

Ward managers could adjust the staffing levels to respond to increases in ward acuity and activity levels. The trust had a ‘staff pool’ system which could be accessed by the wards. This was comprised of staff who were employed to cover set shifts but could be deployed to any ward in the trust where there was a need. Staff employed as part of the ‘staff pool’ received the same mandatory training as regular staff. Ward managers could also access additional staffing through the use of bank and agency staff.

All wards used an induction checklist to ensure that staff who were new to the ward were familiarised with the ward. On Embleton the ward manager had modified the induction checklist to provide new staff with a more in-depth tour of the ward, including potential ligature anchor points. Similarly on Fellside, new staff on the ward from the staff bank needed to complete a ward induction before starting their shift.

During the inspection we observed that nursing staff spent the majority of their time in the communal areas or engaged in one to one interactions with patients. Staff told us this was the expectation of the trust’s engagement and observation policy. Care records provided evidence that patients received regular one to ones with nursing staff. Staff told us it was rare to cancel leave, although it could be rescheduled to take into account ward activity. Staff told us that facilitating leave was regarded as a ward priority. Occupational therapists and occupational therapy assistants were not included in nursing numbers which meant that ward activities were rarely cancelled due to staffing levels. Patients told us that they were usually able to access leave and activities.

All staff including managers told us that there were enough staff to carry out physical interventions such as restraint and seclusion. The wards at the Hopewood Park (Beckfield, Longview, Springrise and Shoredrift) and St. George’s Park (Alnmouth, Embleton and Warkworth) had a ‘response team’ which could attend if there was a need for additional staff to support physical interventions. Staff were positive about the responsiveness of the response team. During the inspection we saw that the response team responded quickly when alarms were activated.

**Definition**

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

| Substantive staff figures | | | Trust target |
|---|---|---|---|
| Total number of substantive staff | At 31 December 2017 | 273.6 | N/A |
| Total number of substantive staff leavers | 1 January 2017 – 31 December 2017 | 10.3 | N/A |
| Average WTE* leavers over 12 months (%) | 1 January 2017 – 31 December 2017 | 3.6% | N/A |
| **Vacancies and sickness** | | | |
| Total vacancies overall (excluding seconded staff) | At 31 December 2017 | 26.4 | N/A |
| Total vacancies overall (%) | At 31 December 2017 | 8.7% | N/A |
| Total permanent staff sickness overall (%) | Most recent month (At December 2017) | 6% | 5% |
| | 1 January 2017 – 31 December 2017 | 7% | 5% |
| **Establishment and vacancy (nurses and care assistants)** | | | |
| Establishment levels qualified nurses (WTE*) | At 31 December 2017 | 154 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 December 2017 | 147 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 December 2017 | 15.5 | N/A |
| Number of WTE vacancies nursing assistants | At 31 December 2017 | 12 | N/A |
| Qualified nurse vacancy rate | At 31 December 2017 | 10% | N/A |
| Nursing assistant vacancy rate | At 31 December 2017 | 8.1% | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 January 2017 – 31 December 2017 | 1,963 (8.8%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 198 (0.9%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 6,412 (23.0%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 3,214 (12.4%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 569 (2%) | N/A |

*Whole-time Equivalent

This core service has reported a vacancy rate for all staff of 8.7% as of 31 December 2017. This was similar to the rate reported at the last inspection (between 1 April 2015 and 26 April 2016).

This core service reported an overall vacancy rate of 9.4% for registered nurses at 31 December 2017. This was lower than the 16.6% reported at the last inspection.

This core service reported an overall vacancy rate of 8.2% for registered nursing assistants. This was higher than the 2.6% reported at the last inspection.

| | Registered nurses | | | Health care assistants | | | Overall staff figures | | |
|---|---|---|---|---|---|---|---|---|---|
| **Ward/Team** | **Vacancies** | **Establishment** | **Vacancy rate (%)** | **Vacancies** | **Establishment** | **Vacancy rate (%)** | **Vacancies** | **Establishment** | **Vacancy rate (%)** |
| **Alnmouth** | 2 | 13 | 15.4% | 0 | 11 | 0% | 2 | 24 | 15.4% |
| **Beckfield** | 5 | 18 | 27.8% | 4 | 33 | 12% | 7.9 | 51 | 39.8% |
| **Collingwood** | 1.3 | 14 | 9.4% | 1 | 12 | 8.3% | 2.3 | 26 | 17.8% |
| **Embleton** | 2.7 | 14 | 19.3% | 07 | 12 | 5.7% | 3.4 | 26 | 25% |
| **Fellside** | 1.4 | 14 | 9.7% | 0.4 | 12 | 3.3% | 1.8 | 26 | 13% |
| **Lamsley** | 0 | 13 | 0% | 0 | 11 | 0% | 0 | 24 | 0% |
| **Longview** | 1 | 13 | 7.7% | 0.5 | 10 | 5% | 1.5 | 24 | 12.7% |
| **Lowry** | -1.3 | 13 | -10.1% | 1.6 | 11 | 14.3% | 0.3 | 24 | 4.2% |
| **Shoredrift** | 2 | 14 | 14.3% | 1.7 | 11 | 15.5% | 3.7 | 26 | 29.7% |
| **Springrise** | 0.4 | 14 | 2.9% | 0.5 | 12 | 4.2% | 0.9 | 26 | 7% |
| **Warkworth** | 1 | 14 | 7.1% | 1.6 | 12 | 13.7% | 2.6 | 26 | 20.8% |
| **Core service total** | 14.5 | 154 | 9.4% | 12 | 147 | 8.2% | 26.4 | 303 | 8.7% |
| **Trust total** | **152.1** | **1,844.4** | **8.2%** | **67** | **1,379** | **4.9%** | **200.4** | **3,969.6** | **5%** |

NB: All figures displayed are whole-time equivalents

Between 1 January 2017 and 31 December 2017, bank staff filled 8.9% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered no shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Alnmouth** | 1802 | 356 | 0 | 22 |
| **Beckfield** | 2477 | 602 | 0 | 59 |
| **Collingwood** | 2019 | 45 | 0 | 7 |
| **Embleton** | 2099 | 184 | 0 | 7 |
| **Fellside** | 1773 | 23 | 0 | 10 |
| **Lamesley** | 1915 | 27 | 0 | 7 |
| **Longview** | 2044 | 262 | 0 | 37 |
| **Lowry** | 1992 | 43 | 0 | 12 |
| **Shoredrift** | 2099 | 181 | 0 | 8 |
| **Springrise** | 2112 | 148 | 0 | 11 |
| **Warkworth** | 1777 | 92 | 0 | 18 |
| **Core service total** | 22,109 | 1,963 (8.9%*) | 0 (0%*) | 198 (0.9%*) |
| **Trust Total** | **94,128** | **6,843** | **5** | **567** |

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| | | **(7.3%)** | **(0.01%)** | **(0.6%)** |

***Percentage of total shifts

Between 1 January 2017 and 31 December 2017, 23% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 10% of shifts. Two percent of shifts were unable to be filled by either bank or agency staff.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| Alnmouth | 1834 | 387 | 250 | 45 |
| Beckfield | 6078 | 1660 | 370 | 159 |
| Collingwood | 2648 | 596 | 272 | 45 |
| Embleton | 2664 | 784 | 437 | 30 |
| Fellside | 2553 | 557 | 285 | 37 |
| Lamesley | 1910 | 343 | 102 | 32 |
| Longview | 2234 | 662 | 398 | 95 |
| Lowry | 2330 | 464 | 819 | 29 |
| Shoredrift | 1657 | 233 | 97 | 25 |
| Springrise | 1907 | 394 | 114 | 18 |
| Warkworth | 2010 | 332 | 70 | 54 |
| **Core service total** | 27,825 | 6,412 (23%*) | 3,214(11.6%*) | 569 (2%*) |
| **Trust Total** | 163,943 | 32,064 (19.4%) | 7,043 (4.3%) | 2,449 (1.5%) |

***** Percentage of total shifts

This core service had 10.3 (3.7%) staff leavers between 1 January 2017 and 31 December 2017. This was lower than the 10% reported at the last inspection (from 1 April 2015 to 26 April 2016).

| Ward/Team | Substantive staff | Substantive staff Leavers | Average % staff leavers |
|---|---|---|---|
| **Lamesley** | 22 | 3 | 12.6% |
| **Alnmouth** | 22 | 2 | 9.7% |
| **Beckfield** | 43.6 | 2 | 4.5% |
| **Longview** | 22.5 | 1 | 4.4% |
| **Fellside** | 24.2 | 1 | 4.1% |
| **Springrise** | 24.1 | 1 | 4% |
| **Embleton** | 22.6 | 0.3 | 1.4% |
| **Collingwood** | 23.7 | 0 | 0% |
| **Lowry** | 23.7 | 0 | 0% |
| **Shoredrift** | 21.8 | 0 | 0% |
| **Warkworth** | 23.4 | 0 | 0% |
| **Core service total** | 273.6 | 10.3 | 3.7% |
| **Trust Total** | **3,696.2** | **252.1** | **6.8%** |

The sickness rate for this core service was 7% between 1 January 2017 and 31 December 2017. The most recent month's data (December 2017) showed a sickness rate of 5.9%. This was higher than the sickness rate of 2.3% reported at the last inspection in April 2016.

| Ward/Team | Total % staff sickness (at latest month) | Ave % permanent staff sickness (over the past year) |
|---|---|---|
| **Alnmouth** | 7.2% | 5% |
| **Beckfield** | 7.0% | 9.2% |
| **Collingwood** | 7.8% | 6.4% |
| **Embleton** | 0.7% | 6.1% |
| **Fellside** | 3.6% | 7.2% |
| **Lamesley** | 10.5% | 9.2% |
| **Longview** | 1.7% | 4.7% |
| **Lowry** | 0.7% | 6.5% |
| **Shoredrift** | 9.0% | 4.3% |
| **Springrise** | 12.6% | 10.1% |
| **Warkworth** | 3.4% | 6.4% |
| **Core service total** | 5.9% | 7.0% |
| **Trust Total** | **6.7%** | **6.3%** |

The below table covers staff fill rates for registered nurses and care staff during December 2017, November 2017 and October 2017.

Shoredrift ward had less than 90% of the planned registered nurses for all day shifts reported.

Key:

| > 125% | < 90% |
|---|---|

| | Day | | Night | | Day | | Night | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff |
| | December 2017 | | | | November 2017 | | | | October 2017 | | | |
| **Alnmouth** | 91% | **177%** | 100% | 116% | 124% | **166%** | 100% | **149%** | 104% | **144%** | 106% | 118% |
| **Beckfield** | 109% | **168%** | 100% | **143%** | 99.6% | **187%** | **141%** | **151%** | 102% | 115% | 108% | **152%** |
| **Collingwood** | **90%** | **140%** | 107% | **167%** | 110% | **180%** | 110% | **231%** | **80%** | **207%** | 106% | **269%** |
| **Embleton** | **90%** | **155%** | 105% | **122%** | 90.5% | **155%** | 104% | 110% | **77%** | **183%** | 104% | **144%** |
| **Fellside** | **71%** | **213%** | 100% | **188%** | 92.7% | **203%** | 100% | **185%** | **77%** | **162%** | 103% | **165%** |
| **Lamesley** | 94 | **128%** | 105% | **122%** | **130%** | 108% | 105% | 108% | 97% | 119% | 108% | 114% |
| **Longview** | **84%** | **175%** | **148%** | 95% | 90.9% | **194%** | **140%** | 102% | **83%** | **191%** | 113% | **152%** |
| **Lowry** | 107% | **130%** | 110% | **158%** | 108% | **183%** | 107% | **239%** | 111% | **194%** | 114% | **232%** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Shoredrift** | **77%** | **145%** | 100% | 100% | **85.1%** | **163%** | 122% | 108% | **88%** | **147%** | **137%** | **87.7%** |
| **Springrise** | **70%** | **167%** | **133%** | 102% | 92.7% | **149%** | 102% | 113% | 96% | **135%** | 100% | 106% |
| **Warkworth** | 107% | **124%** | 100% | 118% | 115% | 93% | 104% | 119% | **87%** | **127%** | 104% | **130%** |

## Medical staff

Between 1 January 2017 and 31 December 2017, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 5% of shifts. Seven percent of shifts were unable to be filled by either bank or agency staff.

Staff told us that permanent medical cover was an ongoing issue for the service. Doctors told us that the service faced difficulties recruiting consultant psychiatrists on permanent contracts which meant that the service frequently relied on agency staff to provide cover. This impacted on the continuity of care and junior doctors told us that this meant they sometimes felt unsupported.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| Alnmonth | 1,115.5 | 0 | 46.6 | 99.5 |
| Beckfield | 1,249.6 | 0 | 57.4 | 105.5 |
| Collingwood | 873,9 | 0 | 70.2 | 39.6 |
| Embleton | 1,077.9 | 0 | 44.4 | 96.8 |
| Fellside | 400.9 | 0 | 43.4 | 5.5 |
| Lamesley | 577.8 | 0 | 53.4 | 18.2 |
| Longview | 1,071.6 | 0 | 48.9 | 90.9 |
| Lowry | 844 | 0 | 68.5 | 37.4 |
| Shoredrift | 1,072.3 | 0 | 48.9 | 91 |
| Springrise | 1,072.4 | 0 | 48.9 | 91 |
| Warkworth | 1,115.6 | 0 | 46.6 | 99.5 |
| **Core service total** | 10,471.6 | 0 (0%*) | 507.1 (4.8%*) | 774.9 (7.4%*) |
| **Trust Total** | 71,731.9 | 0 (0%) | 5,599.5 (8.4%) | 3,437.5 (4.8%) |

***** Percentage of total shifts

## Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 85%. Of the training courses listed three failed to achieve the trust target and of those, two failed to score above 75%.

The training compliance reported for this core service during this inspection was lower than the 92% reported at the last inspection.

Key:

| Below CQC 75% | Between 75% & trust target | **Trust target and above** |
|---|---|---|

| Training course | This core service % | Trust target % | Trustwide mandatory/ statutory training total % |
|---|---|---|---|
| Moving and Handling | 99% | 85% | 96% |
| Health and Safety (Slips, Trips and Falls) | 94% | 85% | 94% |

| | | | |
|---|---|---|---|
| Infection Prevention (Level 1) | 94% | 85% | 95% |
| Safeguarding Adults (Level 1) | 91% | 85% | 94% |
| Information Governance | 90% | 85% | 90% |
| Safeguarding Children (Level 1) | 90% | 85% | 94% |
| Safeguarding Children (Level 2) | 90% | 85% | 94% |
| Fire Safety | 88% | 85% | 90% |
| Medicine Management Training | 76% | 85% | 84% |
| Resuscitation | 72% | 85% | 80% |
| Mental Health Act | 66% | 85% | 80% |
| Core Service Total % | 85% | 85% | 90% |

At the time of inspection compliance rates for resuscitation training and Mental Health Act training had improved although neither had reached the trust's target for mandatory training. The compliance rates for resuscitation training and Mental Health Act training were 82% and 76% respectively.

Staff had a clear understanding of their personal mandatory training compliance. They could access personal dashboards which provided up to date information on their current compliance and early warning of courses which were shortly due to fall out of compliance. Managers had access to dashboards which detailed their team's compliance rates. Managers told us that mandatory training was a key performance indicator which was regularly reviewed.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

We reviewed 64 care records. Staff completed a risk assessment for every patient on admission and updated it regularly, including after any incident. Care records showed that staff updated risk assessments. The trust used the Functional Analysis of the Care Environment risk assessment which is a nationally recognised risk assessment tool.

### Management of patient risk

On most wards we saw that staff were aware of, and dealt with, specific risks issues such as risks posed by ongoing physical health conditions. On Warkworth ward we found that staff were not appropriately managing one patient's risk of choking whilst eating and drinking. This was identified in the patient's risk assessment. However the management plan did not provide staff with clear instructions on how to manage the risk. Staff were not completing food and fluid monitoring charts which was also part of the patient's risk management plan. We raised this with the ward manager on the day of inspection who undertook immediate action. The ward manager briefed all staff on the importance of the care plan and ensured that the correct monitoring was commenced.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Observation levels were determined by individual risk assessment. There were four levels of observations ranging from arms-length observations to general observations at pertinent points in each shift where engagement would naturally occur (handover, meal times and medication rounds). Staff documented these observations in line with the trust's revised policy.

We identified restrictive practices on the wards which were blanket restrictions. On most wards patients were not allowed to have a key to their own bedrooms. All wards apart from Lamesley

had a designated ‘chill out’ room. On three wards this was kept locked. Staff told us that this was due to the ligature risk of some items in the room and to prevent patients taking items from the room. On Beckfield, all patients used plastic crockery and cutlery at mealtimes. On a number of wards patients could only access plastic cups for hot drinks. Not all wards had identified these as potentially blanket restrictions. The trust provided evidence that blanket restrictions were assessed using a restrictive practices audit tool. This tool was completed for Collingwood in January 2018 and noted that there were blanket restrictions in relation to patients accessing their own bedroom keys. These restrictions were still in place in April 2018 during the inspection.

Staff and patients told us that the trust’s smoke-free policy was an ongoing issue. Patients were offered smoking cessation including nicotine replacement therapy. On most wards staff told us that they did not feel supported to challenge patients found smoking in the ward gardens, and the smoke-free policy was one of the main causes of incidents on the ward. Smoking related incidents were monitored by the trust-wide smoke free group led by the Nursing and Chief Operating Officer.

### Use of restrictive interventions

This core service had 1,054 incidents of restraint (on 356 different service users) and 518 incidents of seclusion between 1 January 2017 and 31 December 2017.

The below table focuses on the last 12 months’ worth of data: 1 January 2017 and 31 December 2017.

| Ward name | Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| Alnmouth | 16 | 91 | 39 | 29 (32%) | 46 (51%) |
| Beckfield | 146 | 181 | 44 | 46 (25%) | 51 (28%) |
| Collingwood | 27 | 60 | 15 | 15 (25%) | 13 (22%) |
| Embleton | 49 | 83 | 33 | 28 (34%) | 45 (54%) |
| Fellside | 52 | 68 | 34 | 21 (31%) | 10 (15%) |
| Lamesley | 32 | 65 | 37 | 19 (29%) | 30 (46%) |
| Longview | 26 | 83 | 28 | 22 (27%) | 31 (37%) |
| Lowry | 25 | 171 | 40 | 61 (36%) | 71 (42%) |
| Shoredrift | 53 | 140 | 34 | 51 (36%) | 82 (59%) |
| Springrise | 54 | 59 | 24 | 22 (37%) | 7 (12%) |
| Warkworth | 38 | 53 | 28 | 19 (36%) | 21 (40%) |
| **Core service total** | 518 | 1,054 | 356 | 333 (32%) | 407 (39%) |

The percentage of incidents of prone restraint to total incidents of restraint had decreased since the last inspection. In the six months prior to the last inspection 42% of the incidents of restraint included the use of prone restraint. In the twelve months prior to this inspection, there were 333 incidents of prone restraint which accounted for 32% of the restraint incidents. Staff told us that the use of prone restraint was usually to support the use of intramuscular rapid tranquilisation and that the patient would be turned to face-up restraint as soon as possible after the administration of rapid tranquilisation. The use of prone restraint for intramuscular injection was a requirement of the trust’s ‘Positive and Safe: Recognition, Prevention and Management of Violence and Aggression Policy’.

We reviewed 13 incidents where rapid tranquilisation was used. We found on eight of these occasions staff had not completed physical health observations following the use of rapid tranquilisation or recorded in the notes why physical health observations could not be completed.

There were 14 instances of mechanical restraint over the reporting period. During the inspection we undertook in-depth reviews of two incidents of mechanical restraint. In both cases mechanical restraint was used only after de-escalation and other interventions had failed, and used to support the emergency transfer of patients to seclusion. This was clearly evidenced in the patient record. Staff had obtained agreement from the trust's senior management team before using mechanical restraint. In both cases staff had followed the trust's 'Positive and Safe, Recognition, Prevention and Management of Violence and Aggression (PMVA) Practice Guidance Note: Safe Use of Mechanical Restraint Equipment – V03'.

Over the 12 months, there were 518 incidents of seclusion, with 28% (146) reported by Beckfield which was the trust's psychiatric intensive care unit. We reviewed 22 records of seclusion. Staff kept records for seclusion in an appropriate manner. Staff completed necessary observations and reviews of seclusion in line with the Mental Health Act Code of Practice. Most (19 of 22) seclusion records included a seclusion care plan.

There were three instances of long term segregation over the 12 month reporting period. However there were no patients subject to long term segregation at the time of the inspection.

## Safeguarding

Staff were trained in safeguarding and knew how and when to make a safeguarding alert. Staff had good awareness of safeguarding procedures and could give practical examples of safeguarding patients. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 165 safeguarding referrals between 1 January 2017 and 31 December 2017, of which 128 concerned adults and 37 children.

The number of safeguarding referrals reported during this inspection was higher than the 24 reported at the last inspection.

| Referrals | | |
|---|---|---|
| **Adults** | **Children** | **Total referrals** |
| **128** | 37 | 165 |

Staff followed safe procedures for children visiting the ward. On all wards, a visitors' room was located in the ward entrances. This meant that children could visit patients admitted to each ward without needing to go on to the ward itself.

Northumberland Tyne and Wear NHS Foundation Trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 January 2017 and 31 December 2017) that relate to this core service.

## Staff access to essential information

Staff used an electronic patient record system. All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. The trust's electronic patient record system was used by all wards and community mental health teams which meant that staff had access to historic information about patients known to community services prior to their inpatient admission. On all wards staff also maintained a paper 'support file' which contained paper copies of referrals, correspondence and Mental Health Act documentation. This information was also scanned into the electronic patient record system.

The electronic patient record system was accessible to trust staff including bank staff and staff working as part of the 'staff pool'. The system was not accessible to agency staff. This meant that trust staff were required to update patient records on behalf of agency staff. Agency staff received essential information needed to care for patients in the ward handovers.

## Medicines management

Staff followed good practice in medicines management and did it in line with national guidance. All wards had an electronic automated system to support the administration of medication. This system stored medication at the required temperatures. All wards had regular input from pharmacists and pharmacy technicians. Pharmacists attended the wards' multidisciplinary daily reviews.

Staff monitored the effects of medication on patients' physical health. Hopewood Park (Beckfield, Longview, Spingrise and Shoredrift) and St George's Park (Alnmouth, Embleton and Warkworth) had access to an on-site physical health team or ward based physical health practitioners.

On all wards, patients received a full physical health assessment by the junior doctor or physical health team at the point of admission or soon afterwards. On all wards with the exception of Lowry and Collingwood, there were weekly or fortnightly physical health clinics in which all patients were offered ongoing physical health checks. On Lowry and Collingwood patients received physical health checks if there was an identified need. Staff completed additional physical health monitoring including blood tests and electrocardiogram checks in cases where a patient was prescribed high-dose antipsychotic medication. This is in line with national guidance.

## Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there was one STEIS incident reported by this core service, which was an incident of 'Apparent/actual/suspected self-inflicted harm meeting SI criteria'.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection was lower than the six reported at the last inspection.

| | Number of incidents reported |
|---|---|
| **Type of incident reported on STEIS** | **Core Service Total** |
| **Apparent/actual/suspected self-inflicted harm meeting SI criteria** | 2 |
| **Total** | **2** |

## Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Northumberland, Tyne and Wear NHS Foundation Trust.

All staff knew how to report incidents and the types of incidents which needed to be reported. The trust used an electronic system to support staff to report incidents. All incidents were reviewed by the band six nurses and ward managers. Ward managers were required to sign off all incidents which included adding additional details for any immediate post-incident action taken.

Staff told us that they regularly received a debrief following incidents, although this was not consistently recorded. At Hopewood Park staff had introduced a new system where a senior nurse was allocated to support both staff and patients to debrief following an incident.

Staff received feedback from investigations of incidents including where incidents had taken place on other wards within the service. During the inspection we spoke with staff who had made medication errors in the past who told us that they had been well supported by the pharmacists and ward managers to learn from the incidents. The trust had a central alerting system which cascaded patient safety alerts and lessons learnt from incidents to ward teams. Senior managers met to discuss incidents in a monthly 'lessons learnt' forum. These were attended by all ward managers. Information from these forums was then cascaded to ward teams through monthly team meetings.

As part of the trust's 'Talk-First' initiative, staff were provided with quality dashboards which allowed them to see the themes and trends of incidents on the ward. The dashboards allowed staff to break down incidents to see themes such as the most common time of day or day of the week for incidents to occur. Staff analysed incident trend data and responded with actions such as ward activities and protected time for staff to engage with patients to reduce the number of incident 'hotspots'. Managers on all wards showed consistent enthusiasm for the Talk First initiative and its role in an overall reduction in incidents.

Ward managers and clinical staff had a good understanding of the duty of candour. Staff were aware of the principles of being open and honest following an incident or a mistake. Not all staff

included in the principle of apologising following a mistake in their description of the duty of candour. Staff told us that the principles of being open and honest was part of the trust values.

# Is the service effective?

## Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. All patients received a physical health assessment as part of the admissions process. This was completed by the junior doctor who completed the trust's 'core physical health monitoring record' for each patient.

Staff developed care plans that met the needs identified during the comprehensive assessment. All patients received an initial care plan which was designed to meet basic needs for the first 72 hours of admission. Patients and carers were invited to a '72-hour meeting' involving members of the multidisciplinary team including the admitting consultant and nursing staff. This meeting allowed a more detailed goal-orientated care plan to be produced in conjunction with patients and carers. The meeting also allowed staff to start planning for the patient's eventual discharge.

We reviewed 64 care records and found that most care records included a detailed care plan. In cases where a care plan was less detailed, this was because the patient was newly admitted to the service within the last 72 hours. Care plans were reviewed regularly and updated when necessary.

The level of personalisation within care plans differed between wards. On Collingwood, Embleton, and Shoredrift we found that all 15 care records reviewed had good evidence of personalisation and patient involvement. Staff had recorded discussions with patients and there were examples where staff had used patient quotations within care plans. On other wards we found that the personalisation of care plans was less consistent and was often more limited. However, within progress notes we found examples on all wards of good patient involvement and interaction. Staff regularly discussed care with patients in one to one sessions and recorded these in progress notes. Managers told us that the service had recognised to improve the personalisation of care plans and reflect the level of patient involvement and interaction which was actually taking place on the wards.

## Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Staff had access to a variety of nationally recognised rating scales to record severity and outcomes. These included the Addenbrooke Cognitive Examination, the Beck's Depression Inventory, the Hospital Anxiety and Depression scale, and the Model of Human Occupation Screening tool.

Patients on all wards could access both group and individual psychology sessions. Psychologists also attended multidisciplinary team meetings to provide psychological input. We saw that group psychology sessions such as the 'managing emotions' groups were well-attended by patients. All wards had good access to activities including those designed to support patients with daily living skills, delivered by a number of occupational therapists, occupational therapy assistants and technical instructors. The service also employed exercise therapists who delivered a bespoke

exercise programme both on and off the wards for all patients. A number of patients told us how much they valued the exercise therapists.

The four wards at Hopewood Park (Beckfield, Longview, Springrise and Shoredrift) had access to an occupational therapy programme which was unique within the service and was an example of good practice. As well as a fully equipped gym, patients could access an on-site vocational garden which allowed patients to participate in gardening and woodwork activities. The occupational therapy department had introduced a 'social inclusion programme' which was designed to support patients to access services and activities in the community. Examples of activities included a gardening project at a local church and model making as part of preparation for Sunderland's 2018 Tall Ships Race. The social inclusion programme was celebrated in a national magazine in January 2018 as an example of work which both improved patient wellbeing and reduced the social stigma of mental ill-health.

This core service participated in 22 clinical audits as part of their clinical audit programme 2017.

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **CA-16-0047: Nutrition** | Trustwide | Acute wards for adults of working age and psychiatric intensive care units/ Long stay / rehabilitation mental health wards for working age adults / wards for people with learning disabilities or autism / wards for older people with mental health problems / forensic inpatient / secure wards / child & adolescent mental health wards | Clinical | 15.02.17 | Improved liaison with medical colleagues re consulting with Dietetic Services when considering prescribing nutritional supplements. Auditors fedback to Dietitians and ward managers in areas where screening requires improvement. CNM's asked to follow-up to ensure improvements take place e.g. complete spot checks within their service area. |
| **CA – 16 – 0045: Topic 7e: Monitoring of patient prescribed lithium** | Trustwide | Trustwide Inpatient Wards | Clinical | 18 October 2017 | Some areas of non-compliance identified including: Calcium monitoring is less established in routine practice. Monitoring of weight/BMI during maintenance treatment needs to improve. This is incorporated into all guidance and standard work. |
| **CQA-16-0037: Medicines Management: Safe and Secure** | Trustwide | Trustwide – All inpatient wards | Clinical | 21 June 2017 | 1. Annual MMRA audits downgraded to Trust level priority plan for 2017/2018 rather than Board Assurance plan. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **Medicines Handling (MMRA)** | | | | | 2. Results of the annual 2016/2017 MMRA report shared with the CQCQCG to aid learning.<br><br>3. Process introduction of Temperature Monitoring Sheet kept by the medicines refrigerator, using the Min/Max thermometer.<br><br>4. Risk assessments and audits reported monthly to Pharmacy Managers Group. Escalation to MMC where necessary.<br><br>5. UHM-PGN-01 Safe and Secure Medicines Handling and Supply of Medicines incorporated additional guidance to ward staff on completing and returning the annual Medicines Management Risk Assessment.<br><br>6. SSMH monitoring tool incorporates additional questions, which provide assurance that legally valid Patient Group Directions are being used correctly. |
| **CQ-17-0001: Medicines Management: Prescribing administration and prescribing clinical standards Take 5 Audit** | Inpatient Units | Trustwide – all inpatient units | Clinical | 17 May 2017 | Process changes:<br>1. Data collection and analysis of results from 'Take 5' drug administration and prescribing audits should be conducted by nursing and medical staff, respectively, using the electronic form developed and piloted through CQCQCG.<br><br>2. Audit results now fed back to individual Ward and Service Managers at the time when the audit results are compiled.<br><br>3. Medical, nursing and pharmacy staff now review local audit results with Ward Managers and prescribers to identify themes and learned lessons.<br><br>4. Medical staff now receive a regular feedback of prescribing audit results.<br><br>5. Any red/amber ratings are now discussed and mitigating actions to rectify put in place.<br><br>6. Lead Clinicians and Lead Clinical Pharmacists jointly investigate areas of concern / poor performance. |
| **CA-15-0092: NICE (implementation_ CG103: Audit of clinical practice against Quality Delirium Standards** | Trustwide | Community based MH services for older people<br><br>Acute wards for adults of working age and psychiatric | Clinical | 18 October 2017 | Results disseminated by Group Business Meetings (dates arranged) and cascaded down to CBUs, CMTs and Wards. Providing details on observations that are being completed consistently and emphasise the need for ward staff to be completing measures in cognitive impairment, pain, constipation and nutrition, and to note a |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | intensive care units<br>Wards for older people with MH problems | | | summary of the recordings in the first 24 hours on RiO.<br>Liaison with IT/RiO to put measures (CAM and PINCHE ME) onto RiO and embed into future e-pathways.<br>Tailored care intervention checklist to be constructed around PINCH ME and training providing when introduced to ward staff to improve practice and implemented on all 3 sites.<br>The reviewed delirium information leaflet added to the standard 72-hour meeting pack. Leaflets can also to be put on the intranet and internet. GP delirium leaflet to be included with discharge summary letters to GPs.<br>Delirium status during admission to be stated on all discharge summaries for patients in Older Person's Inpatient Services. Where positive, include the GP delirium leaflet in with the discharge summary as standard. |
| **CA-16-0005: Awareness into the definitions of nature and degree of a mental disorder, as explained in the Mental Health Act 1983: Code of Practice** | (IPCG) | Acute wards for adults of working age and psychotic intensive care unit | Clinical | 14 February 2017 | Presented findings in the Local Post Graduate Teaching Programme (28.07.16)<br>Disseminated findings to the local consultant body through Lead Consultant / Clinical Director. |
| **CA-16-0067: A re-audit of prolactin measurements taken during inpatient admissions** | IPG-Adult | Acute wards for adults of working age and psychiatric intensive care units. | Clinical | 14 February 2017 | Further education on appropriate monitoring of prolactin given via presentation to consultant and junior medical staff.<br>At a glance guideline on physical health monitoring and appropriate bloods to be taken on admission posted in SHO room.<br>Specific guidelines on management of hyperprolactinaemia with flow chart of recommended actions. |
| **CA-14-0100: Prolactin levels monitoring in patients receiving anti psychotics** | South Inpatient | Acute wards for adults of working age and psychiatric intensive care units | Clinical | 11 July 2017 | Trust development of a guidance note regarding Hyperprolactinaemia in liaison with the Pharmacy Department. |
| **CA-15-0121: NICE NO205 Clinical Audit on use of ECT as a quality monitoring tool** | Central inpatient | Acute wards for adults of working age and psychiatric intensive care units | Clinical | 9 May 2017 | ECT nursing staff ensure all patients' prescribing teams receive an ECT discharge letter and that compliance to the guidelines stipulated within this are adhered to. Patient notes to be reviewed at dated intervals, post treatment, to assess this. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | ECT staff contact appropriate care co-ordinators to provide dates for the completion of MMSE post treatment.<br><br>ECT staff ensure that all sections of the ECT RiO pathway are completed appropriately by prescribing teams. We can ensure this is achieved by completing the pre-ECT checklist for each patient.<br><br>Advice and encouragement regularly given to prescribing teams when work up documentation is being completed, during the work up process. |
| **CA-16-0025: NICE NG10: Are we adhering to NICE guidance surrounding management of violence & aggression in patients in seclusion in PICU at Hopewood park** | South Inpatient | Acute wards for adults of working age and psychiatric intensive care units | Clinical | 12 September 2017 | Beckfield medical team informed of the findings by email and a meeting arranged.<br><br>A coherent plan produced for all staff to follow.<br><br>Beckfield clinical ward manager informed of the results, discussion on these results held.<br><br>Ward Manager highlighted the post-incident debrief template on the shared drive to all ward nursing staff.<br><br>Clinical ward manager reviewed the possibility of a post-incident template to be put in Rio progress notes, similar to the template for during seclusion.<br><br>Ward Manager advised all nursing staff of the need for completing the rapid tranquilisation monitoring chart when rapid tranquilisation is given. |
| **CA-16-0049: CG178:ECG monitoring and recording practice ono acute admission service (Re-audit CA-15-0034)** | Central inpatient | Acute wards for adults of working age and psychiatric intensive care unit | Clinical | 9 May 2017 | Addition of column on board to remind staff of outstanding ECGs. Addition of tool in drug Kardex file to identify patients for whom ECG needs to be prioritised.<br><br>Induction information given to SHOs to include advice to record ECG findings on notes and discharge documentation. Poster made for SHO office to act as reminder. |
| **CA-16-0054: Assessment of Compliance with Standards of Physical Health Monitoring: Pregnancy as a crucial aspect of Physical Health Monitoring amongst Women of Reproductive Age Group (15-44) in an In Patient** | Central inpatient | Acute wards for adults of working age and psychiatric intensive care unit | Clinical | 13 June 2017 | Further meeting with nursing staff, pharmacy and medical team on how to improve compliance in terms of providing and documenting pregnancy tests.<br><br>All females of a reproductive age that are admitted to Alnmouth ward at St George's hospital are tested and document in the patient's physical health record on RiO.<br><br>Orientation/Reorientation/Induction for staff. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **Psychiatry Setting** | | | | | |
| **CA-16-0055: Assessment of Capacity in Informal Admission to WAA Inpatient wards at St Georges Park Hospital (Re-audit of CA-15-0080)** | North Inpatient | Acute wards for adults of working age and psychiatric intensive care unit | Clinical | 27 November 2017 | Findings of this audit shared with hospital managers.<br>Findings discussed in local consultant's meeting.<br>Further education as part of junior doctor induction programme.<br>Educational events focusing of implication of MCA on psychiatric inpatient wards.<br>Review of capacity for informal admission and review of quality of documentation at 72 hour review. |
| **CA-16-0073: Audit on the management of diabetes and hypoglycaemia** | Medicines Management | Trustwide Inpatient Wards | Clinical | 3 May 2017 | Policy author of PPT-PGN-02 presented with the findings of this audit and review undertaken by MMC as to the scope of the policy.<br>MMC Newsletter incorporated an article reminding prescribers of the importance of prescribing dextrose and glucagon on the 'as required' side of the Kardex in patients receiving insulin.<br>Physical Health and Wellbeing group received the findings of this audit and established who is appropriate to manage the action. |
| **CA-16-0091: Re-audit: Assessment of Compliance with Standards of Physical Health Monitoring: Pregnancy as a crucial aspect of Physical Health Monitoring amongst Women of Reproductive Age Group (15-44) in an In Patient Psychiatry Setting** | Central Inpatient | Acute wards for adults of working age and psychiatric intensive care units | Clinical | 12 September 2017 | Nursing staff, pharmacy and medical team met on how to improve compliance in terms of providing and documenting pregnancy tests.<br>Developed a checklist for ward staff with named nurse to aid communication.<br>Inclusion of requisite information on orientation, induction for staff February 2018. Junior Doctors (GP and Core Trainees, Trust grade /LAS/F2) to be encouraged to start testing from<br>Ward Consultants to supervise from February 2018. |
| **LLCA-99-0001: A review of inpatient PRN prescribing in a Mental Health Trust** | Medicines Management | Trustwide inpatient wards | Clinical | 17 August 2017 | There is now clarity on process and responsibilities for staff in relation to the review of `as required` medication. There are improved controls in place for the safety of the patient. Review Box was added to Kardex to prompt review of PRN medication once so many administrations had been given, to avoid situations where medication was being over used, should be regularly prescribed or the condition |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | was deteriorating and not getting addressed e.g. pain killers. |
| **LLCA-17-0014: Retrospective audit of police disclosure requests and follow up in acute adult inpatient ward Embleton** | North Inpatient Services CBU | Acute ward for adults of working age and psychiatric intensive care units | Clinical | 30 August 2017 | Awareness raised with MDT team members about police disclosures and Trust MAPPA policy, and handover to community teams about police disclosure follow ups. |
| **LLCA-17-0016: ECG Monitoring & Recording Practice on Acute Admission Service (Re-audit of CA-16-0049).** | Central inpatient CBU | Acute wards for adults of working age and psychiatric intensive care units | Clinical | 31 August 2017 | Continuated the blanket policy of ECGs for all new admissions.<br>Agreement received for physical treatment team to continue to attend ward to perform ECGs.<br>Physical treatment team inform SHOs if they are unable to attend the ward.<br>Educational poster and leaflet for patients designed and implemented.<br>Poster displayed on the ward and information leaflet in welcome packs advising the rationale for ECG and physical health monitoring and prompting to discuss with staff if they have not had one. Admission checklist displayed on the board in the SHO room, including the need for ECG, bloods, enquiry of cardiac risk factors<br>Documentation of ECG included in the following formats: i) discharge letter - essential and then one of the following, ideally both: ii) progress notes iii) Physical health monitoring documents.<br>ECG monitoring policy and Abnormal QTc guidelines displayed on the wall of the SHO room. Agreement for SNHs to re-record patients in the physical treatment diary once mental state has improved. Continued impact to be re-audit by future trainees, manage by Dr Louise Golightly. |
| **CA-16-0079: Audit of Transition between Inpatient and Community Services** | Inpatient/Community | Community-based mental health services for older people / Community-based mental health services for adults of working age / Acute wards for adults of working age and psychiatric intensive care units / Wards for | Clinical | 20.09.17 | Added to the admission checklist, who is invited to the 72 hour meetings and record it on RiO.<br><br>Adult inpatient wards in Northumberland are trialling skype from May to July 2017.<br><br>E-mail sent to all team managers to remind staff of the need to record frequency of care co-ordinator contact whilst patient is an in-patient. Care Co-ordinator to create an individual care Plan. Team Managers to monitor through supervision.<br><br>Frequency of contact agreed now on the Care Co-ordination Review form at the 72 hour meeting. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | older people with mental health problems | | | Produced a briefing sheet outlining expectations including:-<br>1. Need for physical health checks, diagnosis screen and medication screen and mental state to be updated by in-patient staff as part of the discharge process.<br>2. Need to communicate in writing and if possible by telephone to GP, if patient is being discharged, has complex issues and is being discharged on the CTO – e-mail from RN 10/09/2015.<br><br>Standard method introduced of recording the named Community Consultant in the discharge planning meeting on the care co-ordination review form and the discharge summary. |
| **CA-17-0004: Seclusion 16-17** | Trustwide | Wards for adults of working age and psychiatric intensive care units / Long stay / Rehabilitation mental health wards for working age adult / Wards for older people with mental health problems / Forensic inpatient / secure wards / All reported seclusions within inpatients wards for 2016-2017 | Clinical | 20.09.17 | Internal CAS Safety Alert for information and action was circulated on behalf of the Seclusion Steering Group. CAS reminded staff to contact the doctor immediately following the initiation of seclusion and of the importance of completing physical health monitoring following IM medication; including recording the reasons why observations cannot be completed, in particular respirations. |
| **(CA-15-0052: NICE (Implementation CG78: Emotionally Unstable Personality Disorder** | Trustwide | Wards for adults of working age and psychiatric intensive care units / Long stay / Rehabilitation mental health wards for working age adult | Clinical | 15.03.17 | Develop use of screening tools within community services and use of PD Pathway Guidance.<br>Recording of 5P's formulation on Rio, as a minimum.<br>Increased scaffolding checks of diagnosis and formulation on admission.<br>Greater use of PD Pathway Guidance and CRS PGN on PD & co-morbid conditions.<br>More discussion and recording of purpose of admission and goals with |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | / Wards for older people with mental health problems / Forensic inpatient / secure wards Diagnosis of 'definite' or 'probable' diagnosis for EUPD across all inpatient services | | | service user.<br>Recording of links to risk management plans on Rio. Discussion and recording of service user choices on Rio.<br>Roll out of Structured Clinical Management Training in Community Services.<br>Identification of critical indicators for admission, for example, risk management, assessment, specific treatment intervention and clarity about the factors that will confirm that identified goals have been met.<br>Mutually agreed meaningful contact arrangements with care co-ordinator during admission to facilitate timely discharge planning.<br>Continuation of psychological work by community clinical psychologist /psychological therapist on discharge, in collaboration with Community MDT.<br>Improved assessment of self-harm via roll out of SCM training and clinical risk training in community services.<br>Improved assessment of self-harm via roll out of bespoke SCM (or other PD awareness) training and clinical risk training in inpatient services to ensure continuity of care during admission.<br>Explicit self-harm management plan that addresses the need for positive risk taking to be mutually agreed as part of discharge plan.<br>Discussion with service users about the purpose of eyesight observations and any changes to observation levels and their responsibilities during this.<br>Principles of service user responsibility for their safety management to be reinforced via care planning process in community services.<br>Community services MDT and allocated Care coordinators to jointly agree critical indicators for admission and review milestones that will indicate goals have been met. Community MDT and Care coordinator to agree. |
| **CA-16-0062: Controlled Drugs Audit** | (Medicines Management) | Trustwide | Clinical | 03.05.17 | Pharmacy staff undertaking quarterly CD balance checks and annual CD Audits.<br><br>Review of completion of quarterly CD balance checks and escalation to Pharmacy Managers Group where outstanding.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter.<br><br>Pharmacy staff liaised with the Registrant in Charge at the time of CD balance check and review the currency |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | of the authorised signatory list for nursing staff.<br><br>Registrant in Charge reviewed the authorised signatory list and return a signed copy to pharmacy within 28 days.<br><br>UHM-PGN-04 Controlled Drugs, section 11.8 amended to incorporate this requirement.<br><br>Audit tool for Omnicell cabinets had question five removed for the 17/18 audit cycle.<br><br>Question seven of the Omnicell audit tool amended to include further guidance to pharmacy staff to check manual CD orders only for the 17/18 audit cycle.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter. |

Patients had good access to physical healthcare. During the inspection we saw that patients were supported to access services in local acute hospitals including specialist clinics. Care records showed that patients were referred to physical healthcare specialists when there was a recognised need, for example specialist diabetes nurses, dieticians and physiotherapists. Staff on most wards assessed and met patients' needs for food and drink and for specialist nutrition and hydration when there was a recognised need. However on Warkworth we identified that staff were not following a specific care plan for nutrition and hydration for one patient who had an identified risk in relation to eating and drinking. This was raised with the ward manager on the day of inspection who took action to ensure that staff followed the patient's care plan.

## Skilled staff to deliver care

On all wards the multidisciplinary team included a full range of specialists and professionals required to meet the needs of all patients, including consultant psychiatrists, junior doctors, nurses, nursing assistants, occupational therapists, occupational therapy assistants, peer support workers, psychologists, psychology assistants and technical instructors. All trust employed staff were required to undertake the trust's induction for new starters as well as a local ward-based induction process.

Staff had access to additional specialist training to support them in their roles. On a number of wards staff had completed additional training in family therapy to better support families and carers during a patient's admission.

The trust's target rate for appraisal compliance was 85%. As at 31 December 2017, the overall appraisal rates for non-medical staff within this core service was 79%. The wards/teams failing to achieve the trust's appraisal target were Springrise ward with an appraisal rate of 56% and Lamesley ward at 68%. Appraisal rate compliance had improved by the time of inspection for these wards. Lamesley's compliance rate was 82%. Springrise's compliance rate was 92%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 88% reported at the last inspection.

| Ward name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Shoredrift** | 22 | 22 | 100% |
| **Longview** | 23 | 22 | 96% |
| **Collingwood** | 24 | 22 | 92% |
| **Warkworth** | 24 | 21 | 88% |
| **Lowry** | 24 | 20 | 83% |
| **Alnmouth** | 22 | 17 | 77% |
| **Beckfield** | 45 | 34 | 76% |
| **Fellside** | 25 | 18 | 72% |
| **Embleton** | 24 | 17 | 71% |
| **Lamesley** | 22 | 15 | 68% |
| **Springrise** | 25 | 14 | 56% |
| **Core service total** | **280** | **222** | **79%** |
| **Trust wide** | **3922** | **3228** | 82% |

The trust did not provide appraisal data for medical staff for this core service in their submission of data before the inspection.

The trust informed us that a clinical supervision target rate is not specified in their policy. Staff consistently told us that there was a service expectation for all staff to receive supervision on a monthly basis and they received supervision in line with this expectation. Between 1 January 2017 and 31 December 2017 the average rate across all eleven teams in this core service was 86% for non-medical staff. Supervision records on most wards showed that staff received regularly supervision. Alnmouth, Collingwood, Embleton and Lowry ward all exceeded a 100% clinical supervision rate. Supervision rates exceeded 100% in situations where staff had received supervision more frequently than monthly.

Supervision rates had improved on the three wards identified as having significantly low compliance with supervision during 2017 by the time of the inspection. Year to date figures (January to March 2018) for Beckfield, Fellside and Springrise were 85%, 67% and 106% respectively.

Clinical supervision for medical staff has not been broken down by core service. The trust has informed us “As per Royal College of Psychiatry requirements, our medical staff all engage in a process of peer supervision, which occurs at least 4 times a year within their peer group. Clinical work and performance, along with peer supervision notes, are also reviewed annually, through the appraisal process, and ultimately the GMC revalidation process every five years. The trust medical appraisal rates are shown above as a proxy for clinical supervision.

**Caveat**: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it is important to understand the data they provide. The rate of clinical supervision reported during this inspection was lower than the 92% reported at the last inspection.

| Ward name | Clinical supervision sessions required | Clinical supervision sessions delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Collingwood** | 213 | 281 | 132% |
| **Embleton** | 208 | 267 | 128% |
| **Lowry** | 214 | 236 | 110% |
| **Alnmouth** | 148 | 161 | 109% |
| **Warkworth** | 219 | 198 | 90% |
| **Longview** | 219 | 179 | 82% |
| **Lamesley** | 205 | 155 | 76% |
| **Shoredrift** | 278 | 198 | 71% |
| **Beckfield** | 221 | 133 | 60% |
| **Springrise** | 162 | 90 | 56% |
| **Fellside** | 214 | 99 | 46% |
| **Core service total** | **2,558** | **1,997** | **86%** |
| **Trust Total** | **29957** | **26917** | **90%** |

## Multi-disciplinary and inter-agency team work

Staff on all wards held regular and effective multidisciplinary team meetings. In place of a weekly ward round, staff held ‘daily reviews’. These were led by the consultant psychiatrist and ensured that all patients were reviewed regularly. We observed five daily reviews and saw that the meetings were well-led and well-attended.

Staff shared information about patients at effective handover meetings within the team. All wards had a three shift structure of early, late and night shifts. There were three handovers per day on all wards. We observed three handovers and saw that handovers were effective, covered all patients on the wards in sufficient detail and showed that staff had a good understanding of all patients. Handovers covered patients’ observation levels, risk levels, activity levels, medication changes, food and fluids, and discharge plans.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation. Staff working in the community mental health teams were regularly invited to the 72-hour meeting as part of the admissions process. Managers told us that they recognised staff working in the community mental health teams faced their own pressures and that attending the 72-hour meetings in person was sometimes difficult. To support this, the service had put in place teleconference facilities to allow community mental health staff to dial into the meetings and participate remotely.

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

As of 31 December 2017, 66% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. However, at the time of the inspection, compliance with this training was 76%. The training compliance reported during this inspection

was lower than the 89% reported at the last inspection. Despite the lower compliance with training, we found that staff had a good awareness of the Mental Health Act including a knowledge of the sections of the Act, the Code of Practice and the guiding principles.

We reviewed the detention paperwork of 66 patients. Mental Health documentation was stored appropriately and was completed correctly.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The wards at Hopewood Park (Beckfield, Longview, Spingrise and Shoredrift) and St. George's Park (Alnmouth, Embleton and Warkworth) had access to an on-site Mental Health Act administrator's office. Administrative support was off-site for the other wards although this had no impact on how staff were supported in the implementation of the Act.

The trust had a policy to support staff in the implementation of the Mental Health Act. Staff were aware of the policy. The wards had a copy of the Mental Health Act Code of Practice available.

Care records showed that patients received an explanation of their rights on a regular basis. Patients on all wards had access to an independent advocacy service. All wards had posters to advise informal patients on their right to leave the ward freely.

## Good practice in applying the Mental Capacity Act

As of 31 December 2017, 67% of the workforce in this core service had received training in the Mental Capacity Act. However, at the time of the inspection, compliance with this training was 76%. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. The majority of staff we interviewed had a good understanding of the Mental Capacity Act including the guiding principles. Staff told us that they assumed capacity unless they had a reason to doubt it, and were able to give examples of how they would respond in situations where a patient's capacity was questioned.

The trust had a policy to support staff in the implementation of the Mental Capacity Act. We found that staff were not consistently completing the relevant Mental Capacity Act sections of the electronic patient record. Staff instead relied on progress notes to document capacity assessments and associated best interest decisions. This meant that it was difficult for staff to find documentation to demonstrate that staff were following good practice in applying the Mental Capacity Act in situations where restrictive care plans were in place. Staff were able to demonstrate examples of capacity assessments and associated best interest decisions in progress notes and noted that the use of progress notes made these difficult to find.

We also found a restrictive care plan was in place for one patient in relation to mobile phone use without a capacity assessment or best interest decision. This was raised with the ward manager on the day of inspection and following a capacity assessment the restrictive care plan was discontinued.

We did not see evidence of systems in place on the wards to monitor compliance with the Mental Capacity Act.

The trust told us that one Deprivation of Liberty Safeguard (DoLS) application was made to the local authority for this core service between 1 January 2017 and 31 December 2017.

The number of DoLS applications made during this inspection was lower than the 72 reported at the last inspection.

| | Number of DoLS applications made by month | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **Total** |
| **Applications made** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Applications approved** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

During this inspection we spoke with 47 patients and 12 carers. Patients and carers were consistently positive about staff attitudes and behaviours. Patients told us that staff were kind, respectful and available when needed. The consistent theme of patient feedback was that staff in the service respected patients as individuals.

The service ensured that staff spent as much time as possible on the wards. Staff had 'protected time' for engagement where they were expected to be on the wards in communal areas or in one to ones with nursing staff. The majority of patients told us that they regularly received a one to one with nursing staff.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. At Hopewood Park the occupational therapy team had introduced a new social inclusion initiative which was a weekly timetable designed to involve patients in activities in the local community. Occupational therapists were able to work with patients following discharge by providing up to six sessions supporting patients to access services in the community.

All staff were confident that they could raise concerns about disrespectful, abusive or discriminatory behaviour towards patients without fear of negative consequences. Staff had a clear understanding of whistleblowing. Most staff knew about the trust's Freedom to Speak Up Guardian. Staff consistently told us that although they were aware of the process for how to raise concerns, none had felt the need to do so.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at three core service location(s) scored higher than similar organisations.

The campus for ageing & vitality scored lower when compared to other similar trusts for privacy, dignity and wellbeing with 85.2%.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Hopewood park** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety | 94.1% |
| **St Georges Hospital, Morpeth** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/Rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety<br>Wards for older people with mental health problems | 93.3% |
| **Campus for Ageing & Vitality** | Acute wards for adults of working age and psychiatric intensive care units<br>Wards for older people with mental health problems | 85.2% |
| **Trust overall** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/rehabilitation wards for adults of working age | **95.8%** |

| | | |
|---|---|---|
| | Mental health crisis services and health based places of safety | |
| **England average (mental health and learning disabilities)** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/Rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety<br>Wards for older people with mental health problems | **90.6%** |

## Involvement in care

### Involvement of patients

All wards had a clear admissions process to inform and orientate patients to the wards and to the service. Where possible, patients would be welcomed to the ward using the visitors' room and would be introduced to key staff including the patient's named nurse. On Springrise staff had introduced a ward map in patients' bedrooms to orientate patients to key areas on the ward.

Ward managers consistently told us that evidencing patient involvement in care plans was a recognised area for improvement. Care records showed patient involvement within progress notes and notes from one to one sessions with nursing staff. On Collingwood, Embleton and Shoredrift we found care plans were consistently personalised. Staff had recorded discussions with patients and there were examples where staff had used patient quotations within care plans. However, on some wards care plans were mostly written using medical and nursing terminology and there was limited evidence that staff had adapted the language within care plans to make them more personalised and accessible.

All wards had an advocacy service which visited regularly. All patients were offered the support of the advocacy service. If a patient was deemed to lack the capacity to decide whether to request this support, then staff would automatically refer the patient to the advocate.

As part of the trust's Talk First initiative staff had introduced regular 'mutual support meetings'. Talk First was a trustwide initiative which aimed to reduce the need for restrictive interventions including physical restraint. These meetings allowed patients the opportunity to provide feedback about the ward. We attended three mutual help meetings. The meetings were chaired by occupational therapy staff and were well-attended. At one meeting we saw that patients were asked to provide suggestions for new ward activities. Each meeting finished with a challenge of the week which was a fun activity such as juggling, designed to break down barriers between staff and patients.

### Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff told us that involving families and carers was a priority during a patient's admission, providing the patient consented to this. Families were invited to the service's '72-hour meetings'. This was a meeting with the responsible clinician and other members of the multidisciplinary team agreed the goals of the admission.

Carers told us that they felt informed and involved in the care being provided by the service. Staff provided carers with information about how to access a carer's assessment.

# Is the service responsive?

## Access and discharge

### Bed management

During the inspection each ward we visited was operating either at, or above, capacity. Admissions to the wards were managed by the trust's bed management team which was separate to the ward teams. Staff told us that they did not have the option to refuse an admission unless there was an emergency need such as a number of highly acutely unwell patients already being managed on the ward. Patients were routinely admitted to 'leave beds', which are beds left vacant by patients on agreed leave from the wards who were planned to return at a designated time. This was managed by the bed management team who rated leave beds according to risk using a red, amber, green rating scale. Patients who were early into their admission and taking their first leaves from the ward would have their bed rated as red which meant that the service would not admit another patient to this bed. Patients nearing discharge who had a full discharge package in place would have a green rating on their bed which meant that the service could admit another patient to this bed.

Patients were not routinely transferred between wards unless it was in the interest of the patient. Staff told us that, where possible, the service would ensure that patients were 'repatriated' to their local area if they were admitted out of their local ward's catchment area; for example a Sunderland resident admitted to the wards in Northumberland would be transferred as soon as possible to the wards in Sunderland.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. During the inspection we saw examples where staff were supporting patients to access services in acute hospitals for physical healthcare needs. On most wards staff told us that accessing the psychiatric intensive care unit was difficult and that often the wards were expected to manage acutely unwell patients without transfer to the psychiatric intensive care unit.

The trust provided information regarding average bed occupancies for the 11 wards in this core service between 1 January 2017 and 31 December 2017. All of the wards reported average bed occupancies ranging above the national recommended benchmark of 85% over this period.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

| Ward name | Average bed occupancy range (1 January 2017 – 31 December 2017) |
|---|---|
| **Collingwood Court** | 93.8-100 |
| **Lowry** | 87.5 – 106.3 |
| **Alnmouth** | 78.9 – 110.5 |
| **Warkworth** | 84.2 – 105.3 |
| **Embleton** | 84.2 – 110.5 |
| **Springrise** | 94.4 – 105.6 |
| **Longview** | 94.4 – 105.6 |
| **Beckfield** | 57.1 – 92.9 |
| **Lamesley** | 83.3 – 105.6 |

| | |
|---|---|
| **Fellside** | 90 – 105 |
| **Shoredrift** | 88.9 – 105.6 |

The trust provided information for average length of stay for the period 1 January 2017 to 31 December 2017.

On Beckfield there was one patient whose average length of stay significantly exceeded the average for the service. Staff were aware of this and were involved in discussions with services to provide a more appropriate placement.

| Ward name | Average length of stay range (1 January 2017 – 31 December 2017) (current inspection) |
|---|---|
| **Collingwood Court** | 13-110 |
| **Lowry** | 11-60 |
| **Alnmouth** | 8-41 |
| **Warkworth** | 20-46 |
| **Embleton** | 16-64 |
| **Springrise** | 18-65 |
| **Longview** | 21-62 |
| **Beckfield** | 8-1120 |
| **Lamesley** | 17-65 |
| **Fellside** | 19-83 |
| **Shoredrift** | 20-56 |

This core service reported 62 out of area placements between 1 January 2017 and 31 December 2017. There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 123 days.

Thirty-two out of 62 out of area placements were due to placing the patient with another care provider due to this better suiting their care or personal needs, while 30 placements were because of capacity issues.

The number of out of area placements reported during this inspection was higher than the 19 reported at the time of the last inspection (1 November to 30 April 2016).

| Number of out of area placements | Number due to specialist needs | Number due to capacity | Range of lengths (completed placements) | Number of ongoing placements |
|---|---|---|---|---|
| **62** | 32 | 30 | 1-39 | 0 |

This core service reported 151 readmissions within 28 days between 1 January 2017 and 31 December 2017. Sixty-four of the readmissions (42%) were readmissions to the same ward as discharge.

The average of days between discharge and readmission was 38 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were five instances where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 November 2015 to 30 April 2016, there were 158 readmissions within 28 days.

**Caveat**: There are three cases listed where the number of days between discharge and readmission is greater than 28 days. The longest was 3122 days (03/03/2009 to 18/09/2017), the second 543 days (24/08/2015 to 16/02/2017) and the final one 331 days (30/08/2016 to 26/07/2017).

| Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|
| **151** | 64 | 42 | 1 - 3122 | 38 |

### Discharge and transfers of care

Between 1 January 2017 and 31 December 2017, there were 1590 discharges within this core service. This amounts to 65% of the total discharges from the trust overall (2462). Of the 1590 discharges for this core service, eight (less than 1%) were delayed.

Managers consistently told us that the most common reason for a delayed discharge was difficulties in sourcing accommodation through social care services. Senior managers and ward managers were due to meet social care services shortly after the inspection to address this.

## Facilities that promote comfort, dignity and privacy

On all wards patients had their own bedrooms and were not expected to sleep in bays or dormitories. Patients could personalise their bedrooms and were able to bring additional items such as televisions for their rooms. Staff ensured that patient's own electrical equipment was tested appropriately to ensure it was safe. Patients had access to safes in their bedrooms to store their possessions securely. There were also larger locker spaces on the wards for patients to store items securely.

Most wards had a range of rooms and equipment to support treatment and care. The ward facilities at St. George's Park and Hopewood Park were particularly of high quality and offered patients a number of treatment rooms, lounges and other spaces. All wards with the exception of Lamesley had a designated chill-out room with equipment designed to support patients to relax. On Lamesley the chill-out had been repurposed into a patient lounge with a television. Patients could access gym facilities which were supervised by qualified exercise therapists and experienced technical instructors. The exercise therapy team were also able to provide sessions on wards for patients who did not have agreed Section 17 leave.

Patients could access the internet on all wards. St. George's Park (Alnmouth, Embleton and Warkworth wards) had Wi-Fi access which could be accessed via patients' own mobile phones and tablet devices. All other wards had computers which could be accessed by patients. At Hopewood Park (Beckfield, Longview, Spingrise and Shoredrift wards) we saw that the electronic patient record system could be used to give patients individualised access to the internet. Access to the internet was determined by individual risk assessment and could be granted at different

levels which determined which websites could and could not be accessed by a patient's account. The system allowed levels to be changed on an up to daily basis if necessary.

There was a beverage bay available for patients to make hot drinks. All wards had a designated visitors' room which was located within the airlock entrance to the ward. On most wards there was a separate room where patients could make a private phone call. On Lowry and Collingwood there was a patient accessible ward phone which could be moved between rooms for patients to make a private phone call.

The wards at St George's Park (Alnmouth, Embleton and Warkworth) and Hopewood Park (Beckfield, Longview, Spingrise and Shoredrift) were located on the ground floor and had good access to outside space. At Queen Elizabeth Hospital (Fellside and Lamesley) and the Campus for Ageing and Vitality (Collingwood and Lowry), the wards were located above the ground floor which meant that access to outside space was restricted. Patients on these four wards and their carers gave mostly neutral or negative feedback about the ward environments and told us that the wards were dated and needed redecorating. The trust had recognised the limitations of the ward environments in both locations and was in the process of implementing a plan to relocate the wards to more suitable sites.

Most patients told us they were happy with the food provided by the trust. The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts. St George's Hospital (Alnmouth, Embleton and Warkworth) scored lower when compared to other similar trusts for ward food with 88.6%.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Hopewood park** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety | 99.5% |
| **St Georges Hospital, Morpeth** | Acute wards for adults of working age and psychiatric intensive care units<br>Long stay/Rehabilitation wards for adults of working age<br>Mental health crisis services and health based places of safety<br>Wards for older people with mental health problems | 88.6% |
| **Campus for Ageing & Vitality** | Acute wards for adults of working age and psychiatric intensive care units<br>Wards for older people with mental health problems | 99.2% |
| **Trust overall** | | **94.8%** |
| **England average (mental health and learning disabilities)** | | **91.5%** |

## Patients' engagement with the wider community

On all wards the majority of patients were detained under the Mental Health Act. Staff supported patients to engage with the wider community through Section 17 leave. Most patients told us that they could access leave as planned. Carers told us that leave arrangements usually went ahead as planned. Care records showed that within the service there was a strong focus on patients accessing regular Section 17 leave.

Staff supported patients to continue to access education and work opportunities when appropriate. We saw patients had leave arrangements which allowed them to continue to attend university and further education courses.

Carers were encouraged to be active partners in the service. All carers told us that they felt sufficiently informed and involved in the care being delivered by the service. Carers were invited to the initial 72-hour meeting which set the goals for a patient's admission.

## Meeting the needs of all people who use the service

The wards had different levels of accessibility for patients with a physical disability. All wards had accessible bathrooms. All wards with the exception of Lowry and Collingwood were located on the ground floor and had good accessibility for patients with a physical disability. The managers of Lowry and Collingwood told us that the service recognised that these wards were not wholly accessible and that this would be a consideration during the admissions process. Patients who had accessibility needs would not normally be admitted to these wards.

There were information posters and leaflets available on all wards. Staff had access to an interpreter service and translation service for patients whose first language was not English. We saw examples of these being used to care for patients who were admitted at the time of inspection.

There was a good choice of food available on all wards. Both staff and patients told us that the food was of good quality. The service could access foods to cater for specific dietary, cultural and religious needs.

The trust had a chaplaincy service which covered all wards. Patients with appropriate Section 17 leave could access spiritual and religious support including services in the community.

## Listening to and learning from concerns and complaints

Complaints posters and leaflets were prominently displayed on all wards. Staff told us that they encouraged patients to make complaints and would try to solve complaints informally. Patients were aware of how to make a complaint. Most carers told us that they would speak to the nursing team if they wanted to make a complaint.

We saw evidence of staff acting upon patients' complaints. Formal complaints were responded to in line with the trust's complaints policy which included the allocation of an investigating officer. Complaints were reviewed by ward managers and senior managers in the monthly lessons learnt forums or clinical management team meetings. Meeting minutes showed that complainants were kept informed of the outcomes of complaint investigations.

This core service received 71 complaints between 1 January 2017 and 31 December 2017. Three of these were upheld, 13 were partially upheld and 23 were not upheld. No formal complaints were referred to the Ombudsman. In addition to these, 19 complaints were withdrawn, eight were still awaiting investigation, four were unable to be investigated and one complaint had the decision not to investigate.

The number of either partially or fully upheld complaints reported during this was higher than the 13 reported at the last inspection.

| Total Complaints | Fully upheld | Partially upheld | Not upheld | Referred to Ombudsman | Upheld by Ombudsman |
|---|---|---|---|---|---|
| 71 | 3 | 13 | 23 | 0 | 0 |

This core service received 31 compliments during the last 12 months from 1 January 2017 to 31 December 2017, which accounted for 8% of all compliments received by the trust as a whole.

# Is the service well led?

## Leadership

The service was led by a stable management team with managers at all levels who had the skills, knowledge and experience to perform their roles. Ward managers had a clear understanding of the services they managed. Ward managers were highly visible in the service and were approachable for patients and staff. Most ward staff recognised senior managers such as clinical nurse managers and told us that they visited the wards often. A number of staff told us that the trust's chief executive was well-known and had visited the wards.

Leadership development opportunities were available, including opportunities for staff below ward manager level. In two cases the ward manager position was being filled by newly appointed qualified staff who were acting up into the role. Both managers told us that they had been encouraged by their line managers to apply for the role when it became available.

## Vision and strategy

The trust values were caring and compassionate, honest and transparent, and respectful. On all wards we found that staff knew and understood the trust's vision and values and how they were applied in the work of their team. Trust values were used in recruitment and in annual appraisals. Within annual appraisals, staff were required to comment and evidence how they were continuing to work within the trust values. A number of staff told us that the trust values were well known because they reflected the minimum that should be expected from good staff working in healthcare.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff working at Queen Elizabeth Hospital and Campus for Ageing and Vitality were aware of the trust's long term ambition to move premises to improve ward environments and facilities. Senior managers told us that this process was being managed in consultation with ward staff. This consultation had resulted in amendments to the planned transfer of services to try to meet staff needs.

Senior managers told us that the service faced financial pressures in common with similar services in other NHS trusts.

## Culture

Almost all staff we spoke with told us that they felt respected, supported and valued. Feedback from staff of all grades and professions told us that they felt part of a team and that their opinion was treated with equal respect. Across all wards we found that staff were upbeat and positive about working for the trust. A number of staff we spoke with told us that they had been with the trust for a number of years.

Staff had a good understanding of the concept of whistleblowing and knew the trust's processes for raising concerns. The trust had a whistleblowing policy to support staff to raise concerns. Staff at St George's Park and Hopewood Park consistently showed a good awareness of role of the trust's Freedom to Speak Up Guardian.

Ward managers were confident in their ability to manage staff performance including poor performance. The trust had a human resources department to support ward managers to manage poor performance. Ward managers had completed additional training in human resources.

## Governance

The service had good systems and processes in place to assess and monitor quality and safety on the wards. All staff had access to performance dashboards which allowed them to have oversight of key performance indicators including mandatory training compliance, staff sickness rates and annual appraisal rates. Managers consistently showed a high level of ability and willingness to interact and interrogate the dashboards. The trust's Talk First initiative was supported through additional performance dashboards which provided staff teams with more in-depth information on incidents.

Since the last inspection the trust had adopted a locality based operational structure. The eleven wards were managed within three localities. Each locality had a clinical nurse manager who was the senior manager above ward manager level. There was a clear framework of what needed to be discussed within each locality's management team meetings. Meeting minutes showed that ward managers and clinical nurse managers met regularly to discuss key areas of performance including; complaints, estates, incidents, risk registers, and safeguarding.

There was a senior management team of associate directors above the clinical nurse managers. The associate directors had good oversight of the service including the key challenges faced by the service. Associate directors told us that the key challenge faced by the service was recruitment of qualified nursing staff in line with a national shortage of qualified nurses. The service was actively recruiting to vacancies through ongoing recruitment programmes.

Staff undertook or participated in local clinical audits. There were regular audits in key areas such as clinical equipment, medication, infection control and Mental Health Act documentation.

## Management of risk, issues and performance

Ward managers maintained a risk register at ward level. Staff at ward level could escalate concerns when required. Risk registers were reviewed at least monthly on all wards. Staff used risk registers to monitor environmental and other risks faced by the service.

The trust has provided a document detailing their 12 highest profile risks. None related to this core service. Ward risk registers consistently matched staff concerns including bed management pressures and issues implementing the trust's no smoking policy.

The service had planned for emergency situations through business continuity plans.

## Information management

The trust had a number of automated systems in place to capture and monitor performance data. The systems were not overly burdensome for frontline staff although ward managers told us that there was usually a delay for mandatory training compliance figures to update after staff had attended courses. Clinical supervision compliance rates were not collected through an automated system. In response to the inspection ward managers had manually calculated compliance rates based on the number of sessions planned and delivered.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Information systems ensured the confidentiality of patient records. Patient records could only be accessed via the electronic patient record system which was password protected. Staff were required to undertake information governance training as part of their induction and as an annual refresher. Compliance with information governance training was above the trust target of 85%.

## Engagement

Staff had access to up-to-date information about the work of the trust through the trust's intranet. Patients and carers could access information about the trust through the trust's website. Patients and carers could provide feedback for the service through the Family and Friends Test. The Family and Friends Test is a national survey tool which asks people whether they would recommend a service they have used. Associate directors told us that the results of the Family and Friends Test was monitored on the service's performance dashboards.

Senior managers regularly engaged with staff through 'speak-easy' events. These were meetings based on wards where staff could access senior managers to provide feedback about the service. Staff told us that senior managers were visible and approachable. We saw that clinical nurse managers had high visibility on the wards.

## Learning, continuous improvement and innovation

The trust had an annual awards ceremony which recognised individual staff and team achievements. The nominations programme was open for the 2018 Staff Excellence Awards at the time of inspection. Embleton ward received an award in May 2017 from the Northumbria Police, which recognised the good work of staff in safely managing a serious incident on the ward which had resulted in police involvement.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation. All wards with the exception of Alnmouth ward had achieved accreditation for working age adult admission wards or psychiatric intensive care units.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **AIMS – WA (Working age adults)** | Collingwood court, Campus for Ageing and Vitality | Accredited to March 2019 |
| | Embleton Ward, St George's Park | Accredited to April 2018 |
| | Fellside Ward, Tranwell Unit | Accredited to July 2018 (Excellent) |
| | Lamesley Ward, Tranwell Unit | Accredited to June 2019 |
| | Longview Ward, Hopewood Park | Accredited to June 2019 |
| | Lowry Ward, Campus for Ageing and Vitality | Accredited to June 2019 |

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| AIMS – PICU (Psychiatric Intensive Care Units) | Shoredrift, Hopewood Park | Accredited to June 2019 |
| | Springrise, Hopewood Park | Accredited to January 2018 (Excellent) |
| | Warkworth, St George's Park | Accredited to February 2019 |
| | Beckfield, Hopewood Park Full Monty | Accredited to March 2019 |
| | Springrise, Hopewood Park, Full Monty | Embleton, St George's Park – Awaiting decision |
| | Beckfield, Hopewood Park Full Monty | Alnmouth, St George's Park, Benchmarking documentation |
| Star Wards | Longview, Hopewood Park Full Monty | Fellside ward, Tranwell Unit, benchmarking complete, application ready to submit |
| | Shoredrift, Hopewood Park | Lamesley Ward, Tranwell Unit, benchmarking complete, application ready to submit |
| | Collingwood court, Campus for Ageing and Vitality – Full Monty | |
| | Lowry Ward, Campus for Ageing and Vitality – Full Monty | |

# Child and adolescent mental health wards

## Facts and data about this service

Northumberland, Tyne and Wear NHS Foundation Trust provides specialist assessment and treatment for children and young people who have severe and complex mental health conditions, learning disabilities and autism that require treatment in hospital. These types of services are also referred to as tier 4 services.

At our previous inspection in June 2016, at Alnwood in St Nicholas Hospital, there was a ward called Wilton. At this inspection, we found that the beds on this ward had been decommissioned and only staff accessed this space.

The trust has seven child and adolescent mental health wards based at Ferndene in Prudhoe and St Nicholas Hospital in Gosforth, Newcastle. The wards are listed in the table below:

| Location site name | Ward name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| Ferndene | Fraser | 12 | Mixed |
| Ferndene | Redburn | 10 | Mixed |
| St Nicholas Hospital | Ashby | 9 | Mixed |
| Ferndene | Stephenson | 8 | Mixed |
| St Nicholas Hospital | Lennox | 7 | Mixed |
| Ferndene | Riding | 6 | Mixed |
| Ferndene | Ferndene PICU | 4 | Mixed |

**Alnwood at St Nicholas Hospital**

Lennox

Lennox is a seven-bed ward providing assessment and treatment to children and young people within a medium secure environment. The ward accepts patients aged between 12 and 18 with complex mild to moderate learning disabilities.

Ashby

Ashby is a nine-bed unit providing assessment and treatment to children and young people within a medium secure environment. The ward accepts patients aged between 12 and 18 with complex mental health problems.

**Ferndene**

Redburn

Redburn is a 10-bed unit providing comprehensive assessment and treatment for patients under the age of 18 with early onset psychosis and complex mental health disorders.

Ferndene PICU

Ferndene PICU is a four bed psychiatric intensive care unit that supports young people in an acute phase of their illness. It is a locked environment providing a safe, low stimulus environment for young people to receive care and treatment. PICU works predominantly with young people experiencing acute mental illness but can also support young people with a learning disability if required, for short term admission and stabilisation.

Riding

Riding is a six-bed ward providing comprehensive assessment and treatment for patients aged 4 to 18 years of age. Four to 12 year olds with mild to moderate learning disabilities and 13 to 18 year olds with moderate to severe learning disabilities.

Fraser

Fraser is a 12-bed ward providing comprehensive assessment and treatment for patients aged between 12 and 18 years with mental health and developmental needs, mild to moderate learning disabilities.

Stephenson

Stephenson is an eight bed low secure ward providing comprehensive assessment and treatment for patients aged between 14 and 18 years with mild to moderate learning disability and requirement for high levels of supervision in a safe environment.

# Is the service safe?

## Safe and clean care environments

### Safety of the ward layout

Ward managers and the patient safety team completed an annual clinical environmental risk assessment. This included identification of potential ligature anchor points. A ligature anchor point is something that someone could use for the purpose of hanging or strangulation.

The trust submitted copies of the clinical environmental risk assessments. All of the risk assessments contained ward specific data on trends and types of incidents extracted from the trust's Talk First system. The trust completed risk assessments for the wards at Ferndene in July 2017 and the wards at Alnwood in January 2018. The trust had followed external recommendations and lessons learnt from serious case reviews from other trusts and had embedded these into the environmental risk assessments. This widened the scope of their assessments and ensured they assessed dynamic risks across the services.

Staff identified some small areas of work required to reduce risk within the care environments. This included ensuring that smoke detectors and light sensors were vandal proofed and light seals were replaced. The trust had clear action plans for this work to be completed. Fraser and Riding wards had blinds with a pull cord and Stephenson ward had a window in the lounge with a standard handle. These could be used as potential ligature anchor points. However, these were identified on environmental risk assessments and staff told us that they mitigated risk through observation.

Staff maintained observation of wards areas to ensure that patients were safe. Where wards had blind spots, these were mitigated by the use of mirrors, closed circuit television and staff presence.

Guidance on eliminating mixed-sex accommodation does not apply to wards for children and young people. All of the wards provided care and treatment to both male and female patients. In response to individual patient risk, staff applied observation levels to ensure that any risks presented by or towards patients was mitigated. Patients also had access to a mobile nurse call pager system to call for staff assistance if this was required.

Staff and patients had easy access to alarms and nurse call systems. On arrival on shift, reception staff issued staff and visitors with alarms. On each shift, staff were designated responders if an alert for assistance was activated. We saw that staff responded quickly when this occurred. Patients had access to a nurse call system. On Reburn ward, we also saw a pager was in use for one patient so that they could alert staff for assistance if they were not near a nurse call point.

### Maintenance, cleanliness and infection control

Ward areas were clean, had good furnishings and were well-maintained. Domestic staff ensured that regular cleaning took place and recorded this on schedules when completed. Stephenson ward did not have many wall pictures and appeared barer than the other wards. Staff told us that they had already identified this and were in the process of addressing this. Staff practiced effective hand hygiene principles and the wards had anti-bacterial hand gels available.

For the most recent Patient-Led Assessments of the Care Environment assessment (2017) the locations scored better than the similar trusts for three of the four aspects overall and similar to other trusts for one.

St Nicholas Hospital location scored below similar trusts for the disability aspect of the care environment. Ashby and Lennox wards based at St Nicholas Hospital were on the second and third floors of the Alnwood building. There was lift access to these wards for anyone with reduced mobility.
The table below shows the Patient-Led Assessment of the Care Environments scores:

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Ferndene** | Child and adolescent mental health wards | 98.41% | 97.84% | - | 98.21% |
| **St Nicholas Hospital, Gosforth** | Child and adolescent mental health wards, forensic / secure wards, long stay / rehab wards, crisis & health based places of safety | 99.92% | 96.54% | - | 77.92% |
| **Trust overall** | | 99.00% | 96.00% | 88.00% | 86.00% |
| **England average (Mental health and learning disabilities)** | | **98.40%** | **95.13%** | **85.53%** | **86.94%** |

### Seclusion room

Following our last inspection, the trust had undertaken work to increase the seclusion facilities for the children and young people mental health wards. This work was completed to ensure the wards had adequate access to seclusion facilities and reduce the use of seclusion away from the ward environment which in the past had led to the use of mechanical restraint.

The trust had built a new seclusion room, flat and de-escalation suite on Lennox ward and built a shared seclusion room at Ferndene for Fraser and Redburn wards. These wards had direct access to the facility.

At our last inspection, Ferndene PICU was part of Redburn ward. The trust separated the two units to manage the acuity of the patient group. This made up a 10-bed general ward and a four bed psychiatric intensive care unit. Staff reported that this had been effective in managing patient risk and promoted more therapeutic, appropriate environments. However, this meant that Ferndene PICU did not have its own seclusion room. When required, staff moved patients through the ward environments to the seclusion room on Redburn ward. This involved moving through a series of locked doors.

Due to planned changes in service models including the implementation of the Transforming Care agenda, the trust planned to close Riding ward at Ferndene permanently. Managers told us they planned to relocate Ferndene PICU to Riding ward. Riding ward had its own seclusion room.

All of the seclusion facilities complied with the requirements of the Mental Health Act code of practice.

### Clinic room and equipment

Clinic rooms were fully equipped with the required equipment to undertake physical health observations and treatment. Staff kept these tidy and well organised. They had access to grab bags with emergency medicines and equipment. Staff completed records to show that they

checked and maintained equipment regularly in line with the trust standards to ensure this was safe and ready for use when required. Clinic rooms contained the required clinical waste disposal bins.

## Safe staffing

### Nursing staff

The wards had sufficient numbers of staff to provide care and treatment to patients. The trust submitted the following information in relation to key staffing indicators:

**Definition**

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 31 December 2017 | 238 | N/A |
| Total number of substantive staff leavers | 1 Jan 17 – 31 Dec 17 | 13 | N/A |
| Average WTE* leavers over 12 months (%) | 1 Jan 17 – 31 Dec 17 | 5% | N/A |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | At 31 December 2017 | 9 | N/A |
| Total vacancies overall (%) | At 31 December 2017 | 3% | N/A |
| Total permanent staff sickness overall (%) | Most recent month (At December 2017) | 7% | 5% |
| | 1 Jan 17 – 31 Dec 17 | 7% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 December 2017 | 88 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 December 2017 | 148 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 December 2017 | 12 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 December 2017 | -1 | N/A |
| Qualified nurse vacancy rate | At 31 December 2017 | 12% | N/A |
| Nursing assistant vacancy rate | At 31 December 2017 | -1% | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 Jan 17 – 31 Dec 17 | 694 (6%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 Jan 17 – 31 Dec 17 | 0 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 Jan 17 – 31 Dec 17 | 39 (0%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 2478 (11%) | N/A |

| | | | |
|---|---|---|---|
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 1514 (6%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 Jan 17 – 31 Dec 17 | 244 (1%) | N/A |

*WholeTime Equivalent

This core service reported a vacancy rate for all staff of 3% as of 31 December 2017.

This core service reported an overall vacancy rate of 12% for registered nurses at 31 December 2017 and an over-establishment of registered nursing assistants by 1% at 31 December 2017.

The table below shows information on vacancy rates:

| | Registered nurses | | | Health care assistants | | | Overall staff figures | | |
|---|---|---|---|---|---|---|---|---|---|
| Ward /Team | Vacancies | Establishment | Vacancy rate (%) | Vacancies | Establishment | Vacancy rate (%) | Vacancies | Establishment | Vacancy rate (%) |
| **Ashby** | -2.0 | 17 | -13% | -5.5 | 33 | -19% | -7.5 | 44.0 | -17% |
| **Ferndene PICU** | 3.7 | 9 | 29% | 0.7 | 12 | 6% | 2.4 | 26.0 | 9% |
| **Fraser** | 0.2 | 12 | 2% | -1.1 | 23 | -5% | -0.9 | 34.0 | -3% |
| **Lennox** | 7.6 | 12 | 39% | 0.1 | 26 | 0% | 7.6 | 45.9 | 17% |
| **Redburn** | 4.0 | 12 | 25% | 1.6 | 14 | 10% | 5.6 | 31.4 | 18% |
| **Riding** | -0.7 | 12 | -6% | 2.7 | 17 | 13% | 2.0 | 31.0 | 6% |
| **Stephenson** | -1.0 | 14 | -7% | 0.7 | 22 | 3% | -0.3 | 37.0 | -1% |
| **Core service total** | 11.8 | 88 | 12% | -0.9 | 33 | -1% | 9.0 | 249.2 | 4% |
| **Trust total** | **152.1** | **1,844.4** | **8.2%** | **67** | **1,379** | **4.9%** | **200.4** | **3,969.6** | **5%** |

NB: All figures displayed are whole-time equivalents

Although we could not directly compare the time periods from our last inspection to this most recent inspection, the trust had reduced the use of bank and agency staff and increased the shifts filled. We compared the data that the trust reported at our last inspection, for three months with data submitted at this inspection for 12 months. The trust reported that across a three-month period that 2233 shifts were filled by bank and agency staff and 282 shifts were not filled. At this inspection data showed that across a 12-month period, that 3172 shifts were filled by bank and agency staff and 283 shifts were not filled. This showed that the shifts filled by bank and agency staff and the amount of shifts not filled had reduced significantly.

Between 1 January and 31 December 2017, bank staff filled 6% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 0% of shifts for qualified nurses. Less than one per cent of shifts were unable to be filled by either bank or agency staff.

The table below shows shifts filled by bank and agency staff and the amount of shifts not filled for registered nurses:

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Ashby** | 2481 | 113 | 0 | 21 |
| **Ferndene PICU** | 1485 | 110 | 0 | 7 |
| **Fraser** | 1838 | 56 | 0 | 1 |
| **Lennox** | 135 | 104 | 0 | 3 |
| **Redburn** | 1852 | 155 | 0 | 2 |
| **Riding** | 1765 | 60 | 0 | 1 |
| **Stephenson** | 2058 | 96 | 0 | 4 |
| **Core service total** | **11614** | **694 (6%*)** | **0 (0%*)** | **39(<1%*)** |
| **Trust Total** | **94,128** | **6,843 (7%)** | **5 (<1%)** | **567 (<1%)** |

***Percentage of total shifts

Between 1 January and 31 December 2017, 11% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 6% of shifts. One percent of shifts were unable to be filled by either bank or agency staff.

The table below shows shifts filled by bank and agency staff and the amount of shifts not filled for nursing assistants:

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Ashby** | 7110 | 440 | 323 | 90 |
| **Ferndene PICU** | 2423 | 262 | 256 | 58 |
| **Fraser** | 3582 | 357 | 75 | 9 |
| **Lennox** | 788 | 275 | 248 | 32 |
| **Redburn** | 2548 | 149 | 337 | 34 |
| **Riding** | 3048 | 379 | 161 | 6 |
| **Stephenson** | 4086 | 616 | 114 | 15 |
| **Core service total** | 23585 | 2478 (11%) | 1514 (6%) | 244 (1%) |
| **Trust Total** | 163943 | 32064 (20%) | 7043 (4%) | 2449 (1%) |

***Percentage of total shifts

This core service had 13 (5%) staff leavers between 1 January and 31 December 2017.

The table below shows the amount of staff leavers across a 12-month period:

| Ward/Team | Substantive staff | Substantive staff Leavers | Average % staff leavers |
|---|---|---|---|
| Ashby | 52 | 4 | 5% |
| Ferndene PICU | 24 | 0 | 0% |
| Fraser | 35 | 1 | 3% |
| Lennox | 38 | 4 | 11% |
| Redburn | 26 | 2 | 6% |
| Riding | 29 | 2 | 5% |
| Stephenson | 38 | 1 | 3% |
| **Core service total** | **241** | **13** | **5%** |
| Trust Total | 3696.18 | 252.06 | 7% |

The sickness rate for this core service was 7% between 1 January and 31 December 2017. The most recent month's data December 2017, showed a sickness rate of 7%.

The table below shows staff sickness rates across a 12-month period:

| Ward/Team | Total % staff sickness (at latest month) | Ave % permanent staff sickness (over the past year) |
|---|---|---|
| **Ashby** | 12% | 9% |
| **Ferndene PICU** | 8% | 10% |
| **Fraser** | 6% | 6% |
| **Lennox** | 4% | 5% |
| **Redburn** | 10% | 7% |
| **Riding** | 11% | 4% |
| **Stephenson** | 1% | 2% |
| **Core service total** | **7%** | **7%** |
| Trust Total | 7% | 7% |

The below table covers staff fill rates for registered nurses and care staff during October, November and December 2017.

Ashby Ward had too many care staff for day and night shifts for all three months and too many nurses for day and night shifts for day shifts for three months, and night shifts for two months.

Stephenson Ward had too many nurses for day shifts and night shifts for three months and too few care staff for day shifts in October and night shifts in November.

**Caveat:** The trust has informed us 'The safer staffing data on our website for Redburn includes the Ferndene PICU staffing.'

Key:

| > 125% | < 90% |
|---|---|

| | Day | | Night | | Day | | Night | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff |
| | December 2017 | | | | November 2017 | | | | October 2017 | | | |
| Fraser | 85% | 109% | 104% | 172% | 102% | 122% | 108% | 166% | 125% | 103% | 109% | 175% |
| Redburn | 108% | 115% | 74% | 162% | 113% | 96% | 96% | 121% | 114% | 72% | 115% | 149% |
| Ashby | 111% | 208% | 129% | 201% | 141% | 171% | 113% | 182% | 131% | 173% | 100% | 148% |
| Stephenson | 153% | 111% | 153% | 101% | 143% | 102% | 172% | 88% | 162% | 89% | 113% | 170% |
| Lennox | 87% | 194% | 100% | 156% | 89% | 146% | 100% | 160% | 123% | 120% | 100% | 75% |
| Riding | 117% | 76% | 135% | 94% | 106% | 83% | 116% | 107% | 114% | 122% | 112% | 109% |

Managers calculated the number of staff required for each shift. Managers reported they felt supported by the trust to increase staffing levels to ensure wards have enough staff. All wards had sufficient staff to carry out physical interventions and had support from a dedicated response team. Where wards used bank and agency staff, they ensured these were regular wherever possible. Ward managers had started to provide bank staff with regular supervision and agency staff had a buddy allocated on shift. The wards had access to a senior nurse for support on shift.

In the six months leading up to our inspection, staff had not cancelled any section 17 leave due to staff shortages.

**Medical staff**

The wards had adequate medical cover day and night. Out of hours, staff had access to on call doctors who could attend the ward when required. The trust had two non-medical responsible clinicians who worked as a nurse consultant and a psychologist.

Between 1 January 2017 and 31 December 2017, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums. In the same time period, agency staff covered 4% of shifts and 9% of shifts were unable to be filled by either bank or agency staff.

**Caveat**: the number of shifts filled and unfilled does not add up to the total of shifts available.

The table below shows the amount of medical staff shifts filled and not filled by bank and agency/locum staff:

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Ashby** | 296.38 | 0 | 6.42 | 33.21 |
| **Ferndene PICU** | 2.72 | 0 | 0.00 | 0.37 |
| **Fraser** | 192.94 | 0 | 11.00 | 13.87 |

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Lennox** | 764.00 | 0 | 17.57 | 84.43 |
| **Redburn** | 402.72 | 0 | 24.19 | 27.53 |
| **Riding** | 110.19 | 0 | 5.86 | 8.39 |
| **Stephenson** | 530.61 | 0 | 32.25 | 35.85 |
| **Core service total** | 2299.56 | 0 (0%*) | 97.29 (4%*) | 203.65 (9%*) |
| **Trust Total** | 71731.91 | 0 (0%*) | 5599.55 (8%*) | 3437.50 (5%*) |

***** Percentage of total shifts

### Mandatory training

Staff received and were up to date with mandatory training requirements.

The compliance for mandatory and statutory training courses at 31 December 2017 was 91%. Of the 23 training courses listed, four failed to achieve the trust target. No courses fell below 75%.

The training compliance reported for this core service during this inspection was the same as the 91% reported at the last inspection.

The mandatory training rates are shown in the table below:

Key:

| Below CQC 75% | Between 75% & trust target | Trust target and above |
|---|---|---|

| Training course | This core service % | Trust target % | Trust wide mandatory/ statutory training total % |
|---|---|---|---|
| Records and Record Keeping | 100% | 85% | 99% |
| Moving & Handling Awareness Training | 100% | 85% | 96% |
| Safeguarding Children | 99% | 85% | 94% |
| Safeguarding Children Level 2 | 99% | 85% | 94% |
| Infection Prevention & Control - Inoculation Incidents – Hand Hygiene | 98% | 85% | 95% |
| PMVA Breakaway | 97% | 85% | 84% |
| Equality & Diversity Introduction | 97% | 85% | 95% |
| Health & Safety | 94% | 85% | 94% |
| Dual Diagnosis Training | 93% | 85% | 92% |
| Safeguarding Children Level 3 | 92% | 85% | 90% |
| Safeguarding Adults | 92% | 85% | 94% |
| Seclusion Training | 91% | 85% | 90% |
| Clinical Risk Training | 87% | 85% | 92% |
| Mental Health Act 1983 | 86% | 85% | 84% |
| Medicines Management Training | 86% | 85% | 83% |
| Information Governance | 86% | 85% | 90% |
| Deprivation of Liberty Safeguards | 86% | 85% | 82% |
| Clinical Supervision | 85% | 85% | 86% |
| Mental Capacity Act 2005 | 85% | 85% | 82% |
| PMVA Basic | 83% | 85% | 81% |
| Resuscitation | 83% | 85% | 80% |
| Rapid Tranquilisation Training | 82% | 85% | 80% |
| MHA MCA DoLS Combined | 82% | 85% | 79% |
| Fire | 81% | 85% | 89% |

## Assessing and managing risk to patients and staff

### Assessment of patient risk

The trust used the Functional Assessment of Care Environments risk assessment tool and for patients with learning disabilities the adapted version of the tool. All 23 of the patient care and treatment records that we reviewed contained a comprehensive and detailed risk assessment and risk management plan. Staff developed these on admission and regularly reviewed and updated these. Staff recorded information following incidents into risk assessments.

For relevant patients, we saw that the services had used the Junior Management of Really Sick Patients with Anorexia Nervosa guidance and recommendations to assess and manage the risks associated with eating disorders. Staff had sought the input of specialists within this field.

### Management of patient risk

Staff dealt with any specific risk issues by ensuring these were recorded with a clear plan in patients' records. Managers ensured that staff had access to specialist advice and training when required to ensure they could manage patient risk. We saw that staff had sought training and advice in providing care and treatment to patients with eating disorders. There were clear plans to identify signs of deterioration to ensure enhanced treatment was in place where required. We saw examples of how staff had followed these plans in practice appropriately.

Staff completed detailed assessments and developed comprehensive positive behavioural support reports that consisted of a letter with detailed information and a more practical A4 sized one page at a glance behavioural plan. The letter contained the report with pen picture, cognitive profiling, needs, skills, known problematic behaviours and health information. The report listed triggers and the possible functions of each problematic behaviour and then detailed primary, secondary and reactive interventions.

Staff followed the trust policy on observation to ensure that patients were safe and well at the intervals required.

The wards had appropriate restrictions for the level of security required. None of the wards permitted items that were illegal. This included alcohol, drugs, access to illegal material, or material not suitable for certain ages (for example, age restricted films and games). Other prohibited items included those that could be used as weapons or fire lighting equipment. None of the wards practiced routine searching of patients.

Staff only searched patients where there was concern about risk items entering the service. Each of the wards had arrangements for searches to be completed out of sight of others. At Alnwood, staff searched all visitors before entering the ward areas. This included a pat down search and the use of a wand that detected metal items.

The hospital was smoke free. If staff were aware that patients had purchased tobacco products, they had a responsibility to report this in line with legislation. Staff supported patients with smoking cessation advice and support including nicotine replacement when relevant.

For the wards that accepted informal patients, posters were displayed on the relevant wards for informal patients to understand that they could leave the ward at will. All of the wards had controlled access. Staff ensured that young informal patients who would not be safe to leave the ward without support could not leave to keep them safe.

### Use of restrictive interventions

The trust had committed to reducing the use of restrictive interventions. At our last inspection, we raised concerns about the use of mechanical restraint. We told the trust that it must ensure that the use of mechanical restraint is used in exceptional circumstances when it is in the best interests of the patient and provides the least restrictive intervention.

Information submitted by the trust showed that comparing the period 1 January 2016 to 31 December 2016 and the same period for 2017 that the use of restrictive interventions had reduced as follows:

- Incidents of restraint by 28% (from 3162 to 2280 incidents)
- Use of prone restraint by 46% (from 1255 to 683 incidents)
- Use of mechanical restraint by 68% (from 266 to 84 uses)
- Administration of rapid tranquilisation by 54% (from 443 to 202 uses)
- Episodes of seclusion by 37% (from 481 to 304 episodes

Data submitted by the trust showed that from 1 January 2018 to 31 March 2018 that the use of these restrictive interventions has remained consistently lower and had not increased.

The trust reported an increase in the use of long-term segregation from no episodes in 2016 to six episodes in 2017. From 1 January 2018 to 31 March 2018, there was one new episode of long-term segregation and two episodes that continued.

Since our last inspection, the trust had invested, built and developed a model of care and a bespoke system called Talk First. The model was based upon the principles of providing positive care, reducing the use of restrictive interventions, lowering the level and severity of incidents occurring.

The trust had staff trained some staff up to diploma level in positive behavioural support. The services also implemented Safewards and Star wards principles. Both of these initiatives are aimed at making inpatient wards calmer and safer for everyone through reducing conflict and restriction by changing staff approach.

Staff received training on the Talk First approach. Teams created action plans to show how they aimed to make improvements in their services. The Talk First system used live information reported through the trust's web based incident reporting system. It provided a dashboard to enable monitoring of incidents and the use of restrictive interventions by many different factors. Some examples included time of day, frequency, level of restraint used. The system enabled staff and managers to look at patterns and trends in data at core service level, ward level and for individual patients.

Clinical teams discussed data on individual patient incidents during the patient's multi-disciplinary team meetings. They also discussed information from patient debriefs. Staff told us that they used the data to learn from incidents and reduce the chance of reoccurrence. Staff on Lennox ward had adjusted the timing of shifts to provide more staff to support one patient at the time of day when incidents increased.

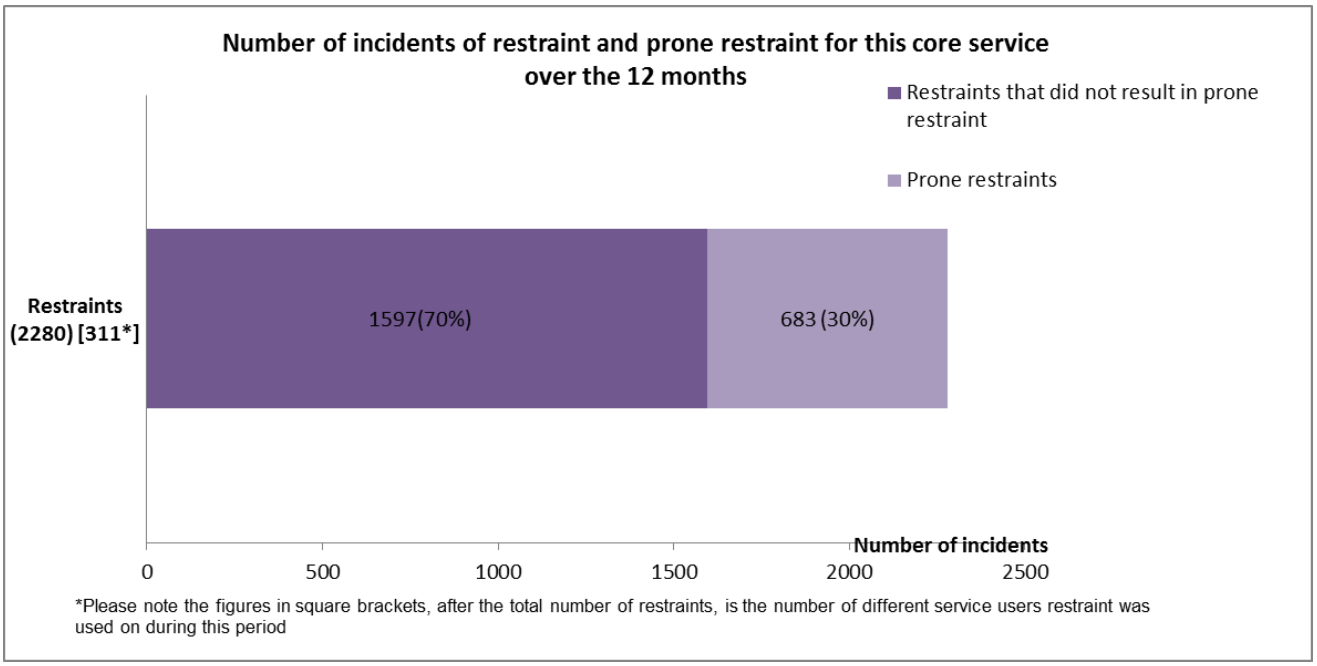
This core service had 2,280 incidents of restraint (on 311 different service users) and 304 incidents of seclusion between 1 January and 31 December 2017.

The below table focuses on the last 12 months' worth of data: 1 January to 31 December 2017.

| Ward name | Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| **Lennox** | 72 | 263 | 30 | 91 (35%) | 13 |
| **Stephenson** | 72 | 297 | 47 | 115 (39%) | 31 |
| **Redburn** | 62 | 372 | 81 | 113 (30%) | 51 |
| **Ashby** | 54 | 645 | 40 | 223 (35%) | 53 |
| **Ferndene PICU** | 23 | 358 | 41 | 76 (21%) | 42 |
| **Fraser** | 19 | 167 | 43 | 54 (32%) | 12 |
| **Riding** | 2 | 178 | 29 | 11 (6%) | 0 |
| **Core service total** | 304 | 2280 | 311 | 683 (30%) | 202 |

There were 683 incidents of prone restraint which accounted for 30% of the restraint incidents.

There have been 84 instances of mechanical restraint over the reporting period. The trust had a policy on restraint and a comprehensive practice guidance note on the use of mechanical restraint. The practice guidance note provided staff with clear expectations about the use of mechanical restraint in line with national guidance and legislation. There were flowcharts to show the protocol for the use of mechanical restraint when planned and in an emergency. Where the use of mechanical restraint was planned, it had to be authorised in line with the protocol for each use and directors signed off the mechanical restraint care plan. We saw that a few patients had care plans in place for the use of mechanical restraint and these had been authorised by directors.




There were 304 incidents of seclusion. Lennox ward had the highest number of incidents with 186 and Fraser Ward had the lowest number with three.

The number of seclusion incidents reported during this inspection was lower than the 418 reported at the time of the last inspection November 2015 – April 2016).

There have been four instances of long-term segregation over the 12-month reporting period.

The number of segregation incidents reported during this inspection was higher than the one reported at the time of the last inspection (November 2015 to April 2016).

We reviewed the records of 13 episodes of seclusion and one episode of long-term segregation. Records were kept appropriately and reviews followed legislation and guidance. Records of the care and treatment of another were unclear whether the practice was seclusion or long-term segregation. Nevertheless, we saw that reviews were taking place in line with guidance on long-term segregation. When we raised this with senior leaders at our feedback, they provided assurance that long-term segregation had been commenced and this was recorded on documentation as outlined in the trust policy.

There were no recent administrations of rapid tranquilisation on the medications cards that we reviewed. We reviewed some examples of previous administrations of rapid tranquilisation and records contained evidence that the appropriate physical health monitoring took place post-administration.

Ward staff representatives attended monthly positive and safe care meetings with colleagues from across the child and adolescent mental health wards. The purpose of the meetings was to provide oversight, support and guidance about the use of restrictive interventions and promotion of reducing restrictive practices.

## Safeguarding

The services had comprehensive arrangements and procedures to safeguard children and young people. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust had a safeguarding structure with safeguarding practitioners and administrators allocated for the locality areas. Each day a safeguarding practitioner was on duty and responded to safeguarding enquiries from the services, referrals and reviewed all safeguarding incident reports. The services had access to social workers and the associate medical director was safeguarding lead within the services.

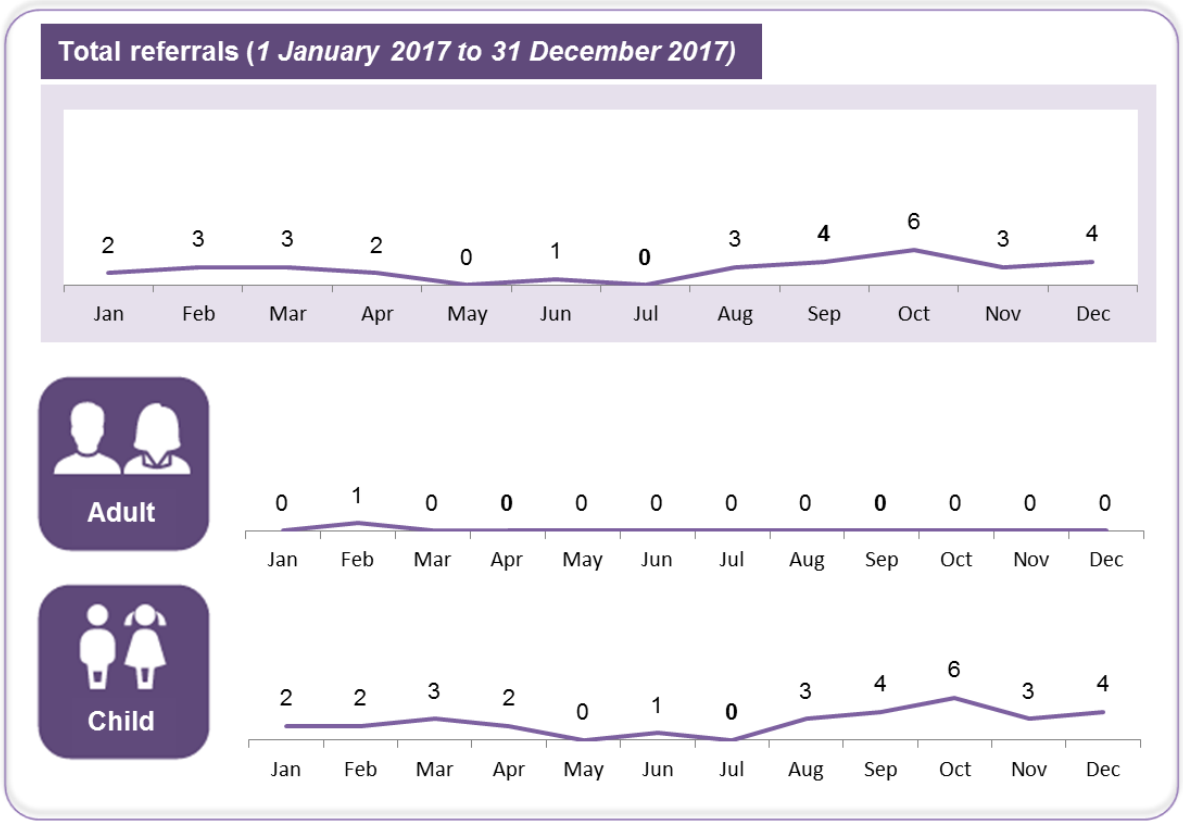
Staff received safeguarding supervision every six months for cases where a child or young person was subject to a child protection plan. Ninety two percent of staff had received training in safeguarding adults and safeguarding children level three. Staff demonstrated sound understanding of the potential signs of abuse and neglect. They told us that they observed behaviour changes and looked for physical indicators of abuse and neglect. Staff told us that they could ask for advice from safeguarding practitioners in the trust or the nurse in charge and could access online advice on the trust intranet. Staff told us that any specific safeguarding issues were recorded in the individual patient records.

Staff provided us with examples of how they had reported safeguarding concerns to the appropriate agencies in response to safeguarding concerns. This included the disclosure and barring service.

This core service made 31 safeguarding referrals between 1 January 2017 and 31 December 2017, of which one concerned an adult and 30 concerned children. The trust has not broken this data down to ward level.

The table below shows the number of safeguarding referrals completed:

| | Number of referrals | | |
|---|---|---|---|
| **Ward name** | **Adults** | **Children** | **Total referrals** |
| **Not provided** | **1** | **30** | **31** |




## Staff access to essential information

All information needed to deliver patients care was available to all relevant staff when needed. The trust had an electronic patient record system that contained most of the care and treatment records. Some documents were paper-based. These included kardex medication charts, seclusion records, long-term segregation records, observation records and some of the multi-disciplinary team assessments and records. Once these documents were complete, staff scanned these onto the electronic patient record system. We saw that staff could find the information that they required easily when needed. All of the paper records were accessible on the ward that the patient was receiving care and treatment.

## Medicines management

Staff followed safe and proper medicines management practices. Staff ordered medicines from the pharmacy within the trust. Pharmacy delivered medicines daily in sealed bags. Staff returned any medicines no longer required or safe to use to the pharmacy for safe disposal and this included prompt disposal of controlled drugs.

Staff maintained safe medication storage. All medication cupboards and fridges were locked. Registered nursing staff held medication keys. Keys to controlled drugs cupboards were kept on a separate key ring. Staff ensured that the controlled drugs register was checked and up to date

each shift, they recorded clinic and fridge temperatures and these were all within the recommended ranges.

Staff had access to the most recent copy of the British National Formulary. During our inspection, we reviewed 32 medication charts. These contained complete patient information. All prescriptions were signed and dated. The wards had patient group directives for specific medicines so that staff could administer medication without a written prescription. This ensured patients had timely access to medications such as paracetamol and simple linctus.

The services followed a policy for medicines to take away for patients requiring medication to take on leave.

Relevant staff completed an annual medication competency assessment for managers to be assured that staff demonstrated safe and proper medicines management practices.

The trust had introduced a medicines optimisation needs assessment. This was a document that staff completed to audit medicines reconciliation on admission, check side effect monitoring, drug history, check the relevant documentation and plans were in place and check appropriate monitoring was completed of specific medicines including high dose antipsychotic, clozapine and lithium medication therapies.

## Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were six serious incidents reported by this core service. All incidents related to incidents where the trust had failed to obtain an appropriate bed for a child who needed it. All of these incidents resulted in a child or young person being admitted to wards for adults. The last time this occurred was July 2017. The trust policy explained the action that staff should take in the event of a young person being admitted to an adult ward to ensure that young people were appropriately safeguarded and their stay on an adult ward was for the shortest time possible.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with Strategic Information Executive System.

The number of serious incidents reported during this inspection was higher than the two reported at the last inspection (1 January 2015 to 31 December 2015).

Of the incidents reported, five related to Redburn ward, and one related to Ferndene PICU.

| | **Number of incidents reported** | | |
|---|---|---|---|
| **Type of incident reported on STEIS** | Redburn | Ferndene PICU | Total |
| **Failure to obtain appropriate bed for child who needed it** | 5 | 1 | 6 |
| **Total** | **5** | **1** | **6** |

## Reporting incidents and learning from when things go wrong

Staff knew what types of occurrences they should report as incidents. All staff had access to the trust's intranet page where they could access and complete a web-based incident reporting form.

Staff and patients routinely received debriefs following incidents. At Alnwood, a member of staff who had completed training in facilitating de-briefs was on a responsive on call to all incidents between 9am and 5pm specifically to facilitate a debrief. If incidents occurred out of hours, this was passed onto the next on call debrief facilitator.

Staff discussed incidents and outcomes of debriefs in staff reflective practice sessions and in patients' clinical team meetings with the multi-disciplinary team. Any changes to practice or learning from incidents was shared through staff team meetings and where relevant in changes to patients' care plans.

All staff from senior (band six) registered nurses up to and including the associate directors for the business unit received an email with summaries of each incident reported. Ward managers had responsibility for reviewing incidents and received monthly incident reports that enabled them to identify patterns and trends in incidents.

In response to specific incidents, the trust completed after action reviews facilitated by an independent staff member and thematic reviews of patterns and trends in incidents to identify key learning. In some cases, incidents were escalated to the patient safety team to ensure that learning was shared with other services in the trust. Staff also received safety bulletins and alerts following some incidents.

Staff demonstrated a commitment to openness and transparency following incidents. They understood their responsibilities under the Duty of Candour.

# Is the service effective?

## Assessment of needs and planning of care

Staff completed comprehensive mental health assessments of patients prior to and soon after their admission. Doctors attended and completed mental state examinations, a physical examination and requested a full suite of physical health investigations. Where a patient had been transferred from another placement or inpatient ward, staff ensured that they requested previous records to ensure that these were not repeated unnecessarily. Records showed that where patients' provided consent that staff completed physical health checks promptly and doctors reviewed results on completion.

Staff worked flexibly and took all practicable steps to ensure that they assessed and monitored patients' physical health effectively. Where patients did not provide consent to physical health testing, staff continued to have discussions with patients and offer them opportunities to consent to taking physical observations. We saw that where patients could not tolerate staff obtaining physical observations that staff had worked with patients to show them how to take their own observations. In one patient record, we saw that a patient had graded exposure care plans informed by assessments to enable a patient to have their physical health observations taken through a structured programme of desensitisation. This had successfully led to some observations being completed.

Care plans were holistic, personalised and set out how staff would provide care and treatment to meet the needs identified in patients' initial assessments. Staff had reviewed all of the 23 care plans that we reviewed regularly and had updated these with any changes required. For example, after incidents or when risks emerged.

## Best practice in treatment and care

The services provided a wide range of care and treatment interventions that were suitable for the recovery of children and young people. As well as medication treatments, each patient had an individual weekly timetable that included education, recreation, therapies and recovery focussed activities. Patients had access to psychological therapies, occupational therapies and speech and language therapy. Staff tailored treatment interventions to the individual needs of patients including accessing specialist treatment interventions, we saw individualised treatments.

Staff ensured that patients had good access to physical healthcare and specialists when required. The trust had a service level agreement with local GPs and dentists who visited Ferndene and Alnwood regularly to see patients. We saw that they worked flexibly to see patients including those who had complex needs who may not be able to tolerate a full examination.

The services had clear strategies to support staff and patients to live healthier lives. Staff representatives across the services attended a physical health meeting every two months. This was also attended by the trust's physical health lead nurse, physical health lead trainer, a specialist dietician and where required input from staff from specific specialist teams for example, eating disorders. Through the work of physical health groups, teams had introduced healthy initiatives. At Ferndene, occupational therapy set up and a dietician supported patients from Fraser ward to run a healthy tuck shop. Ferndene had a café that was accessible to patients, staff and visitors. This sold low sugar drinks and healthy food options. The vending machines at Ferndene had fresh snacks including fresh fruit and cereal snack bars.

The physical health group had worked on providing the services with increased focus on the importance of physical health. They had introduced training in diabetes for staff, flowcharts and glucose supplies to manage hypoglycaemia, a food clinic for patients to provide feedback on menu options and oversight of the service meeting the needs of patients with eating disorders. They had attended an external event to showcase how they met the physical health care needs of patients in long-term segregation.

The services had been involved in trialling a nutrition screening tool for children and young people and provided feedback. The initial feedback was that this tool needed to be further refined prior to full implementation.

The trust were in the process of adapting the National Early Warning Score to ensure this was appropriate and effective to identify risk from physical health observations in children and young people. A task and finish group were working on developing a training package for staff before this was implemented within the services.

Staff used recognised rating scales to assess and record outcomes. We saw example of the use of the Health of the Nation Outcome Scales for Children and Adolescents, Children's Global Assessment Scale and the Vineland Adaptive Behavioural Scale. We also saw some examples of patient goal based outcomes. However, these required some further development as it was not clear how staff would support patients or what steps patients could take to try to work towards these goals.

This core service participated in 25 clinical audits as part of their clinical audit programme 2016 – 2017. These are shown in the table below:

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **CA-15-0044: Taking a Spiritual History in Choice (First) Assessment of Child & Family in Tier 3 CYPS & at Initial Assessment in Redburn Ward** | (SCG - CYPS) | MH: Child & Adolescent Mental Health Wards | Clinical | 22.02.17 | After MDT discussion, it was agreed that referrals might be appropriate to chaplaincy or faith groups to provide support further to that provided by the MDT.<br><br>Training department working with chaplaincy, service users (e.g. EYE group) and CYPS clinicians to develop a CPD training module on spirituality history taking specific to children and young people. |
| **CA-16-0015: 5-a-Day: Are young people with a learning disability supported to meet this target? A re-audit following improvements** | (SCG-CYPS Inpatient and Regional Service) | MH: Child & Adolescents mental health wards<br>MH: Specialist community mental health services for children and young people | Clinical | 22.02.17 | Ongoing review of menu<br>Education of staff with relation to diet and exercise<br>Continue with healthy breakfast group, healthy tuck shop and healthy cooking sessions.<br>Considered provision of Wake up and Shake up on the wards as opposed to the ARC.<br>Review access to cake every supper time. |
| **CA-16-0044: Do we provide copies of section 17 leave forms** | (SCG-CYPS Inpatient and Regional Service) | MH: Child and adolescent mental health wards<br>MH: Specialist | Clinical | 22.03.17 | Audit results shared with the multidisciplinary team to raise awareness of the Code of Practice guidance and NTW policy in this area. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **to young people and carers?** | | Community mental health services for children and young people | | | Administrative staff routinely print and distribute H17L forms following each weekly clinical team meeting, or whenever notified that changes to leave have been agreed. Brief entry in progress notes recorded, to evidence this practice. |
| **CA-16-0059: NICE CG72: Audit of ADHD Medication Height & Weight Monitoring on Growth Charts in CAMHS Inpatients.** | (SCG-CYPS Inpatient and Regional Service) | MH: Child and adolescent mental health wards | Clinical | 22.02.17 | Growth charts introduced to all CAMHS inpatient units. Medical/Dietetic staff provided brief teaching sessions to nursing staff on CAMHS inpatient wards re: recording of height and weight on growth charts. Prompt added to growth chart to record height and weight at baseline, weight at 3 months post-initiation and then height and weight at 6 monthly intervals. |
| **CA-15-0031: Young Person and Parental Involvement in Clinical Team Meetings.** | (North Specialist CYPS) | MH: Child and adolescent mental health wards | Clinical | 28.06.17 | Units reviewed process for improvements to be made. |
| **CA-15-0032: Young Person and Parental Involvement in Care Co-ordination Reviews.** | (North Specialist CYPS) | MH: Child and Adolescent mental health wards | Clinical | 28.06.17 | Each unit carried out a co-produced review of the structure and process of their CPA meetings. Involvement of parents / carers added to future audits of CPA attendance. |
| **CA-16-0051: Compliance with nationally agreed standard of completing a comprehensive MDT summary within five working days of discharge** | (North Specialist CYPS) | MH: Child & Adolescent Mental Health Wards | Clinical | 27/11/2017 | Different teams worked together to complete the MDT discharge summary within 5 days from the day of the discharge.<br><br>Each team now has input in the discharge letter even if they didn't do much work with the patient.<br><br>The consultant reviews the discharge summary, or delegates one of the junior doctors to do so, to make sure there is no repetition of the data by the different teams. |
| **CA-16-0081: Audit of Borderline Personality Disorder: Treatment and Management, Second Cycle, Alnwood, St Nicholas Hospital** | (North Specialist CYPS) | MH: Child & Adolescent Mental Health Wards | Clinical | 28/06/2017 | Produced an information booklet on Mixed Disorder of Conduct and Emotions suitable for adolescents with 'Emerging Borderline Personality Disorder'. |
| **LLCA-99-0006: Improving physical healthcare to reduce premature mortality in** | Secure Care Services CBU | MH: Child and Adolescent Mental Health Wards | Clinical | 21/08/2017 | Physical health monitoring reminders have been placed in weekly ward round minutes. Medics continued to retain a monitoring chart of when this |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **people with serious mental illness.** | | | | | needed.<br>This has increased the services' knowledge of where results need to be recorded. Refusal of monitoring is now recorded on physical health recording sheet. |
| **LLCA-17-0017: Vitamin D deficiency – monitoring and treatment in patients with in Medium secure unit (NICE PH56)** | North Specialist CYPS CBU | MH: Child and Adolescent Mental Health Wards | Clinical | 28/09/2017 | Vitamin D monitoring of patients is carried out routinely, thus ensuring physical well-being of patients and preventing Vitamin D deficiency symptoms. |
| **LLCA-17-0021: Re-Audit of ADHD Medication Height & Weight Monitoring on Growth Charts in CAMHS Inpatients (Ferndene & Alnwood)** | North Specialist CYPS CBU | MH: Child & Adolescent Mental Health Wards | Clinical | 11/12/2017 | Reminders given to staff on wards that children and young people prescribed medication for ADHD need their height and weight recorded on a growth chart at baseline and then at regular intervals. Physical health champions for each ward are leading on this. |
| **LLCA-17-0041: Assess the frequency that staff assault is reported to the Police in line with promoted Zero Tolerance for staff assault in the NHS** | North Specialist CYPS CBU | MH: Child & Adolescent Mental Health Wards | Clinical | May 2017 | None Specified. |
| **CA-16-0047: Nutrition** | Trustwide | MH - Acute wards for adults of working age and psychiatric intensive care units<br>MH - Long stay / rehabilitation mental health wards for working age adults<br>MH - wards for people with learning disabilities or autism<br>MH - wards for older people with mental health problems<br>MH - Forensic inpatient / secure wards<br>MH - child & adolescent | Clinical | 15.02.17 | Improved liaison with medical colleagues re consulting with Dietetic Services when considering prescribing nutritional supplements. Auditors fedback to Dietitians and ward managers in areas where screening requires improvement.<br>CNM's asked to follow-up to ensure improvements take place e.g. complete spot checks within their service area. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | mental health wards | | | |
| **CA-16-0023: Clinical Supervision** | CYPS | CHS - Community mental health services for people with learning disabilities or autism<br>MH - child and adolescent mental health wards<br>MH - specialist community mental health serves for children and young people | Clinical | 21.06.17 | The need for separate safeguarding supervisors in training has been disseminated to staff. Also liaising with safeguarding regarding capacity to deliver regular training.<br>Increased awareness promoted on the differences between management and clinical supervision.<br>Increased training on both types of supervision to raise awareness and to identify separate people within the workforce in the service area to deliver both types of supervision.<br>Procedural clarification of holding site/storage and ownership of Clinical Supervision Contracts in order that Supervisors can have access and contracts can be audited/accessed appropriately if necessary. Trust examining the possibility of the development of individual e-learning courses for core clinical refresher and training of trainers to improve access to mandatory training. |
| **CA-16-0088: Learning Disabilities Transformation** | Trustwide | CHS: Community mental health services for people with learning disabilities or autism<br>MH: wards for people with learning disabilities or autism<br>MH: Child and adolescent mental health wards<br>MH: Specialist Community mental health services for children and young people | Clinical | 15.11.17 | CDT identified to undertake the role of a Programme Board for this project.<br>Governance structure considered and to put in place in advance of future transformation projects. |
| **CA-15-0120: NICE (Baseline) CG128,CG70,QS51: Autism in Children and Young People** | Trust - CYPS | CHS: Community mental health services for people with learning disabilities or autism | Clinical | 19.07.17 | Team Managers / CCM's developed a 'throughput' model of assessment in each locality to manage the backlog of referrals waiting to start assessment.<br>Team Managers developed a standardised letter to GP/Paediatrician to request |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | MH: wards for people with learning disabilities or autism<br>MH: Child and adolescent mental health wards<br>MH: Specialist Community mental health services for children and young people | | | medical information current and past history.<br>Team Managers ensuring that diagnostic reports will be completed within 3 weeks of the MDT diagnostic formulation meeting.<br>Parents will be provided with a diagnostic report within 3 weeks of completion of the written report.<br>Team Managers ensuring that all staff have access to the CYPS Foundation Training Programme and attend relevant modules – identified within PDP.<br>Diagnostic report now includes statement about co-existing conditions.<br>Team Managers ensuring that diagnostic reports will be completed within 3 weeks of the MDT diagnostic formulation meeting.<br>Parents will be provided with a diagnostic report within 3 weeks of completion of the written report. |
| **CA-15-0084: Blood Pressure and Pulse monitoring in children with ADHD on medication in adherence with NICE guidance** | (SCG- CYPS) | CHS: Community mental health services for people with learning disabilities or autism<br>MH: Child & Adolescent mental health wards<br>MH: Specialist Community mental health services for children and young people | Clinical | 22.01.17 | Disseminated information to the clinical team and charts for BP centile and instruct they are used 100% of the time.<br>Education provided to staff on the importance of recognising centile for clinical interpretation. |
| **CA-16-0003: NICE CG72: Adherence to NICE Guidance for ADHD in the Adult ADHD Service** | (SCG- Adult ADHD Service) | CHS: Community mental health services for people with learning disabilities or autism<br>MH: Child & Adolescents mental health wards<br>MH: Specialist community mental health services for children and young people | Clinical | 22.02.17 | Dissemination of audit findings to the ADHD Team.<br>Training provided to ADHD Team on cardiovascular risk factors.<br>Review of minimum expected standards of review documentation. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **CA-16-0045: Topic 7e: Monitoring of patients prescribed lithium** | Trust Wide | Trustwide Inpatient Wards | Clinical | 18.10.17 | Calcium monitoring is included in all lithium documentation (including RiO and shared care) at baseline and maintenance.<br><br>Calcium monitoring added to clinic standard work at baseline and maintenance.<br><br>Publish article in the MMC Newsletter on monitoring calcium in lithium therapy.<br>The pharmacy team carries out a Medicines Management Risk Assessment annually in all wards and teams across the Trust. The following questions have been added to the checklist: |
| **CA-16-0037: Medicines Management: Safe and Secure Medicines Handling (MMRA)** | Trustwide | Trustwide - All Inpatient Wards | Clinical | 21.06.17 | 1. Annual MMRA audits downgraded to Trust level priority plan for 2017/2018 rather than Board Assurance plan.<br>2. Results of the annual 2016/2017 MMRA report shared with the CQCQCG to aid learning.<br><br>3. Process introduction of Temperature Monitoring Sheet kept by the medicines refrigerator, using the Min/Max thermometer.<br><br>4. Risk assessments and audits reported monthly to Pharmacy Managers Group. Escalation to MMC where necessary.<br><br>5. UHM-PGN-01 Safe and Secure Medicines Handling and Supply of Medicines incorporated additional guidance to ward staff on completing and returning the annual Medicines Management Risk Assessment.<br><br>6. SSMH monitoring tool incorporates additional questions which provide assurance that legally valid Patient Group Directions are being used correctly. |
| **CA-17-0001: Medicines Management: Prescribing Administration and Prescribing Clinical Checking Standards Take 5 Audit** | Inpatient Units | Trustwide - All Inpatient Wards | Clinical | 17.05.17 | Process changes:<br>1. Data collection and analysis of results from 'Take 5' drug administration and prescribing audits should be conducted by nursing and medical staff, respectively, using the electronic form developed and piloted through CQCQCG.<br>2.Audit results now fed back to individual Ward and Service Managers at the time when the |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | audit results are compiled.<br>3. Medical, nursing and pharmacy staff now review local audit results with Ward Managers and prescribers to identify themes and learned lessons.<br>4. Medical staff now receive a regular feedback of prescribing audit results.<br>5. Any red/amber ratings are now discussed and mitigating actions to rectify put in place.<br>6. Lead Clinicians and Lead Clinical Pharmacists jointly investigate areas of concern / poor performance. |
| **CA-16-0073: Audit on the management of diabetes and hypoglycaemia** | (Medicines Management) | Trustwide Inpatient Wards | Clinical | 03.05.17 | Policy author of PPT-PGN-02 presented with the findings of this audit and review undertaken by MMC as to the scope of the policy.<br><br>MMC Newsletter incorporated an article reminding prescribers of the importance of prescribing dextrose and glucagon on the 'as required' side of the Kardex in patients receiving insulin.<br><br>Physical Health and Wellbeing group received the findings of this audit and established who is appropriate to manage the action. |
| **LLCA-99-0001: A review of inpatient PRN prescribing in a Mental Health Trust** | Medicines Management | Trustwide Inpatient Wards | Clinical | 17.08.17 | There is now clarity on process and responsibilities for staff in relation to the review of `as required` medication.<br>There are improved controls in place for the safety of the patient.<br>Review Box was added to Kardex to prompt review of PRN medication once so many administrations had been given, to avoid situations where medication was being over used, should be regularly prescribed or the condition was deteriorating and not getting addressed e.g. pain killers. |
| **CA-16-0062: Controlled Drugs Audit** | (Medicines Management) | Trustwide | Clinical | 03.05.17 | Pharmacy staff undertaking quarterly CD balance checks and annual CD Audits.<br><br>Review of completion of quarterly CD balance checks and escalation to Pharmacy Managers Group where outstanding.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | Pharmacy staff liaised with the Registrant in Charge at the time of CD balance check and review the currency of the authorised signatory list for nursing staff.<br><br>Registrant in Charge reviewed the authorised signatory list and return a signed copy to pharmacy within 28 days.<br><br>UHM-PGN-04 Controlled Drugs, section 11.8 amended to incorporate this requirement.<br><br>Audit tool for Omnicell cabinets had question five removed for the 17/18 audit cycle.<br><br>Question seven of the Omnicell audit tool amended to include further guidance to pharmacy staff to check manual CD orders only for the 17/18 audit cycle.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter. |
| **LLCA-17-0017: Vitamin D deficiency – monitoring and treatment in patients with in Medium secure unit (NICE PH56)** | North Specialist CYPS CBU | MH: Child & Adolescent Mental Health Wards | Clinical | 28.09.17 | Vitamin D monitoring of patients is carried out routinely, thus ensuring physical well-being of patients and preventing Vitamin D deficiency symptoms. |

## Skilled staff to deliver care

The teams included the full range of specialisms required to meet the needs of patients. Teams comprised of doctors, nurses, occupational therapists, psychologists, speech and language therapists, social workers and dieticians. In response to complex patient needs, the services had effective access to advice and support from other specialists including external organisations and other trusts. The services had recently recruited three peer support workers.

The trust ensured that they provided training to ensure staff had the right skills and knowledge to meet the needs of the patient group. The trust had fully funded some staff tuition fees and paid placements so that they could complete mental health nurse training. Managers discussed individual training needs with staff through staff appraisal.

Staff including bank staff received supervision and reflective practice sessions led by psychologists. Between 1 January 2017 and 31 December 2017 the average rate across all teams in this core service was 84% for non-medical staff. Ashby Ward had an average clinical supervision rate of 52%, which was the lowest in this core service. However, between January 2018 and April 2018, the average clinical supervision rate had increased to 111%, which was above the trust policy standard. Stephenson ward achieved the highest rate with 96%. The trust has informed us a clinical supervision target rate is not specified in their policy.

Clinical supervision for medical staff has not been broken down by core service. The trust informed us “As per Royal College of Psychiatry requirements, our medical staff all engage in a process of peer supervision, which occurs at least 4 times a year within their peer group. Clinical work and performance, along with peer supervision notes, are also reviewed annually, through the appraisal process, and ultimately the GMC revalidation process every five years. The trust medical appraisal rates are shown above as a proxy for clinical supervision.”

**Caveat:** there is no standard measure for clinical supervision and trusts collect the data in different ways, so it’s important to understand the data they provide.

The table below shows the rate of clinical supervision across the service at ward level:

| Ward name | Clinical supervision sessions required | Clinical supervision sessions delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Stephenson** | 407 | 389 | 96% |
| **Lennox** | 414 | 384 | 93% |
| **Fraser** | 392 | 362 | 92% |
| **Riding** | 375 | 339 | 90% |
| **Ferndene PICU** | 70 | 55 | 79% |
| **Redburn** | 275 | 213 | 77% |
| **Ashby** | 407 | 213 | 52% |
| **Core service total** | **2,340** | **1,954** | **84%** |
| **Trust Total** | **29957** | **26917** | **90%** |

The trust’s target rate for appraisal compliance was 85%. As at 31 December 2017, the overall appraisal rates for non-medical staff within this core service was 85%. The wards failing to achieve the trust’s appraisal target were Ashby with an appraisal rate of 65% and Redburn at 56%. We requested updated appraisal rates and as of 24 May 2018, the trust reported that the appraisal rate for Redburn had increased to 76% and Ashby had increased to 64%. The trust reported that staff sickness, maternity leave and increase patient observation levels had affected Ashby wards’ ability to increase the appraisal rate further. The team had an action plan in place and aimed to complete this by the end of June 2018.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 79.3% reported at the last inspection.

The table below shows appraisal rates for non-medical staff:

| Ward name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Fraser** | 36 | 36 | 100% |

| Ward name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Riding** | 32 | 32 | 100% |
| **Lennox** | 38 | 37 | 97% |
| **Stephenson** | 37 | 33 | 89% |
| **Ferndene PICU** | 25 | 22 | 88% |
| **Ashby** | 51 | 33 | 65% |
| **Redburn** | 27 | 15 | 56% |
| **Core service total** | **246** | **208** | **85%** |
| **Trust wide** | **3922** | **3228** | 82% |

The trust did not provide appraisal data for medical staff for this core service in their submission of data. Managers ensured that staff had access to team meetings. Minutes from team meetings showed that these were well attended. Teams also had away days. Managers ensured that they used the trust policies and procedures and advice from human resources to manage staff performance issues promptly and effectively.

## Multi-disciplinary and interagency team work

Staff held regular and effective multi-disciplinary meetings. We saw that the full multi-disciplinary team attended patients' multi-disciplinary meetings routinely. A pharmacist and the locality safeguarding lead attended a sample of these meetings. Staff invited patients' community care co-ordinators and social workers from the local authority and independent mental health advocates.

Multi-disciplinary teams discussed patients' progress through care and treatment including any incidents, risks, engagement in therapeutic and recovery focussed interventions, physical health and discharge.

The trust had increased the duration of staff handover from shift to shift to 30 minutes. This allowed staff sufficient time to ensure that staff arriving on shift were aware of all of the pertinent information and that staff leaving shift had access to a well-being check and debrief if required.

The service had effective working relationships with external agencies including advocacy and the local police service. The police were invited to visit the wards at Alnwood to understand the service and the needs of the patient group. The service was working with NHS England around the changes to service models through the Transforming Care Agenda.

A service level agreement was in place for visiting health practitioners including dentist and GPs.

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

As of 31 December 2017, 86% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. Staff had a reasonable level of understanding of the Mental Health Act, the code of practice and its guiding principles.

Staff told us that they could contact a central Mental Health Act office within the trust, refer to the trust policies and procedures and refer to legislation and the code of practice for advice and support on the Mental Health Act.

Patients had easy access to information about independent mental health advocacy. Regular independent mental health advocates visited Ferndene and Alnwood several times per week.

Staff explained patients their rights under section 132 of the Mental Health Act at regular intervals. Staff had access to easy read materials to ensure that the understanding of patients was maximised. Staff ensured that patients had access to legal advice and accessed their right to appeal detention when relevant.

Records contained valid consent to treatment documentation including T2 and T3 certificates. A T2 certificate is complete where a patient has capacity and consents to treatment. A T3 certificate is completed by a second opinion appointed doctor from the CQC where patients cannot or will not consent to treatment.

Staff kept copies of detention documentation on the ward and original copies of detention documents were sent to the Mental Health Act central office and scanned onto electronic records. Patients with access to section 17 leave had up to date electronic forms. These showed the conditions and level of leave authorised by responsible clinicians.

Wards that accepted informal patients had signs displayed to inform informal patients they could leave the ward freely.

## Good practice in applying the Mental Capacity Act

The Mental Capacity Act and its code of practice apply to individuals aged 16 and over. For children and young people aged under 16 years; the ability to make decisions without parental consent relies on the test of Gillick competency. Gillick competency involves a young person having sufficient understanding and intelligence to make a choice or decision without parental permission or knowledge. .

As of 31 December 2017, 85% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. Staff had a reasonable level of understanding of the Mental Capacity Act and the five statutory principles.

Deprivation of liberty safeguards only applies to individuals aged 18 and over. As this service provides care and treatment to those under 18 years old, we did not inspect adherence to deprivation of liberty safeguards.

The trust had policies on consent that staff could access on the trust website and intranet page. Staff told us that they would seek advice and support on the Mental Capacity Act from their colleagues, medical staff and the Mental Health Act office in the trust.

We saw examples of capacity and competency assessments to manage finances and in sharing information with relatives. Where patients lacked mental capacity, records contained evidence that staff had followed the best interest decision making process.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were calm, positive, respectful and responsive to the needs of patients. It was clear that staff knew patients well and how to meet their individual needs. The feedback that we received from most patients was positive. Patients felt they could speak to staff and trust them. However, three of the patients that we spoke with on Redburn ward told us that they had overheard staff speaking about other patients.

Patients told us that staff helped them to understand their conditions and their care and treatment. They helped them access different services including advocacy.

Patients felt confident about raising any concerns to staff. Those that had raised concerns to staff told us this was mainly concerning interpersonal patient relationships. They told us that staff had helped them to resolve the issues and their relationships with others had improved as a result.

The last Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing in 2017 for the core service locations scored higher than similar organisations. These are shown in the table below:

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Ferndene** | Child and adolescent mental health wards | 100.00% |
| **St Nicholas Hospital, Gosforth** | Child and adolescent mental health wards, forensic / secure wards, long stay / rehab wards, crisis & health based places of safety | 97.83% |
| **Trust overall** | | **93.59%** |
| **England average (mental health and learning disabilities)** | | **90.00%** |

## Involvement in care

### Involvement of patients

Staff used the admission process to orient patients to the ward. Where admissions were planned, staff provided patients with welcome packs about the services. These packs contained information and pictures about the wards and facilities. In addition, important information about treatment programmes, routines, personal belongings, consent, keeping in touch with other people and discharge processes were also explained. Where appropriate, some patients could visit the ward with their families and carers to see what it was like before their admission started. Where patients could not visit before their admission, staff visited patients and spent some time with them so that they were familiar with them before they arrived into the hospital.

Staff involved patients in their care and treatment. Patients could attend meetings about their care and treatment. If they did not want to or could not attend meetings about their care, they could input their views and questions into their clinical team meetings and care programme approach meetings for discussion. After the meeting staff met with patients to talk to them about the outcome of the meetings. We saw that on Riding ward, one patient had recorded their views to be played in their care programme approach meeting because they could not attend. Patients had access to a copy of their care plans and this included accessible and easy to read care plans for

some patients. However, care plans did not always evidence patient involvement and patient views.

The wards had many resources to enable communication with people who may have difficulty in understanding information. This included easy read documents with pictures and simple language.

When local recruitment took place, patients were involved in the recruitment process through interview panels and being involved in deciding what questions they would like candidates to answer.

Staff encouraged patients and their carers and relatives to give feedback on the services they received. The trust had a questionnaire called Points of You. This consisted of 10 questions with picture of faces to represent different levels of satisfaction about the services. The forms were self-adhesive with a free postal address to a central point in the trust. Patients had regular community meetings where they could discuss anything about the services that they wanted to.

Advocates visited the wards regularly. All of the patients that we spoke with knew who the advocates were and felt they could speak to them if they wanted to.

An officer from the Patient Advice and Liaison Service visited Lennox and Ashby wards each fortnight to listen to the views of patients. They encouraged them to complete the Points of You survey and also provided confidential advice, information and support to patients. The officer had plans to extend this out to the five wards for children and young people at Ferndene.

**Involvement of families and carers**

Staff involved families and carers appropriately. They ensured that they shared information with the parents, relatives or carers with parental responsibility for patients and they ensured that information was shared with the patients consent where appropriate. For example, where patients had competency or capacity and did not want to share information with their families or carers, staff ensured that they balanced the rights of patients with safety.

Families and carers could provide feedback on the service. They could attend and be involved in meetings about care and treatment. They could also complete the Point of You survey. The service ran a monthly carers group where carers could attend to be involved in the service and provide feedback.

Staff ensured that families and carers knew how they could access a carers' assessment through the local authority teams.

# Is the service responsive?

## Access and discharge

### Bed management

The trust had reduced the amount of inpatient mental health beds for children and young people. This was partly to improve the safety and quality of care to improve patient experience and also because the trust was working with NHS England through the changes in care models for people with learning disabilities and autism as part of the Transforming Care agenda.

Transforming Care sets out to improve health and care services so that people can live in the community with the right care and support and less people will need to go into hospital for their care. As part of Transforming Care, in consultation with commissioners, the trust had closed Wilton six-bed medium secure ward and had reduced the beds provided at Riding from six to four beds.

The trust had immediate plans to reduce the beds on Fraser ward from 12 to eight beds. The trust was also due to close the four beds on Riding ward permanently and estimated that would take place in September 2018. That timescale would depend on the discharges of current patients staying there.

Staff were involved in the trust's project to develop community-based services within the area to ensure that the right care to prevent hospital admission could be provided in the community. They anticipated that the services would need to be specialist in order to meet the needs of children and young people with autism and complex needs. Staff told us that this would be focussed on a positive behavioural support approach and they would support children and young people at home, school and in respite services as an alternative to inpatient admission.

The trust provided information regarding average bed occupancies for all seven wards in this core service between 1 January 2017 and 31 December 2017.

Two of the wards within this core service reported average bed occupancies ranging above the benchmark of 85% over this period. Redburn general ward and Ferndene PICU had maximum occupancy levels of 100%. Lennox ward is the only ward to have a maximum occupancy level of less than 50%.

The average bed occupancy ranges are shown in the table below:

| Ward name | Average bed occupancy range (1 January 2017 to 31 December 2017) (current inspection) |
|---|---|
| **Ashby** | 44.4% - 66.7% |
| **Fraser** | 50.0% - 75.0% |
| **Lennox** | 28.6% - 42.9% |
| **Redburn** | 70.0% - 100.0% |
| **Ferndene PICU** | 75.0% - 100.0% |
| **Riding** | 33.3% - 66.7% |
| **Stephenson** | 50.0% - 62.5% |

Dependent on the type of bed required, beds were usually available for patients living within the catchment area. Redburn and Ferndene PICU wards sometimes did not have available beds when at full occupancy. Where a bed was required on Ferndene PICU and the ward was full, the clinical team would ensure that patients were not staying within the ward for longer than appropriate to lower the risk of bed blocking access to psychiatric intensive care. The last time that a bed was not available on a ward for children and adolescents was July 2017.

This core service also reported no out of area placements between 1 January 2017 and 31 December 2017.

The trust provided information for average length of stay for the period 1 January 2017 and 31 December 2017. The trust has informed us "Length of stay is calculated as the total length of stay across the trust for those patients discharged from that ward in that month. This can be heavily skewed by low numbers and discharge of long stay patients."

Redburn ward had the lowest length of stay with two days, and Lennox ward had the highest length of stay with 1,683 days.

| Ward name | Average length of stay range (1 January 2017 – 31 December 2017) (current inspection) |
|---|---|
| **Ashby** | 393 days to 1,179 days |
| **Fraser** | 5 days to 433 days |
| **Lennox** | 6 days to 1,683 days |
| **Redburn** | 2 days to 177 days |
| **Ferndene PICU** | 18 days to 244 days |
| **Riding** | 88 days to 255 days |
| **Stephenson** | 73 days to 1,034 days |

This core service reported eight readmissions within 28 days between 1 January 2017 and 31 December 2017. Three readmissions (38%) were readmissions to the same ward as discharge. Fraser ward had one readmission to the same ward, and this was the only readmission of a patient from Fraser ward. The remaining seven readmissions were of patients who had been discharged from Redburn Ward.

The average of days between discharge and readmission was 16.79 days. There were no instances whereby patients were readmitted on the same day as being discharged and there were no instances where patients were readmitted the day after being discharged.

The table below shows the number of readmissions for the applicable wards:

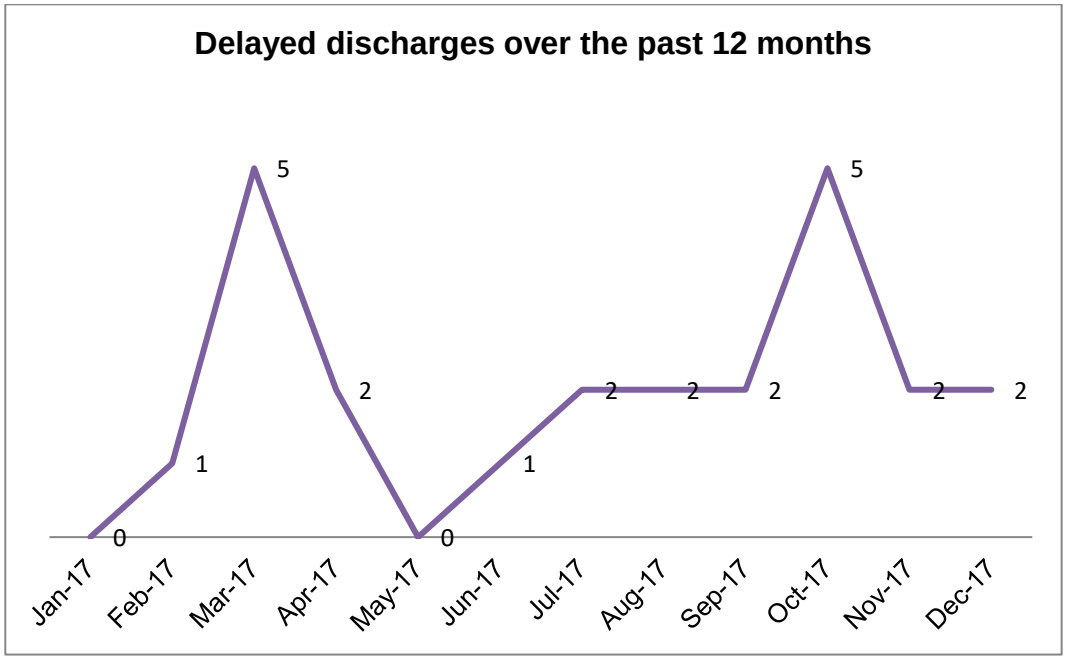
| Ward name | Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|---|
| **Fraser** | 1 | 1 | 100% | 19.14 days* | 19.14 days* |
| **Redburn** | 7 | 2 | 29% | 6.52 days to 23.11 days | 16.46 days |

*Days provided are for one readmission and therefore not a range or average

**Discharge and transfers of care**

Between 1 January 2017 and 31 December 2017, there were 93 discharges within this core service. This amounted to 4% of the total discharges from the trust overall (2,462). Redburn ward had the highest number of discharges with 48 while Lennox ward had the lowest with four discharges.

The graph below shows the trend of delayed discharges across the 12-month period:




We were unable to determine accurately the amount of delayed discharges in total. This is because a delayed discharge was included from delay until the month of discharge in the figures provided.

We reviewed 23 patients' care and treatment records. These did not contain formalised discharge plans. However, we saw consideration of discharge including future placements where these were required in other areas of patients' records and observed clinical team meetings where discharge was discussed. Patients with learning disabilities and autism also had care and treatment reviews completed by an independent panel commissioned by NHS England. These reviews aim to increase the effectiveness of treatment to ensure that hospital inpatient stays are no longer than required.

Staff including leaders told us consistently that they experienced challenges with ensuring timely discharges could take place due to the limited appropriate social care services to meet patients' needs. They hoped that through working with commissioners to develop new care models to reduce inpatient care that this would help improve services available in the local areas to prevent admission and facilitate discharges.

We saw that the services provided the required amount of staff to support patients when they required treatment in acute hospitals including accident and emergency departments.

## Facilities that promote comfort, dignity and privacy

Ferndene and Alnwood environments provided recovery and comfort. The areas were light and had appropriate decoration for children and adolescents. Patient art work and projects were displayed in the care environments. All patients had their own bedrooms and most patient bedrooms were ensuite. Patients could personalise their bedrooms with their own belongings. Patients had access to secure storage for any items that were restricted, valuable items and money to keep them safe.

Staff and patients had access to the full range of rooms and equipment to support care and treatment. All of the wards had access to art rooms, fully equipped music rooms, educational

space, information technology suites, indoor and outdoor sports facilities, activities and recreation rooms, horticulture areas, workshops for woodwork, rooms for groups, interviews, visits and meetings. Patients also had access to training and therapeutic kitchens where they could prepare their own meals.

Alnwood was a historical adapted building and had some environmental limitations as a result of this. This included access to outdoor space which was on the ground level and the wards were situated on the second and third floors which meant that free access to outdoor space was not possible.

Ferndene was a purpose built hospital and was centred around a woodland theme and situated in a semi-rural location in Prudhoe. The entrance to Ferndene and central areas accessible to patients and staff were welcoming and bright with comfortable furnishings and areas to complete activities. In addition to the above facilities, Ferndene also had pods which were small classrooms and therapeutic space for patients to have individual or small group sessions. Ferndene has a café for patients, staff and visitors. Since our last inspection, a day unit had been developed for Redburn ward and Ferndene PICU. This provided a structured day of activities, education and therapies for patients away from the ward area.

Ferndene and Alnwood each had accommodation that families, carers and visitors could use to stay and spend time with patients away from the care environments. Staff told us they could use this accommodation to try section 17 home leave with the external staff support close by.

Patients could access hot drinks and snacks at any time. The kitchenettes on Ashby and Lennox wards at Alnwood were locked because they contained water boilers. Staff provided and supervised patients access on request.

The 2017 Patient-Led Assessments of the Care Environment score for ward food at the locations scored better than similar trusts.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Ferndene** | Child and adolescent mental health wards | 100.00% |
| **St Nicholas Hospital, Gosforth** | Child and adolescent mental health wards, forensic / secure wards, long stay / rehab wards, crisis & health based places of safety | 95.97% |
| **Trust overall** | | **94.76%** |
| **England average (mental health and learning disabilities)** | | **91.50%** |

Patients provided positive feedback about the quality and choice of food available. A representative from the trust had held food clinics and involved patients in selecting meals for the menus.

## Patients' engagement with the wider community

The trust had arrangements for education provision in partnership with a local education provider. Each week patients had individual personalised timetable of education sessions, therapies and recreational activities.

Patients could work towards completing the Duke of Edinburgh's Award. This consisted of volunteering, physical activities and learning life skills. The services had connections in the local communities to facilitate patients to maintain these links in the wider community.

Pets as Therapy Dogs visited the services each week to spend time with patients. These were well received by patients.

Staff supported patients to maintain contact with their families and carers.

## Meeting the needs of all people who use the service

The services were accessible for patients with disabilities. Lift and ramp access was in place to ensure that patients could access upper levels. Staff ensured that on an individual basis that reasonable adjustments were made including access to assistive technology.

Wards had easy read information available about incidents, debriefs, mental health conditions, understanding rights under the Mental Health Act available to support patients to understand and be involved in their care and treatment. Staff developed easy read care plans for patients who needed these.

Staff had access to information in different languages and braille. They could access signers and interpreters when required.

Menus provided a range of foods to meet specific dietary requirements to meet the needs of specific religious and ethnic groups, medical conditions and choice.

Patients had access to spiritual support. A chaplain visited the services regularly and alternative faith leaders were sourced to support patients with other spiritual beliefs outside of the Christian faith. Patients had access to space to practice their faith. The wards had a box that contained materials relating to different faiths that patients could use to learn more about religions and faiths.

## Listening to and learning from concerns and complaints

Patients knew how to raise concerns or to make a complaint. They told us that they would speak to staff about things that they were not happy with. Patients told us that when they raised concerns to staff that they helped them to resolve issues.

This core service received 12 complaints between 1 January 2017 and 31 December 2017. None of these were upheld, two were partially upheld and four were not upheld. One was withdrawn, one ‘decision not to investigate’ and one ‘unable to investigate’. Three complaints were still awaiting completion.

The number of either partially or fully upheld complaints reported during this inspection was lower than the five reported at the last inspection (1 November 2015 to 30 April 2016).

The table below shows information on complaints:

| Ward name | Total Complaints | Fully upheld | Partially upheld | Not upheld | Withdrawn | Decision not to investigate | Unable to investigate | Still awaiting completion |
|---|---|---|---|---|---|---|---|---|
| **Ashby** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Fernden e PICU** | 5 | 0 | 1 | 2 | 0 | 0 | 1 | 1 |
| **Redburn** | 5 | 0 | 0 | 2 | 1 | 1 | 0 | 1 |
| **Stephen son** | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **12** | **0** | **2** | **4** | **1** | **1** | **1** | **3** |

This core service received 23 compliments during the last 12 months from 1 January 2017 and 31 December 2017 which accounted for 6% of all compliments received by the trust as a whole.

# Is the service well led?

## Leadership

Since our last inspection, the trust had implemented a new leadership strategy, restructure of operational management and reconfiguration of services successfully. The trust had a vision and strategy of leadership focused on refining services to improve the quality of patient care and to make the best use of resources available through cost efficiency and reducing bureaucracy. The trust had invested in implementing the collective leadership model. Collective leadership is a model that promotes distributing decision-making power and breeding a culture of shared leadership. It promotes empowering those who have the capability, expertise and motivation to lead on specific areas as alternative to leadership defined by level of seniority within an organisation. Leaders including senior leaders told us that they knew the restructure was going to happen and why. They had opportunities to provide their views and be involved.

Although the trust had only implemented the organisational changes six months prior to our inspection, the services had clear leadership structures. The child and adolescent mental health wards were situated under the specialist children and young people's clinical business unit. The senior leadership team of the clinical business unit comprised five associate directors of the following roles: an associate director, an associate allied health professional's director, an associate medical director, an associate nurse director and an associate psychological services director. Three clinical nurse managers had responsibility for the seven child and adolescent mental health wards. They also had other areas of responsibility for other services or on transformational projects. Each of the wards had a ward manager. Leaders including senior leaders told us that the trust had managed the change and transition well and there had been many opportunities to review the changes.

All leaders above ward manager level had received comprehensive training in collective leadership and away days as a group, which they felt had prepared them with the skills and culture change required to embed the new ways of working. They had expertise in line with clinical business unit with experiences of children and young people's services and learning disabilities.

Leaders including senior leaders had a good understanding of the services. They explained that the governance systems and processes enabled them to have oversight of the services. They aimed to be as visible as possible. The associate medical director and associate psychological services directors maintained clinical roles as a consultant psychiatrist and consultant clinical psychologist within the child and adolescent services as well as designated sessions within the senior leadership roles.

## Vision and strategy

The trust had longstanding values that it had initially developed following consultation with staff, patients and carers. The trust had embedded the values into the staff appraisal process. Each year all staff considered how their performance and role demonstrated the values.

The trust's vision was amended following the publication of its latest strategy. The trust's vision and values are available on the public website.

The services were in a period of change as a result of work completed in line with new care models under the Transforming Care Agenda for people with learning disabilities and autism. The services had changed since our last inspection with the closure of Wilton ward and the reduction of beds on Riding ward. Further changes were planned to the services closing all beds at Riding ward and reducing the beds on Stephenson ward. Staff had been involved in discussions with the trust and commissioners to look at alternative and more effective services that would prevent the

admission of children and young people to hospital and provide community based mental health services.

Leaders and senior leaders told us that they ensured that services provided high quality care and tried to ensure that this was as cost effective as possible.

## Culture

Staff felt supported, respected and valued by their colleagues and the trust. Staff felt positive and proud of working in the services and for the trust.

Staff felt confident about raising concerns and did not fear retribution. Staff were familiar with the trust's whistleblowing procedures. Not all staff were aware of the Freedom to Speak Up Guardian however, they were clear that if they had concerns they would be confident to use the trust's policies and procedures to raise concerns.

Managers dealt with performance issues promptly and staff attended regular team meetings where any low level issues were discussed as teams.

Staff felt there were opportunities for progression and development. Many of the staff within the services had started their career with the trust and progressed into different roles including senior leadership positions. The trust had fully funded some places for staff to undertake mental health nurse training and this included paid placements and tuition fees.

The core services staff sickness rate was the same as the trust average at 7%. The wards average sickness rates ranged from two percent (Stephenson ward) up to 10% (Ferndene PICU). Staff had access to support for their own physical and emotional needs through the trust's occupational health services.

The service held away days with staff to have time away from the clinical environment and focus on specific areas for improvement and innovation.

Since our last inspection, staff working in child and adolescent mental health wards had been nominated and won at the annual staff excellence awards. This included two awards for clinician of the year, health care worker of the year, an individual award and Lennox ward won the clinical team of the year award.

## Governance

The services had a clear framework of meetings from ward level up to the clinical business unit level. These consisted of monthly ward team meetings, clinical team meetings following the mental health and learning disabilities pathways and weekly clinical business unit meetings. A framework of governance meetings comprised positive and safe care, physical health, medicines management, skills development, service user and carer review, risk register, finance and performance and new care model implementation group. These took place on either monthly or two monthly intervals and had a dedicated chair person. Minutes showed a clear reporting and escalation process upwards and downwards from the ward teams up to clinical business unit level.

Staff had implemented the recommendations following serious case reviews that took place in other organisations and internal lessons learnt. Examples of this included adapting the clinical environmental risk assessments to consider issues as a result of external lessons learnt.

Staff undertook and participated in clinical audits. The trust had an audit programme and staff undertook specific audits in response to issues or into the effectiveness of changes in processes implemented. The trust had intelligent systems which could be used to audit information quickly and efficiently. For example, the Talk first system which enabled access to dashboards of live data which could be analysed by many factors.

Staff had established links with other teams internal and external to the trust. The services reciprocated advice and support with other teams.

There are no corporate risks detailed in the trust's risk register that relate to this core service.

## Management of risk, issues and performance

Staff were aware of the risk registers for the service and team meeting minutes showed that these were discussed from ward level up to the clinical business unit level. Staff, managers and senior leaders told us that they could escalate issues through the trust for consideration to be managed under the risk register.

The services had business continuity plans in case of emergencies, outbreaks and adverse weather to ensure that staff were clear what action to take to continue providing safe services.

Where potential areas of risk or performance issues arose, leaders responded using a range of different methods. This included undertaking after action reviews of specific occurrence, completing a review of incidents where a theme was identified, convening complex case meetings and completing staff surveys on stress. These methods were used to understand risk issues including: admission of a young person to an adult ward, increase in absence without official leave, a pattern of self-harm through ingestion, managing discharge of a patient no longer suitable for a child and adolescent inpatient ward and staff stress.

## Information management

The trust invested in innovative systems to capture and show information on a range of areas of performance and to improve the quality of care delivered. Systems were intelligent and enabled information to be presented on dashboards with limited burden on frontline staff. This included information on staff training, appraisals, supervision, outcome of the Points of You patient and carer surveys and data from Talk first on incidents and restrictive interventions.

Staff had access to the relevant systems and these enabled them to record and review information they required to provide patient care and treatment.

## Engagement

Staff, patients and carers had access to up-to date information. Staff received information from their managers and in direct communications from the trust. Patients received information from the trust through community meetings with staff. Carers received information through contact with staff and through regular carers meetings. Managers had access to dashboards with feedback from the Points of You survey.

Senior leaders had connections with external stakeholders including commissions and local Heathwatch.

## Learning, continuous improvement and innovation

The collective leadership model promoted the engagement of those with an interest or an expertise to become involved in improvement and innovation. The teams had regular meetings, away days and opportunities to take part in projects. Staff were invited to attend development and consultation sessions where changes in the services were being considered. There were opportunities for staff to take part in task and finish groups for quality improvement and service development projects.

Staff, patients and their carers had the opportunity to participate in research. Research projects have included:

- Coping with uncertainty in everyday situations
- Cost of autism assessment through different pathways
- Pre-school autism community trial
- Managing repetitive behaviours
- Family focussed therapy for adolescents with bi-polar

Staff had had publications of their work in the following documents:

- Exploring feelings a guide for training leaders
- Viewpoint on Pathological Demand Avoidance

Clinicians within the service also held academic roles working with other organisations, trusts and universities. One clinician was the chair of the Autism and Learning Disability Academic Clinical Collaboration and was part of the academic partnership between the trust and external organisations. Another clinician was a member of the Child and Adolescent Psychiatry Surveillance. This group studies rare mental health conditions in children and young people and aims to increase awareness for all and conduct surveillance system into these conditions.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **Quality Networks – Quality Network for Inpatient CAMHS (QNIC)** | Fraser, Ferndene<br>Annual peer reviews<br><br>Redburn, Ferndene<br>Annual peer reviews<br><br>Riding, Ferndene<br>Annual peer reviews<br><br>Alnwood, St Nicholas Hospital<br>Annual peer reviews<br><br>Stephenson, Ferndene<br>Annual peer reviews | None provided |
| **Star Wards** | Stephenson, Ferndene<br>Full Monty<br><br>Riding, Ferndene<br>Full Monty | None provided |

Star Wards provides and shares positive, recovery focused, imaginative and fun ideas for mental health inpatient services to implement and share. The project has 75 ideas for services to use.

Services that demonstrate all 75 ideas in practice can achieve the Full Monty Star ward. Star Wards is also supported by Safewards.

Fraser, Riding and Stephenson wards had achieved the Full Monty Star ward.

# Wards for older people with mental health problems

## Facts and data about this service

| Location site name | Ward name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| Campus for Ageing and Vitality | Akenside | 18 | Mixed |
| Campus for Ageing and Vitality | Castleside | 20 | Mixed |
| Monkwearmouth Hospital | Cleadon | 18 | Mixed |
| Monkwearmouth Hospital | Marsden | 18 | Mixed |
| Monkwearmouth Hospital | Mowbray | 12 | Female |
| Monkwearmouth Hospital | Roker | 12 | Male |
| St George's Park | Hauxley | 18 | Mixed |
| St George's Park | Woodhorn | 14 | Mixed |

# Is the service safe?

## Safe and clean care environments

### Safety of the ward layout

During this inspection, we found all wards complied with Department of Health guidance on same sex accommodation. Over the 12-month period from 1 January 2017 to 31 December 2017, the trust reported no same sex breaches for the older people's service. Six wards were mixed sex and had clearly identifiable male and female areas. On Castleside, we found that a male patient was using the female only lounge and no one was using the male only lounge. Following our visit staff swapped the lounges around so that the male patient could continue to use the lounge of their choice and the female patients had somewhere they could sit. Each ward had rooms that could be used by patients who needed more assistance. On the mixed sex wards there were rooms that could be allocated to patients of either gender.

Mowbray and Roker were the only same sex wards. Akenside, Castleside and Marsden had separated male and female patient areas with a lockable door and there were individual bathroom facilities in each section. Hauxley, Cleadon and Woodhorn had separate male and female corridors and patients all had en-suite facilities.

There were ligature risks on six wards within this core service. The trust had undertaken recent (from 1 March 2017 onwards) ligature risk assessments at two locations.

None of the wards presented a high level of ligature risk and six wards presented a lower risk due to minimal risk of self harm / ligature use on older peoples ward.

The trust had taken actions to provide ligature knife guidance in order to mitigate ligature risks.

All wards had mitigated risks with an in date comprehensive environmental risk assessment. This identified areas where patients might harm themselves. Due to the lower risk of ligature on the older people's wards the units managed risk with the use of staffing levels, supportive engagement, observation levels, and ongoing risk assessments depending on the patients' risks.

The risk assessments did not include the garden areas. Following our visit staff had commenced risk assessments for the gardens. Staff told us they had not considered the risks in the gardens because they were always present when patients went outside. Equipment brought on to the ward such as dynamic pressure mattresses had bespoke ligature risk assessments in place. Six of the eight wards visited were purpose built wards and had CCTV in the communal areas to help staff with observations.

Staff held handover meetings three times per day, where they reviewed and discussed patient risks and their required engagement levels. Nurses increased the level of engagement quickly if patients were at increased risk. Staff understood that engagement meant having a conversation with a patient rather than just observing a patient's whereabouts. This meant staff had a good awareness of risk to each individual patient and could manage these risks effectively.

Bedrooms in the purpose built wards were ensuite with shower, washbasin, and toilet. On the wards that had been adapted for use, bathrooms were available for members of each sex to use without passing the bedroom of a member of the opposite sex. The wards followed good practice and provided dedicated female only lounges as well as communal areas where all patients could be together.

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

There was a nurse call system in patient bedrooms. Staff attended quickly when we tested these on an unannounced basis. All staff carried personal alarms that linked with control panels throughout the wards. This meant that when they triggered their alarm, staff identified the area easily and responded quickly.

Staff carried out appropriate health and safety checks on equipment, such as checks on the fire extinguishers throughout the wards and appropriate electrical testing.

**Maintenance, cleanliness and infection control**

All wards were clean and tidy with well-maintained furnishings with the exception of Castleside. On Castleside, we found that there was an area that had an unpleasant smell and signage on some of the doors had been ripped off as well as flooring that had been damaged by a patient. Domestic staff maintained cleaning records, which were up to date, and demonstrated that staff had regularly cleaned the environment. All of the cleaners spoken with felt part of the team and took pride in the ward environment. Patients commented favourably on the cleanliness of the wards.

The trust had originally scheduled Akenside and Castleside for major refurbishment in 2017, as the environment did not meet with current good practice around providing dementia friendly environments. The trust was aware of these issues but the environment had not improved. Senior managers told us that the trust was in discussion with the commissioners about moving the service to a more suitable environment and so had postponed any repairs or improvements.

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

Patient led assessments of the care environment (known as PLACE) had been undertaken in 2017 for Northumberland Tyne and Wear NHS Foundation Trust in relation to cleanliness. The patient led assessments of the care environment scores for all wards were above the national average of 98%.

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017) the location(s) scored better than the similar trusts for two of the four aspects overall and similar to other trusts for one. Campus For Ageing and Vitality received a score worse than other similar trusts for disability scoring 72.7% compared to 86.3% nationally. The facilities on the Campus for Ageing and Vitality were dated, and whilst they could support someone with disabilities, patients could not manage independently.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Campus For Ageing and Vitality** | MH - Wards for older people with mental health problems | 99.1% | 93.4% | 89.2% | 72.7% |
| **Monkwearmouth Hospital** | MH - Wards for older people with mental health problems | 99.6% | 95.6% | 93.4% | 85.4% |
| **St Georges Hospital, Morpeth** | MH - Wards for older people with mental health problems | 98.24% | 95.06% | 89.76% | 88.77% |
| **Trust overall** | | **99.3%** | **95.8%** | **88.1%** | **85.8%** |
| **England average (Mental health and learning disabilities)** | | **98%** | **95.2%** | **84.8%** | **86.3%** |

### Seclusion room (if present)

None of the wards had seclusion facilities. When patients were distressed, staff used a talk first strategy, using soft words, and diversion and/or de-escalation techniques. Staff also used a chill out room or if a room was not available, they had a box of items that helped distract patients including a stuffed dog and/or cat.

### Clinic room and equipment

Each ward had a well-equipped clinic room, which was clean, tidy and well organised. Medicines were stored in a unit with access restricted to the fingerprint of authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were contained in electronically monitored medication fridges that ensured temperature ranges remained within an acceptable range. Staff undertook regular comprehensive checks of equipment, resuscitation equipment, controlled drugs and stock medication to ensure everything was in working order and in date. All staff had a key to access the clinic room so that they could access emergency equipment in the case of an emergency. There was appropriate equipment in the clinic rooms for the monitoring of medical observations; this included a blood pressure machine and weighing scales.

## Safe staffing

### Nursing staff

The trust were able to recruit staff to this core service.

- This core service reported an overall vacancy rate of 7% for registered nurses.
- This core service reported an overall vacancy rate of less than 1% for nursing assistants.
- This core service had 13 (5%) staff leavers between 1 January 2016 and 31 December 2017.

At the time of the inspection:

- Castleside had 1.2 whole time equivalent nursing vacancies and no health care vacancies
- Cleadon ward had no vacancies
- Akenside had no vacancies
- Mowbray had no vacancies
- Woodhorn had three nurse vacancies and no healthcare vacancies, although were in the recruitment process
- Roker had one nurse vacancy
- Hauxley had two nurse vacancies
- Marsden had three whole time equivalent healthcare assistant vacancies

Each ward had agreed minimum staffing levels of two qualified staff, four health care assistants that would ensure patients received the support they required, and managers could increase the staffing levels if the acuity levels on the ward increased. Managers told us they tried to ensure that bank or agency staff were known to the patients and or ward staff to ensure continuity of care.

The rotas for the month prior to inspection showed that all shifts had been filled and where there had been cover needed overtime for current staff or bank staff were used. Agency staff were rarely used on the wards. This meant that staff were familiar with the patients. New bank and agency staff received an induction to the ward.

Shifts not meeting the fill rate were usually due to unplanned events, such as staff illness or admission of a new patient needing high levels of observation. We saw that no leave or activity had been cancelled because of shifts not being filled.

Patients told us that there was enough staff around and available when they needed them. We observed staff available for patients to support their leave arrangements, planned activities, and supportive engagement. There was a protected time each day for therapeutic engagement.

All qualified nurses actively on duty at the core service were up to date with their life support training. This was also a requirement for bank and agency nurses working on the ward. This meant the wards always had adequately trained staff on duty at all times.

The staff fill rates for each ward shows where the staffing was over the assessed compliment. It also shows where the staffing levels were below what was considered safe for these wards. During our inspection, we saw that the occupancy level for some of the wards, such as Akenside and Castleside had reduced but the expected staffing ratios had not been adjusted to accommodate the reduction in patient beds. Where qualified nursing staff levels were reduced, the trust had compensated with extra nursing assistants.

## Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 31 December 2017 | 238 | N/A |
| Total number of substantive staff leavers | 1 January 2017 – 31 December 2017 | 13 | N/A |
| Average WTE* leavers over 12 months (%) | 1 January 2017 – 31 December 2017 | 5% | N/A |

| Vacancies and sickness | | | |
|---|---|---|---|
| Total vacancies overall (excluding seconded staff) | At 31 December 2017 | 7.1 | N/A |
| Total vacancies overall (%) | At 31 December 2017 | 3% | N/A |
| Total permanent staff sickness overall (%) | At 31 December 2017 | 6% | 5% |
| | 1 January 2017 – 31 December 2017 | 8% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 December 2017 | 102 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 December 2017 | 139.2 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 December 2017 | 6.9 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 December 2017 | 0.2 | N/A |
| Qualified nurse vacancy rate | At 31 December 2017 | 7% | N/A |
| Nursing assistant vacancy rate | At 31 December 2017 | <1% | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (Qualified nurses) | 1 January 2017 – 31 December 2017 | 458 (3%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 108 (1%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 3605 (16%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 924 (4%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 178 (1%) | N/A |

*Whole-time Equivalent

This core service reported a vacancy rate for all staff of 3% as of 31 October 2017.

This core service reported an overall vacancy rate of 7% for registered nurses at 31 December 2017and less than 1% for nursing assistants.

NB: All figures displayed are whole-time equivalents

Between 1 January 2017 and 31 December 2017, bank staff filled 3% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered no shifts for qualified nurses and 1% of shifts were unable to be filled by either bank or agency staff. No data was provided for Woodhorn ward.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **Marsden** | 2139 | 142 | 0 | 2 |
| **Mowbray** | 2088 | 7 | 0 | 2 |
| **Roker** | 1820 | 10 | 0 | 1 |
| **Akenside** | 1657 | 165 | 0 | 14 |
| **Castleside** | 1429 | 16 | 0 | 8 |

| | | | | |
|---|---|---|---|---|
| **Hauxley** | 1581 | 73 | 0 | 80 |
| **Cleadon** | 2479 | 45 | 0 | 1 |
| **Core service total** | **13193** | **458 (3%*)** | **0 (0%*)** | **108 (1%*)** |
| **Trust Total** | **94128** | **6843 (7)** | **5 (<1%)** | **567 (1%)** |

***Percentage of total shifts

Between 1 January 2017 and 31 December 2017, 16% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 4% of shifts. 1% of shifts were unable to be filled by either bank or agency staff. No data was provided for Woodhorn ward.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| Marsden | 4750 | 1012 | 60 | 17 |
| Mowbray | 2702 | 349 | 22 | 21 |
| Roker | 2889 | 356 | 45 | 19 |
| Akenside | 2131 | 71 | 37 | 8 |
| Castleside | 4103 | 776 | 373 | 56 |
| Hauxley | 2725 | 541 | 317 | 33 |
| Cleadon | 3040 | 500 | 70 | 24 |
| **Core service total** | 22340 | 3605 (16%*) | 924 (4%*) | 178 (1%*) |
| **Trust Total** | 163943 | 32064 (20%) | 7043 (4%) | 2449 (1%) |

***** Percentage of total shifts

This core service had 13 (equal to an average of 5%) staff leavers between 1 January 2017 and 31 December 2017.

| Ward/Team | Substantive staff | Substantive staff Leavers | Average % staff leavers |
|---|---|---|---|
| **Cleadon** | 32 | 3 | 10% |
| **Woodhorn** | 33 | 3 | 9% |
| **Akenside** | 27 | 2 | 7% |
| **Hauxley** | 25 | 2 | 6% |
| **Marsden** | 37 | 2 | 5% |
| **Roker** | 27 | 1 | 4% |
| **Castleside** | 29 | 1 | 3% |
| **Mowbray** | 27 | 0 | 0% |
| **Core service total** | **238** | **13** | **5%** |
| **Trust Total** | **3696** | **252** | **7%** |

The sickness rate for this core service was 8% between 1 January 2017 and 31 December 2017. The most recent month's data (December 2017) showed a sickness rate of 6%.

| Ward/Team | Total % staff sickness (at latest month) | Ave % permanent staff sickness (over the past year) |
|---|---|---|
| **Cleadon** | 8% | 11% |
| **Woodhorn** | 8% | 10% |
| **Hauxley** | 2% | 8% |
| **Marsden** | 5% | 8% |
| **Roker** | 8% | 8% |
| **Mowbray** | 6% | 6% |
| **Akenside** | 9% | 5% |
| **Castleside** | 3% | 4% |
| **Core service total** | **6%** | **8%** |
| **Trust Total** | **7%** | **6%** |

The below table covers staff fill rates for registered nurses and care staff during October, November and December 2017.

All wards had close to planned levels of registered nurses for all night shifts. Hauxley ward had close to planned levels for registered nurses and care staff for all day and night shifts. Castleside ward had shifts above 125% fill rate of the planned shifts for care staff for all months.

Key:

| > 125% | < 90% |
|---|---|

| | Day | | Night | | Day | | Night | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff |
| | October 2017 | | | | November 2017 | | | | December 2017 | | | |
| Akenside | 87% | 89% | 108% | 115% | 115% | 105% | 111% | 115% | 101% | 89% | 100% | 114% |
| Castleside | 81% | 130% | 107% | 131% | 86% | 150% | 103% | 134% | 82% | 138% | 100% | 135% |
| Cleadon | 96% | 76% | 116% | 72% | 87% | 79% | 107% | 79% | 87% | 71% | 103% | 90% |
| Hauxley | 89% | 113% | 102% | 110% | 101% | 118% | 105% | 118% | 91% | 117% | 105% | 112% |
| Marsden | 100% | 139% | 110% | 121% | 112% | 159% | 111% | 126% | 137% | 125% | 103% | 115% |
| Mowbray | 111% | 103% | 110% | 125% | 131% | 93% | 105% | 105% | 127% | 86% | 103% | 98% |
| Roker | 112% | 88% | 112% | 153% | 98% | 133% | 104% | 153% | 95% | 117% | 104% | 133% |

| | Day | | Night | | Day | | Night | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff |
| | October 2017 | | | | November 2017 | | | | December 2017 | | | |
| Woodhorn | 62% | 137% | 100% | 146% | 74% | 105% | 104% | 116% | 63% | 98% | 100% | 104% |

## Medical staff

There was adequate medical cover for the service throughout the day. Each site visited had access to psychiatrists, and junior doctors. The wards had access to out of hour's medical arrangements and emergency services.

Between 1 January 2017 and 31 December 2017, zero shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 1221 shifts and 805 shifts were unable to be filled by either bank or agency staff.

| Ward/Team | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|
| Akenside | 0 | 296 | 226 |
| Castleside | 0 | 319 | 197 |
| Cleadon | 0 | 6 | 31 |
| Hauxley | 0 | 299 | 243 |
| Marsden | 0 | <1 | 25 |
| Mowbray | 0 | <1 | 24 |
| Roker | 0 | <1 | 24 |
| Woodhorn | 0 | 299 | 242 |
| **Core service total** | 0 (0%*) | 1221 | 805 |
| **Trust Total** | 0 (0%) | 5600 (8%) | 3438 (5%) |

***** Percentage of total shifts

## Mandatory training

The compliance for training courses as of 31 December 2017 was 93%. Of the training courses listed one failed to achieve the trust target of 85% and all training scored above 75%.

The training for Mental Health Act also included information about the Mental Capacity Act and this had the lowest percentage of staff having completed this training at 83%. During our inspection, we found that managers were aware of the shortfall and were taking action to ensure all staff had completed this training.

The training compliance reported for this core service during this inspection was the same as the 93% reported at the last inspection.

All staff had oversight of their mandatory training performance and booked onto the courses they needed to complete. Please refer to the table below for the details of all the mandatory training.

Key:

| Below CQC 75% | Between 75% & trust target | Trust target and above |
|---|---|---|

| Training course | This core service % | Trust target % | Trustwide mandatory/ statutory training total % |
|---|---|---|---|
| Moving and Handling | 100% | 85% | 96% |
| Resuscitation | 100% | 85% | 80% |
| Infection Prevention (Level 1) | 99% | 85% | 95% |
| Health and Safety | 98% | 85% | 94% |
| Safeguarding Adults (Level 1) | 98% | 85% | 94% |
| Information Governance | 97% | 85% | 90% |
| Safeguarding Children (Level 1) | 94% | 85% | 94% |
| Safeguarding Children Level 2 | 94% | 85% | 94% |
| Fire Safety - 3 Years | 94% | 85% | 90% |
| Medicines Management | 93% | 85% | 84% |
| Mental Health Act | 83% | 85% | 80% |
| Core Service Total % | 93% | | |

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Staff undertook a risk assessment of every patient on admission. They received previous risk assessments if patients transferred from another ward or the community teams. If this were the case, they would still revisit all risks as an update. The trust used the Functional Analysis of Care Environments risk assessment tool. This assessment included assessment of suicide, self-harm, harm to others, self-neglect, physical conditions, clinical symptoms, history and personal circumstances for example, isolation, financial and housing. We looked at 32 patient records and each patient had a risk assessment in place. However, some of the information in the assessments was very brief, with little or no explanation, and some of the information was not dated. Staff told us that further information about risks to patients was provided through either the Newcastle or five P model of formulation.

Initial risk assessments were completed and updated before admission to the ward by either the trust community mental health team or the trust crisis team for older people. This formed the basis for the initial safety plans nurses developed during the admission process. Staff used the Newcastle model of formulation for patients on the organic wards; this provided staff with a framework in which to understand behaviour that challenged. On the functional wards staff used the five P's and plan formulation. This tool looks at past difficulties, triggers, current issues and positives, what behaviours are stuck and how can patients change and move forward. We were able to observe three formulation meetings and all staff were able to contribute to the meeting to help develop an understanding of the behaviour of the patients.

Risk assessments included routine and ongoing monitoring of existing physical health problems and potential physical health risks that might develop. Staff assessed patients for the risk of falls and the risk of developing venous thromboembolism as part of their admission assessment process. Venous thromboembolism also known as deep vein thrombosis is a blood clot that forms in the veins of the leg. This can cause strokes or other health conditions. Staff used nationally recognised tools to assess various physical health conditions. For example, they used the Waterlow tool to assess and manage the risk of developing pressure ulcers. Risk assessments were reviewed each month at the multi disciplinary meeting and/or following an incident.

**Management of patient risk**

The formulation processes, observation levels, handover, and reviews meant staff were up to date with their knowledge of individual patient risks. Staff were trained in the prevention and management of violence and aggression and used 'Talk first'. This meant that when a patient's behaviour presented as challenging staff used de-escalation techniques such as soft words, diversion and reassurance. Patients had access to quiet rooms, or areas that were quieter including the garden. All of the wards had access to a garden and access to the garden was risk assessed. If staff increased levels of engagement, they made team decisions to review and reduce the level as soon as possible.

The wards followed the trust policy for searching of patients. Staff checked patients' belongings on admission to the ward. They carried out random searches on patients returning from leave to check for restricted items. Staff gave patients and carers information about restricted items and searches in patients' welcome packs on admission.

All of the wards displayed a clear notice at the entrance that informed all patients how they could leave the ward. Patients knew how they could leave, and we observed how staff supported patients to leave the ward according to their status under the Mental Health Act and leave arrangements.

We looked at whether there were any blanket restrictions in place. A blanket restriction is a restriction imposed on a full ward due to the risks of some patients. On inspection, we noted that staff had locked bedroom doors on Woodhorn, Akenside, Castleside and Mowbray. Staff told us that patients were able to ask a staff member at any time for access to their rooms and that they had locked the rooms to protect patients' possessions. Some patients or their carers had asked for their rooms to be locked. Patients were able to request their door to be unlocked if they wished. Staff on Mowbray, had individually assessed a patient resulting in one patient having a key to their room.

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

Access to hot and cold refreshments and snacks was variable among the wards. Hauxley, Akenside, Castleside Marsden, Cleadon and Mowbray wards had readily available snacks and refreshments. Hot drinks were by request on Woodhorn and Roker though cold drinks were freely accessible.

Managers we spoke to informed us that they were continuing to consider the least restrictive options whilst at the same time protecting the safety and possessions of their patients. We saw minutes from staff meetings that confirmed these discussions were taking place.

**Use of restrictive interventions**

Staff understood the definition of seclusion and only used restraint as a last resort. Staff described and we observed how they used de-escalation to manage incidents. Staff used an electronic incident reporting system to report their use of all restraint. The Talk First approach and recording of restraints allowed the manager to look at the specific detail of the incident. They looked for the triggers around the behaviour that challenged staff and how they could change their practice, or the environment to prevent further distress to the patient. In one instance, they had adapted the ward routine to allow a patient to get up later and eat their meal watching the TV as this was the routine they had followed at home.

Between the period of 1 January 2017 and 31 December 2017, there had been 926 episodes of restraint (on 138 different patients). However, 511 of these episodes referred to Woodhorn. The majority of patients on Woodhorn presented challenging behaviours and 43 of these incidents resulted in prone restraint. The National Institute for Health and Care Excellence guidance NG10: Violence and Aggression, recommends avoiding prone restraint, and only using it for the shortest possible time if needed. During our inspection, we reviewed records and spoke to staff regarding the episodes of prone restraint. Where patients had placed themselves down on their front during restraint, the staff had quickly turned them, or if staff turned a patient to administer medication, they then documented this as prone restraint. Staff told us if they needed to put hands on patients for anything other than personal care then they recorded it as restraint. Staff used Talk First de-escalation techniques the majority of time to manage behaviour. All staff were trained in the prevention and management of violence and aggression techniques; this included bank and agency staff.

There were 55 incidents of seclusion between 1 January 2017 and 31 December 2017 for this core service. None of the wards had seclusion facilities, they used quiet areas, and chill out rooms. Seclusion happened for the shortest amount of time and patients were reoriented to the ward as soon as possible. There had been 54 episodes of seclusion on Woodhorn ward in the twelve months leading up to our inspection. These were related to one patient. All of the incidents lasted between 10 and 20 minutes and took place in the patient's bedroom. Seclusion records were completed in line with good practice.

Staff sought approval to support this patient in segregation on the ward. This allowed them to provide support in a low stimuli environment. Approval for this action came from the associate directors of this service. It had been clearly care planned. One of the organic wards had purchased a 'seclusion' chair that sat low to the ground. Patients needed support to get out of the chair and staff told us they did not have to use supine or prone restraint. The use of restraint and seclusion was for the least possible time.

This core service had 926 incidents of restraint (on 138 different service users) and 55 incidents of seclusion between 1 January 2017 and 31 December 2017. Over the 12 months, there were 55 incidences of seclusion, of which 54 were at Woodhorn ward.

Please refer to the table below for information about the use of seclusion, long-term segregation, restraint and rapid tranquillisation in this service between 1 January 2017 and 31 December 2017.

We saw records to show that appropriate physical health checks were carried out following the use of rapid tranquillisation.

| Ward name | Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| Akenside | 0 | 19 | 9 | 3 (33%) | 12 (63%) |
| Castleside | 0 | 113 | 27 | 5 (4%) | 33 (29%) |
| Cleadon | 0 | 27 | 10 | 1 (3%) | 6 (22%) |
| Hauxley | 1 | 72 | 10 | 15 (21%) | 54 (75%) |
| Marsden | 0 | 108 | 15 | 0 (0%) | 68 (63%) |
| Mowbray | 0 | 27 | 12 | 0 (0%) | 4 (15%) |
| Roker | 0 | 49 | 12 | 1 (2%) | 17 (35%) |
| Woodhorn | 54 | 511 | 43 | 39 (8%) | 20 (4%) |
| **Core service total** | 55 | 926 | 138 | 64 (7%) | 214 (X%) |

There were 64 incidents of prone restraint which accounted for 7% of the restraint incidents.

There have been three instances of mechanical restraint over the reporting period which all occurred on Woodhorn ward.

There were three instances where mechanical restraints were used; this was approved by the senior management team at the trust. In each case mechanical restraint was used only after other interventions had failed and was used to support the transfer of a patient to hospital. This was clearly evidenced in the patient record. Staff had obtained agreement from the trust's senior management team before using mechanical restraint. In both cases staff had followed the trust's 'Positive and Safe, Recognition, Prevention and Management of Violence and Aggression (PMVA) Practice Guidance Note: Safe Use of Mechanical Restraint Equipment – V03'.

Staff told us for any instance of restraint or seclusion a debrief session took place to look at how the situation had developed and how staff could manage future situations differently.

## Safeguarding

Staff we spoke with had a good understanding of the trust safeguarding procedure and knew what to do when faced with a safeguarding concern. The ward had an identified safeguarding link at the trust and there was a safeguarding champion on each ward. We saw evidence that staff raised safeguarding incidents through the electronic system making appropriate referrals. We observed staff discuss safeguarding issues at their multi-disciplinary and formulation meetings.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 121 safeguarding referrals between 1 January 2017 and 31 December 2017, of which 120 concerned adults and one children.

| Number of referrals | | |
|---|---|---|
| **Adults** | **Children** | **Total referrals** |
| **120** | **1** | **121** |

There were rooms off the wards that children who were visiting patients could use. This meant that patients could see their young family members in private and in a suitable environment.

Northumberland Tyne and Wear NHS Foundation Trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 January 2017 to 31 December 2017) that relate to this core service.

## Staff access to essential information

Patient information was stored on a computer and all staff could access it. All information needed to provide patient care was computer based and available to all relevant staff. In addition, staff kept written records throughout the day of patients' dietary intake their health checks and how their mood was. This information was added to the progress notes on the computer. However, we saw that these notes were not always added to the record in a timely way.

## Medicines management

The trust had introduced a management of medicines system where staff could only access the medicines with their fingerprint. To access controlled drugs two staff had to access the system. Ward staff told us that pharmacists and pharmacy assistants worked closely with them. They visited the wards daily as well as attending the multidisciplinary team meetings. One manager told us this daily support had meant that when a patient had been unable to take their medication in tablet form they were able to switch to liquid medication, without missing any medication. Pharmacy staff also labelled medicines on the ward ready for patient discharges or periods of home leave. There were adequate supplies of emergency equipment, oxygen and defibrillators. The wards kept stocks of emergency medicines as per the trust resuscitation policy, and a system was in place to ensure they were fit for use.

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

During our inspection, we reviewed all the medication charts. We found systems in place to monitor the quality of medicine administration records. The wards had appropriate arrangements for the management of controlled drugs. These medicines require extra checks and special storage arrangements because of their potential for misuse. We saw one example of medicines given covertly (this is where medicines are disguised in food or drinks when patients lack capacity). The decision to give medication covertly was in accordance with the Mental Capacity Act, we saw corresponding records of best interests decisions in the patient's notes.

Staff ensured they monitored the effects of medication on those patients prescribed medication for physical co-morbidities. No patients received high doses of anti-psychotic medication at the time of our inspection. These medicines require additional physical health checks.

## Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were two STEIS incidents reported by this core service. Both of these were categorised as 'Slips/trips/falls meeting SI criteria'.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS where only one serious incident was reported for this core service.

The number of serious incidents reported during this inspection was lower than the nine reported at the last inspection.

| | Number of incidents reported | | |
|---|---|---|---|
| Type of incident reported on STEIS | Roker | Woodhorn | Total |
| Slips/trips/falls meeting SI criteria | 1 | 1 | 2 |
| Total | **1** | **1** | **2** |

## Reporting incidents and learning from when things go wrong

Staff had a clear understanding of what constituted an incident and how to report it using the trust's electronic risk management system. We reviewed a range of incidents reported by staff during the three months preceding the inspection. This included verbal and physical aggression, damage to property and low staffing. The system escalated notifications of incidents to ward managers, and if appropriate to senior managers, dependent upon the severity. This ensured appropriate investigation.

Staff on all wards confirmed they received debriefing after serious incidents. Staff discussed incidents and lessons learned during handover and team meetings. Information was shared amongst the trust on a monthly Safe Care bulletin. This meant that staff learnt from incidents in order to improve their practice. Other staff could also be involved in the debrief including the psychologist, tissue viability nurse, the dietician and the managing violence and aggression trainers.

Staff had access to a Positive and Safe Supervision Group this met every fortnight. All staff were welcome and it was an opportunity to discuss situations and issues that had arisen. The psychologists provided support to the staff and carers on the organic wards and to patients, staff and carers on the functional ward.

Staff knew about the requirements placed on them to meet the duty of candour. Duty of candour regulations ensure that providers are open and transparent with patients and people acting on

their behalf in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Duty of candour was included in the incident reporting system as a prompt and actioned where necessary. Staff were aware of the need for openness and transparency if there was an incident. They encouraged patients and their carers to complain if they were concerned about any aspect of care. Records showed that managers apologised to relatives for shortfalls in patient care and sent formal letters of apology.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Northumberland Tyne and Wear NHS Foundation Trust.

# Is the service effective?

## Assessment of needs and planning of care

We looked at 32 patients' care and treatment records across the core service Patients had well-organised and documented assessments and care plans that were clear, up to date and available to all staff providing care.

Across the service staff kept components of patients' assessments and care plans in different places on the computer system. This could potentially lead to confusion for anyone not working regularly on the ward. The care records seen were holistic and were individual to the patient concerned. Staff had used either the Newcastle model or the five Ps model of formulation depending on whether they were in hospital because of an organic or functional issue.

Medical and nursing staff carried out their initial assessment over a three-day period. This included both mental and physical health assessments with junior doctors taking the lead for physical health. There were appropriate investigations to rule out a physical health cause for people admitted with confusion or suspected early stages of dementia.

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

Following assessment, staff formulated care plans relating to different aspects of the patient's care. These covered diet and hydration, challenging behaviours, tissue viability, falls and other patient specific needs. They recorded the care plans onto the electronic system. Of the 32 electronic records we looked at, 30 had current care plans. The other two patients had been very recently admitted and care plans were still in the formulation process. We found that care plans were focused on the individual and provided staff with an overview of the help and support a patient might need.

We did observe personalised and detailed care discussions in multi-disciplinary meetings. However, staff had not always reflected these in care plans recorded on the electronic system.

Staff discussed levels of care within handover meetings. There were three handover points during the day with two meetings scheduled for only 10 minutes and one scheduled for longer. The care plans contained personalised detail for example where a patient could be vocally aggressive and what actions staff should take to mitigate this behaviour. Other plans included what meaningful activities would help staff, for one patient staff were instructed to give them a picture of their family whilst trying to assist with personal care as it comforted and calmed them. In another care plan it had been identified that a patient who was losing weight would eat and drink from china crockery whereas if a plastic mug was used then they would throw the drink away, so china crockery was provided.

Staff on all wards were knowledgeable about the patients they were caring for and we observed positive interactions. This included staff knowing when to leave a patient alone or encourage them to join in with an activity.

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

Doctors carried out physical examination of patients on their admission. Doctors were easily available at all times to undertake physical examinations. Patients with physical health problems received on-going appropriate monitoring, for example physical observations and blood tests, in accordance with national guidance.

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

## Best practice in treatment and care

We looked at 32 patient care records and 67 prescription records.

The multidisciplinary team provided a range of care and treatment interventions suitable for the patient group. Staff used and followed guidance recommended by the National Institute for Health and Care Excellence. For example, 'Violence and aggression: short-term management in mental health, health and community settings' (NG10) and 'Falls in older people: assessing risk and prevention' (CG161).

The service offered medication and psychological therapies. We found evidence of good practice in recording and reviewing all prescription records. We found medical staff followed National Institute for Health and Care Excellence best practice guidance and prescribed medication within British National Formulary limits in the 67 records we reviewed. No patients were prescribed high dose antipsychotics. There was a low use of psychiatric medications although many patients had physical co-morbidities. Medical staff did not prescribe hypnotics for more than seven days. The pharmacist regularly checked that prescribing and relevant physical checks were in keeping with best practice.

All wards had psychological provision. The psychologist provided cognitive testing and facilitated reflective practice and formulation sessions with staff, which supported them with the work they did with patients. They also provided support to carers through the formulation sessions helping them to cope, with emotions and long-term conditions.

Staff worked with patients, relatives, and carers to obtain accurate information about patients' life stories, which they summarised in a formulation document. This ensured staff provided care and

treatment to patients with dementia, which was individualised and respected patients' individuality in line with recognised research into providing quality dementia care.

Physical health needs were an essential feature of patient care on the wards. Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Medical and nursing staff considered, addressed and monitored patients' physical health needs and ensured patients accessed specialist advice if needed.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. They completed the malnutrition universal screening tool for relevant patients with corresponding care plans. Staff used the modified early warning system tool to help monitor patients' physical health. National early warning scores monitor heart and breathing rate, blood pressure, level of consciousness, oxygen saturation, and temperature. Patients had physical observations taken daily if staff had concerns.

Patients received electrocardiogram testing to check the heart's rhythm and electrical activity and had blood tests where appropriate. Falls and osteoporosis screening tools were completed and staff referred patients to physiotherapy if required.

Staff supported patients to live healthier lives. For example, they offered patients advice and support with healthier eating and dealt with issues relating to substance misuse such as alcohol detoxification.

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

Staff participated in clinical audits specific to the service. These included audits such as compliance with the Mental Health Act and Mental Capacity Act, and defensible documentation. Staff also carried out regular checks of equipment and medicines to make sure they were safe to use.

Please refer to the table below for information about 14 clinical audits the core service participated in as part of their clinical audit programme for 2017.

This core service participated in 20 clinical audits as part of their clinical audit programme 2016-2017.

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **CA-17-0014: Evidencing Person Centred Care through collaborative Care Planning within Older Peoples in-patient services** | Older peoples inpatient services | MH: wards for older people with mental health problems | Clinical | 20.09.17 | The Ward Managers refreshed their ward action plans to focus on standards 9 and 10.<br>The Clinical Nurse Lead's focus on standards 9 and 10 in clinical supervision. |
| **CA-17-0021: Evidencing Person Centred Care through collaborative Care** | Older Peoples Inpatient Services | MH: wards for older people with mental health problems | Clinical | 15.11.17 | Indicators listed on the older people wards plans, for targeted action Clinical Supervision and |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **Planning within Older Peoples in-patient services** | | | | | will be monitored by the Clinical Managers. |
| **CA-15-0112: Physical Health Monitoring in Antipsychotic medication according to Trust guidelines.** | (North Inpatient Services) | MH: wards for older people with mental health problems | Clinical | 13.06.17 | For doctors - commencing antipsychotics to developed a good practice for documenting when 3 month and 6 month monitoring.<br>Developed a good practice for regularly documenting the antipsychotic medication side effects weekly during the ward rounds.<br>Physical health monitoring guidelines distributed onto ward.<br>Developed a good practice of documenting weight and BMI in physical health monitoring section on RiO. |
| **CA-16-0063: Evidencing Person Centred Care through collaborative Care Planning within Older Peoples` in-patient service** | (Central Inpatient) | MH: wards for older people with mental health problems | Clinical | 25.04.17 | The Senior Clinicians planed and delivered a series of 6 development days commencing January 2017 to all registered nurses in Older Peoples Services refocussing on care planning principles particularly in relation to personalisation and collaborative working. |
| **CA-16-0064: Discharge Summaries for Older Peoples Inpatient Services** | (Central Inpatient) | MH: wards for older people with mental health problems | Clinical | 26.09.17 | 1. Shared audit findings.<br>2. Disseminated audit report.<br>3. Discussed findings at Medical Education Programme's meeting at St Georges Park.<br>4. Team managers emailed reminder to staff responsible for discharge summaries. |
| **CA-16-0068: Baseline monitoring on initiation of antipsychotics in the elderly (>65 years) in** | (Central Inpatient) | MH: wards for older people with mental health problems | Clinical | 11.07.17 | 1. Presented findings to MDT on 6/6/17 to raise awareness of the findings.<br>2. Provided information summarising guidelines at induction to new |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **concordance with NICE guidelines** | | | | | doctors working on Akenside and Castleside. |
| **LLCA-99-0027: Are 72-hour meetings being completed within the recommended time limit on organic in-patient wards (Mowbray & Roker)** | South Inpatient CBU | MH: wards for older people with mental health problems | Clinical | 01.06.17 | Staff made aware of Trust Policy stating that MDT meeting should take place within 72-hours.<br>72 hour meetings now arranged at the time of admission.<br>Consideration given to the use of a simple proforma to clearly document efforts made to arrange meetings. |
| **CA-16-0062: Controlled Drugs Audit** | (Medicines Management) | Trust wide | Clinical | 03.05.17 | Pharmacy staff undertaking quarterly CD balance checks and annual CD Audits.<br><br>Review of completion of quarterly CD balance checks and escalation to Pharmacy Managers Group where outstanding.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter.<br><br>Pharmacy staff liaised with the Registrant in Charge at the time of CD balance check and review the currency of the authorised signatory list for nursing staff.<br><br>Registrant in Charge reviewed the authorised signatory list and return a signed copy to pharmacy within 28 days.<br><br>UHM-PGN-04 Controlled Drugs, section 11.8 amended to incorporate this requirement.<br><br>Audit tool for Omnicell cabinets had question five removed for the 17/18 audit cycle.<br><br>Question seven of the Omnicell audit tool amended to include further guidance to pharmacy staff to check |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | manual CD orders only for the 17/18 audit cycle.<br><br>Guidance for ward staff provided in the next edition of the MMC Newsletter. |
| **CA-16-0037: Medicines Management: Safe and Secure Medicines Handling (MMRA)** | Trust wide | Trust wide - All Inpatient Wards | Clinical | 21.06.17 | 1. Annual MMRA audits downgraded to Trust level priority plan for 2017/2018 rather than Board Assurance plan.<br>2. Results of the annual 2016/2017 MMRA report shared with the CQCQCG to aid learning.<br>3. Process introduction of Temperature Monitoring Sheet kept by the medicines refrigerator, using the Min/Max thermometer.<br>4. Risk assessments and audits reported monthly to Pharmacy Managers Group. Escalation to MMC where necessary.<br>5. UHM-PGN-01 Safe and Secure Medicines Handling and Supply of Medicines incorporated additional guidance to ward staff on completing and returning the annual Medicines Management Risk Assessment.<br>6. SSMH monitoring tool incorporates additional questions which provide assurance that legally valid Patient Group Directions are being used correctly. |
| **CA-17-0001: Medicines Management: Prescribing Administration and Prescribing Clinical Checking Standards Take 5 Audit** | Inpatient Units | Trustwide - All Inpatient Wards | Clinical | 17.05.17 | Process changes:<br>1. Data collection and analysis of results from 'Take 5' drug administration and prescribing audits should be conducted by nursing and medical staff, respectively, using the electronic form developed and piloted through CQCQCG.<br>2.Audit results now fed back to individual Ward and Service Managers at the time when the audit results are |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | compiled.<br>3. Medical, nursing and pharmacy staff now review local audit results with Ward Managers and prescribers to identify themes and learned lessons.<br>4. Medical staff now receive a regular feedback of prescribing audit results.<br>5. Any red/amber ratings are now discussed and mitigating actions to rectify put in place.<br>6. Lead Clinicians and Lead Clinical Pharmacists jointly investigate areas of concern / poor performance. |
| **CA-16-0045: Topic 7e: Monitoring of patients prescribed lithium** | Trust Wide | Trust wide Inpatient Wards | Clinical | 18.10.17 | Calcium monitoring is included in all lithium documentation (including RiO and shared care) at baseline and maintenance.<br>Calcium monitoring added to clinic standard work at baseline and maintenance.<br>Publish article in the MMC Newsletter on monitoring calcium in lithium therapy.<br>The pharmacy team carries out a Medicines Management Risk Assessment annually in all wards and teams across the Trust. The following questions have been added to the checklist: |
| **CA-16-0073: Audit on the management of diabetes and hypoglycaemia** | (Medicines Management) | Trust wide Inpatient Wards | Clinical | 03.05.17 | Policy author of PPT-PGN-02 presented with the findings of this audit and review undertaken by MMC as to the scope of the policy.<br>MMC Newsletter incorporated an article reminding prescribers of the importance of prescribing dextrose and glucagon on the 'as required' side of the |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | Kardex in patients receiving insulin.<br><br>Physical Health and Wellbeing group received the findings of this audit and established who is appropriate to manage the action. |
| **LLCA-99-0001: A review of inpatient PRN prescribing in a Mental Health Trust** | Medicines Management | Trust wide Inpatient Wards | Clinical | 17.08.17 | There is now clarity on process and responsibilities for staff in relation to the review of `as required` medication.<br>There are improved controls in place for the safety of the patient.<br>Review Box was added to Kardex to prompt review of PRN medication once so many administrations had been given, to avoid situations where medication was being over used, should be regularly prescribed or the condition was deteriorating and not getting addressed e.g. pain killers. |
| **CA-16-0046: Topic 11c: Prescribing antipsychotic medication for people with dementia** | Trust Wide | MH - wards for older people with mental health problems | Clinical | 20.09.17 | Process change introduced the requirement for Medical staff to complete RiO form 'Prescribing of Antipsychotics - Initiation Plan' at specified time points. Instruction cascaded to relevant areas.<br><br>Audit results and actions fedback to OPS team.<br><br>Consideration of introduction of governance system for monitoring completion of RiO initiation and review forms.<br><br>Produced and circulated reminder document on use of antipsychotics in patients with dementia to all relevant prescribers<br><br>Discussed with RiO team addition of link to |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | initiation and review RiO forms to aid locating forms and addition box to reflect capacity status.<br><br>Instruction cascaded to relevant areas. |
| **CA-16-0047: Nutrition** | Trustwide | MH - Acute wards for adults of working age and psychiatric intensive care units<br>MH - Long stay / rehabilitation mental health wards for working age adults<br>MH - wards for people with learning disabilities or autism<br>MH - wards for older people with mental health problems<br>MH - Forensic inpatient / secure wards<br>MH - child & adolescent mental health wards | Clinical | 15.02.17 | Improved liaison with medical colleagues re consulting with Dietetic Services when considering prescribing nutritional supplements. Auditors fedback to Dietitians and ward managers in areas where screening requires improvement. CNM's asked to follow-up to ensure improvements take place e.g. complete spot checks within their service area. |
| **CA-17-0004: Seclusion 16-17** | Trustwide | MH - Wards for adults of working age and psychiatric intensive care units<br>MH: Long stay / Rehabilitation mental health wards for working age adult<br>MH: Wards for older people with mental health problems<br>MH: Forensic inpatient / secure wards<br>All reported seclusions within inpatients wards for 2016-2017 | Clinical | 20.09.17 | Internal CAS Safety Alert for information and action was circulated on behalf of the Seclusion Steering Group. CAS reminded staff to contact the doctor immediately following the initiation of seclusion and of the importance of completing physical health monitoring following IM medication; including recording the reasons why observations cannot be completed, in particular respirations. |
| **(CA-15-0052: NICE (Implementation CG78: Emotionally** | Trustwide | MH - Wards for adults of working age | Clinical | 15.03.17 | Develop use of screening tools within community services and |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **Unstable Personality Disorder** | | and psychiatric intensive care units<br>MH: Long stay / Rehabilitation mental health wards for working age adult<br>MH: Wards for older people with mental health problems<br>MH: Forensic inpatient / secure wards<br>Diagnosis of 'definite' or 'probable' diagnosis for EUPD across all inpatient services | | | use of PD Pathway Guidance.<br>Recording of 5P's formulation on Rio, as a minimum.<br>Increased scaffolding checks of diagnosis and formulation on admission.<br>Greater use of PD Pathway Guidance and CRS PGN on PD & co-morbid conditions.<br>More discussion and recording of purpose of admission and goals with service user.<br>Recording of links to risk management plans on Rio. Discussion and recording of service user choices on Rio.<br>Roll out of Structured Clinical Management Training in Community Services.<br>Identification of critical indicators for admission, for example, risk management, assessment, specific treatment intervention and clarity about the factors that will confirm that identified goals have been met.<br>Mutually agreed meaningful contact arrangements with care co-ordinator during admission to facilitate timely discharge planning.<br>Continuation of psychological work by community clinical psychologist /psychological therapist on discharge, in collaboration with Community MDT.<br>Improved assessment of self-harm via roll out of SCM training and clinical risk training in community services.<br>Improved assessment of self-harm via roll out of bespoke SCM (or other PD awareness) training and clinical risk training in inpatient services to |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | ensure continuity of care during admission.<br>Explicit self-harm management plan that addresses the need for positive risk taking to be mutually agreed as part of discharge plan.<br>Discussion with service users about the purpose of eyesight observations and any changes to observation levels and their responsibilities during this.<br>Principles of service user responsibility for their safety management to be reinforced via care planning process in community services.<br>Community services MDT and allocated Care coordinators to jointly agree critical indicators for admission and review milestones that will indicate goals have been met. Community MDT and Care coordinator to agree. |
| **CA-15-0092: NICE (Implementation) CG103: Audit of clinical practice against Quality Delirium Standards** | Trustwide | CHS: Community based mental health services for older people<br>MH: Acute wards for adults of working age and psychiatric intensive care units<br>MH: Wards for older people with mental health problems | Clinical | 18.10.17 | Results disseminated by Group Business Meetings (dates arranged) and cascaded down to CBUs, CMTs and Wards. Providing details on observations that are being completed consistently and emphasise the need for ward staff to be completing measures in cognitive impairment, pain, constipation and nutrition, and to note a summary of the recordings in the first 24 hours on RiO.<br><br>Liaison with IT/RiO to put measures (CAM and PINCHE ME) onto RiO and embed into future e-pathways.<br><br>Tailored care intervention checklist to be constructed around PINCH ME and training providing when introduced to ward staff |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | to improve practice and implemented on all 3 sites.<br><br>The reviewed delirium information leaflet added to the standard 72-hour meeting pack. Leaflets can also to be put on the intranet and internet. GP delirium leaflet to be included with discharge summary letters to GPs.<br><br>Delirium status during admission to be stated on all discharge summaries for patients in Older Person's Inpatient Services. Where positive, include the GP delirium leaflet in with the discharge summary as standard. |
| **CA-16-0079: Audit of Transition between Inpatient and Community Services** | Inpatient/Community | CHS: Community-based mental health services for older people<br>CHS: Community-based mental health services for adults of working age<br>MH: Acute wards for adults of working age and psychiatric intensive care units<br>MH: Wards for older people with mental health problems | Clinical | 20.09.17 | Added to the admission checklist, who is invited to the 72 hour meetings and record it on RiO.<br><br>Adult inpatient wards in Northumberland are trialling skype from May to July 2017.<br><br>E-mail sent to all team managers to remind staff of the need to record frequency of care co-ordinator contact whilst patient is an in-patient. Care Co-ordinator to create an individual care Plan. Team Managers to monitor through supervision.<br><br>Frequency of contact agreed now on the Care Co-ordination Review form at the 72 hour meeting.<br><br>Produced a briefing sheet outlining expectations including:-<br>1. Need for physical health checks, diagnosis screen and medication screen and mental state to be updated by in-patient staff as part of the discharge process. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | 2. Need to communicate in writing and if possible by telephone to GP, if patient is being discharged, has complex issues and is being discharged on the CTO – e-mail from RN 10/09/2015.<br><br>Standard method introduced of recording the named Community Consultant in the discharge planning meeting on the care co-ordination review form and the discharge summary. |
| **CA-15-0050: Audit of cognitive enhancer prescribing, in NTW, in relation to NICE guidance** | (CSG) | CHS: Community-based mental health services for older people<br>MH: Wards for older people with mental health problems | Clinical | 21.02.17 | A quality literature review as a reference was undertaken. Presentation of audit results within an NTW Trust audit meeting and highlight the audit findings to prescribing groups and for them to consider their practice in this area. |

## Skilled staff to deliver care

The team had access to a full range of staff required to meet the needs of patients on the wards. This included consultant psychiatrists, doctors, qualified nurses, healthcare assistants, pharmacists, psychologists, occupational therapists and assistants. Staff had access to other specialists within the trust such as speech and language therapists and physiotherapists.

Staff were experienced and had the right skills and knowledge to meet the needs of the patient group. New staff undertook an employee induction and this included local team induction and a corporate induction workshop.

Staff had access to team meetings, which took place on each ward. We saw minutes from several team meetings. They were informative, detailed and evidenced that staff discussed a variety of topics including training and supervision, changes within the trust and acknowledgement and praise to individual staff. Staff could also access a Positive and Safe supervision group which met twice a month.

Psychology support was available to staff, patients and carers and reflective practice meetings were held following any incidents on the ward.

The trust's target for appraisal compliance was 85%. As at 31 December 2017, the overall appraisal rate within this core service was 95%.

In information provided before the inspection Castleside had reported a compliance rate of 82% for appraisals, however, during the inspection, we were able to see that this figure had risen to above 85%. There was no medical appraisal information provided for this core service.

The wards/teams failing to achieve the trust's appraisal target were Castleside with an appraisal rate of 82%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 100% reported at the last inspection.

| Ward name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Castleside** | 33 | 27 | 82% |
| **Marsden** | 39 | 35 | 90% |
| **Roker** | 28 | 27 | 96% |
| **Mowbray** | 29 | 28 | 97% |
| **Akenside** | 28 | 28 | 100% |
| **Cleadon** | 34 | 34 | 100% |
| **Hauxley** | 26 | 26 | 100% |
| **Woodhorn** | 34 | 34 | 100% |
| **Core service total** | **251** | **239** | **95%** |
| **Trust wide** | **3922** | **3228** | 82% |

Managers provided staff with regular supervision, which was used to help review and identify any areas for development and good practice. Staff told us they found supervisions useful and they were able to be open about all areas of their work and wellbeing. We saw that qualified staff received supervision monthly and we saw that unqualified staff had signed a contract for supervision and they received supervision bi-monthly.

Staff had opportunities to develop their skills and knowledge within their roles. Staff were encouraged to take on lead roles and act as champions in key areas in which they were supported to undertaken additional training. Staff had access to further training and some were completing specialist training in the areas of personality disorders, dementia awareness, alcohol and substance misuse and other subjects. Staff told us they felt supported and able to access further training to aid their personal development. Some staff were able to have dedicated time to use for their own development.

Managers were able to deal with poor staff performance when necessary. Dependent on the issues, they would seek to identify whether the staff member had any additional training needs or required extra support. Where cases required disciplinary action, the trust had a policy and procedures to help managers ensure due process was followed. Managers also received training to support them with the disciplinary process.

The trust has informed us a clinical supervision target rate is not specified in their policy.

Between 1 January 2017 and 31 December 2017, the average rate across this core service was 95% ranging from 79% for Woodhorn ward to 135% for Hauxley ward.

Clinical supervision for medical staff has not been broken down by core service. The trust has informed us “As per Royal College of Psychiatry requirements, our medical staff all engage in a process of peer supervision, which occurs at least 4 times a year within their peer group. Clinical work and performance, along with peer supervision notes, are also reviewed annually, through the appraisal process, and ultimately the GMC revalidation process every five years. The trust medical appraisal rates are shown above as a proxy for clinical supervision.”

**Caveat:** there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

The rate of clinical supervision reported during this inspection was higher than the 75% reported at the last inspection.

| Ward name | Clinical supervision sessions required | Clinical supervision sessions delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Woodhorn** | 278 | 220 | 79% |
| **Marsden** | 432 | 352 | 81% |
| **Akenside** | 309 | 270 | 87% |
| **Cleadon** | 335 | 301 | 90% |
| **Castleside** | 247 | 229 | 93% |
| **Roker** | 254 | 249 | 98% |
| **Mowbray** | 1035 | 1040 | 100% |
| **Hauxley** | 188 | 254 | 135% |
| **Core service total** | **3078** | **2915** | **95%** |
| **Trust Total** | **29957** | **26917** | **90%** |

## Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss and inform the needs of patients receiving support at the service. We observed four separate multidisciplinary meetings on the Castleside, ward, Roker ward, Mowbray ward and Hauxley ward. These included a range of professionals from the service and patients, and carers, were able to attend. We observed that staff were respectful and knowledgeable about patient’s care needs and the meetings were centred on the needs of patients. Staff told us there were some challenges in including all relevant people at such meetings. This included community co-ordinators, caseworkers and sometimes nursing staff on the wards. Each ward had an ‘at a glance board’ that allowed staff to see what the issues were that needed attention before the patient could be discharged. This included social issues such as housing, finances, and family and carer networks alongside information about their admission to hospital.

The wards had a system for handover of patient information to help ensure effective care. Staff handovers occurred at each shift change where staff relayed information about patient’s care needs. We observed one handover that took place in the middle of the day. The other handovers

were at the change of shift and were allocated 10 minutes, however, they over ran and staff did not leave until all pertinent information had been shared. Staff discussed a range of useful information where there was significant information to report. This included patient risk, safeguarding matters and incidents. All patients were discussed at handover.

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

As of 31 December 2017, 84% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 92% reported at the last inspection.

Staff had access to administrative support and legal advice from the trust's Mental Health Act administrations office. Staff knew who the administrators were and how to make contact with them. There were copies of the Mental Health Act code of practice on wards and staff could access this electronically and access guidance via the trust intranet.

Patients had access to information about advocacy support available to them. Information was displayed around the wards about how to contact the service and advocates attended the wards. Some individual patients told us about their experiences with the advocacy service which were positive.

Staff explained detained patients' rights to them in accordance with the provisions of the Mental Health Act in a way they could understand. There was evidence of staff making repeat attempts where a patient did not understand their rights and also referring them to an advocate. Patients told us they were aware of their rights and staff had explained these. Records showed patients had all been informed of their rights recently and their understanding of these was documented.

Staff ensured patients were able to take section 17 leave from hospital where this had been granted. We reviewed the leave forms of the detained patients care records we reviewed. These were in order. We did find that an informal patient had section 17 leave forms in their notes, the leave notes were removed before we left the site.

Staff requested an opinion from a second opinion appointed doctor when necessary. We saw evidence of doctors making requests for this service where required.

Staff stored copies of patients' detention papers and associated records so they were available to all staff that needed access to them. Copies were kept on the electronic patient record but staff also kept a paper copy in the office so all staff could access this. Wards also scanned and sent copies of detention paperwork to the main Mental Health Act office for their records.

The wards displayed a notice to tell informal patients that they could leave the ward freely.

The Mental Health Act team completed regular audits to ensure that the Mental Health Act was being applied correctly and to establish whether there was any learning from these. Managers told us that any results and actions would be fed back for them to review and act upon.

## Good practice in applying the Mental Capacity Act

Staff we spoke with understood the basic principles of the Mental Capacity Act and its application. They knew how to access information about the Mental Capacity Act and trust policy online and where they could seek further advice from within the trust. The service took part in a trust audit to monitor its adherence to the Mental Capacity Act.

Staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis about significant decisions. Staff gave patients assistance to make a specific decision for themselves where possible. When staff deemed patients lacked capacity, they made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture, and history. We saw completed best interest decisions; including comprehensive best interest decision records around do not attempt resuscitation orders and covert medication.

As of 31 December 2017, data for the Mental Capacity Act training was not submitted, however it was outlined as a Mandatory course in the last inspection. Mental Capacity Act training was included in the Mental Health Act training and 84% of staff had completed it.

The training compliance reported for the last inspection was 94%.

The trust told us that 23 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 January 2017 and 31 December 2017.

The greatest number of DoLS applications were made in June with four.

The trust reported 87 notifications made to CQC in their PIR submission and 41 applications approved.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

We carried out eight short observational framework inspections and we observed positive interactions between staff, patients and their carers. There was a strong, visible person centred culture, which stemmed from staff knowledge and skill in managing their patients' preferences. Staff offered care that was calm, kind, and promoted people's dignity. We also observed the multi-disciplinary team's consideration and regard for patient privacy and dignity and how this translated into practice. Staff actively protected distressed patients and patients whose circumstances made them vulnerable, while providing emotional and practical support to the patients' carers and relatives. They participated in individual patient activities and provided patients and carers with help, support and advice as it was required.

Staff involved patients in their care in a meaningful way due to their cognitive impairment. They engaged with relatives to help them understand how to manage their loved ones' care, treatment, and condition. We saw that staff used distraction to help patients when they were frustrated and getting angry; these included putting music on that they enjoyed and danced to, making a cup of tea or taking them for a walk.

At Akenside, Cleadon and Hauxley wards, staff helped patients understand and manage their care and treatment during one to one time, reception meetings and care plan discussions. Staff on both wards understood their patients' individual physical, emotional, and social needs and reflected this in the care and treatment they provided.

On Hauxley, ward one patient told us that staff were polite and respectful and they could access an advocate if they wanted to. All of the other patients we spoke with shared this view.
We spoke with 18 carers and they told us that staff were ‘brilliant’ and ‘they do a marvellous job’. Relatives told us they felt involved in the care planning process and staff took the time to discuss any issues they might have. Relatives also told us the wards kept them informed of any incidents or changes in the care plan. Relatives who lived away from the area told us the staff kept them informed about any changes or incidents involving their relative. They told us they used programmes such as Skype to enable them to be involved in the care planning process and to keep in contact with their relative.

Staff maintained confidentiality of information about patients. The location and design of the staff office on both wards meant that it was not possible for others to see confidential information contained on visual display boards.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location scored higher than similar organisations.

One location, Campus For Ageing and Vitality (85.2%) scored lower when compared to other similar trusts for privacy, dignity and wellbeing.

Please refer to the table below for details of the patient led assessment of care environment score.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Campus For Ageing and Vitality** | MH - Wards for older people with mental health problems | 85.2% |
| **Monkwearmouth Hospital** | MH - Wards for older people with mental health problems | 92.1% |
| **St Georges Hospital, Morpeth** | MH - Wards for older people with mental health problems | 93.25% |
| **Trust overall** | | **93.6%** |
| **England average (mental health and learning disabilities)** | | **90.6%** |

## Involvement in care

### Involvement of patients

Staff on all the wards helped orient patients to the ward with a tour of the ward and a comprehensive information pack welcoming them to the ward. The pack discussed practical matters about being a patient and explained the care and treatment provided.

Staff involved patients and their carers in their care planning and risk assessments. Not all patients could remember if staff offered them copies of their care plan. The care plans we reviewed showed staff had offered patients and/or their carers a copy of their care plan. Staff clearly documented patient involvement in their care plan records, where this was possible.

Staff encouraged patients to give feedback on the service in a variety of ways. Patients had an opportunity to comment on the running of the ward at the community meetings. This included discussion about the environment, cleanliness, activities and catering amongst other things. Due to patients' cognitive impairment, staff on Castleside, Marsden, Roker, Mowbray and Woodhorn wards consulted with patients' carers and relatives where this was appropriate.

Staff ensured that all patients had access to an advocacy service, including specialist advocacy for patients detained under the Mental Health Act known as independent mental health advocates. We saw information displayed on the wards about advocacy services. Staff told us that there were good links with the advocacy service. 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 advocacy service.

**Involvement of families and carers**

Staff involved carers and relatives as early as possible in the care planning and risk assessment process, where this was appropriate. Staff gave them a flow chart explaining the order in which things usually happened once a patient came on the ward. This informed carers and relatives about attending the patient's reception meeting, carer's support session, and when the formulation meeting took place. The flow chart included a glossary of terms to help carers and patients understand the terminology used by clinical staff.

The service sought feedback from families and carers using the friends and family survey. The service displayed these results on notice boards.

Carers we spoke with valued their relationships with the staff team and felt that staff were committed to working in partnership with them to understand patients' individual preferences and needs. Staff recognised the importance of patients being in their own communities and we saw evidence that patients had been moved within the trust area to ensure they were near to their own communities. Staff referred carers to the local authority for carer's assessments where appropriate. We saw information boards and information leaflets available for carers on the wards.

We saw very good involvement of families and carers. Wards invited carers and families to the 72-hour post admission meeting and all relevant meetings thereafter. Carers we spoke with valued their relationships with the staff team and felt that staff were committed to working in partnership with them to understand patients' individual preferences and needs. Staff referred carers to the local authority for carer's assessments where appropriate. We saw information boards and information leaflets available for carers on the wards. Some staff on wards took on a carers champion role to ensure the carers and families were integral to the patient's care. Psychologists worked with families to help them understand their relatives mental health condition and how best they could help their relative.

# Is the service responsive?

## Access and discharge

### Bed management

The trust provided information regarding average bed occupancies for eight wards in this core service between 1 January 2017 and 31 December 2017.

Three of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Castleside ward had the lowest occupancy rate at 30 – 50%.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

| Ward name | Average bed occupancy range (1 January 2017 – 31 December 2017) (current inspection) |
|---|---|
| **Akenside** | 44.4% – 66.7% |
| **Castleside** | 30% – 50% |
| **Cleadon** | 83.3% – 100% |
| **Hauxley** | 66.7% – 75% |
| **Marsden** | 38.9% – 72% |
| **Mowbray** | 75% – 108.3% |
| **Roker** | 75% – 116.7% |
| **Woodhorn** | 41.7% – 54.2% |

The trust provided information for average length of stay for the period 1 January 2017 to 31 December 2017.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

| Ward name | Average length of stay range (1 January 2017 – 31 December 2017) (current inspection) |
|---|---|
| **Akenside** | 35 – 90 days |
| **Castleside** | 8 – 163 days |
| **Cleadon** | 61 – 262 days |
| **Hauxley** | 41 – 193 days |
| **Marsden** | 105 – 679 days |
| **Mowbray** | 36 – 119 days |
| **Roker** | 76 -152 days |
| **Woodhorn** | 38 - 197 |

This core service reported six out of area placements between 1 January 2017 and 31 December 2017.

As of 29 March 2018 this core service had no ongoing out of area placements. However, patients could be placed out of their locality but still within trust accommodation. During our inspection we

observed one patient being transferred back to their home location of Sunderland. This ensured family were able to visit on a more regular basis.

No placements that lasted less than one day, and the placement that lasted the longest amounted to 13 days.

Five out of the six out of area placements were due to capacity issues, while one placement was due to the specialist needs of the patient.

| Number of out of area placements | Number due to specialist needs | Number due to capacity | Range of lengths (completed placements) | Number of ongoing placements |
|---|---|---|---|---|
| **6** | 1 | 5 | 2-13 days | 0 |

This core service reported 13 readmissions within 28 days between 1 January 2017 and 31 December 2017.

Five of readmissions (38%) were readmissions to the same ward as discharge.

The average of days between discharge and readmission was 15 days. There were no instances whereby patients were readmitted on the same day as being discharged and there were no instances where patients were readmitted the day after being discharged.

| Ward name | Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|---|
| **Akenside** | 1 | 1 | 100% | 12 | 12 |
| **Cleadon** | 1 | 0 | 0% | 9 | 9 |
| **Hauxley** | 9 | 5 | 56% | 2 - 23 | 18 |
| **Marsden** | 1 | 1 | 100% | 13 | 13 |
| **Roker** | 1 | 1 | 100% | 5 | 5 |

### Discharge and transfers of care

Between 1 January 2017 and 31 December 2017 there were two delayed discharges within this core service. This amounted to less than 1% of the total discharges from the core service overall (4027).

Planning for a patients discharge started from the point of admission. Staff made robust plans to prevent a patient's re-admittance once the discharge plans commenced. If a patient was moving to on-going care facilities, the patient's named nurse would visit the team at the new care facility. This gave an opportunity to present all information so that their future care was effectively managed. This included the patient's likes, dislikes, history, needs and risks. Staff invited family and carers to the presentation and the nurse lead for challenging behaviour would work with onward care facilities if needed. The Hauxley and Woodhorn wards benefited from the Sunderland Intensive Support Team. They worked with ward staff, families and other care facilities to ensure care packages were successful. This reduced the trauma patients may face due to being moved and therefore reduce the likelihood of being re-admitted to the wards. Staff from the patient's ongoing care facilities were also invited on the wards prior to a patient's discharge to observe methods of care proven to give positive outcomes.

## Facilities that promote comfort, dignity and privacy

Wards had sufficient space for activities and care. Rooms were comfortable, clean and spacious. However, there was limited space for visitors on Castleside and Akenside meaning visiting mostly took place in patient's bedrooms. All of the wards with the exception of Castleside had used colour and clear signage to help patients identify where in the ward they were. On Castleside, some of the signage had been removed and had not yet been replaced.

Patients could personalise their bedrooms if they wished. Memory boxes were located outside bedrooms on Roker ward. Family and carers had filled these with family pictures, cards or memorabilia to help orientate the patients with dementia and know where their room was.

Bedrooms contained clocks and some had digital screens displaying the date and time. Patients could also use these to view photo shows through a personal memory stick. There was access to a telephone to make a private phone call on each of the wards. For some wards this was a ward mobile phone that patients could use and on others, there was a private booth where patients could sit to make their call. Bedrooms on all the wards except Akenside and Castleside had motion activated lighting, which meant if patient got up in the middle of the night lighting would come on. If necessary, the motion sensors would alert staff to someone getting out of bed. This meant staff were aware of when someone got out of bed and could go and provide appropriate assistance. All of the bedrooms had a nurse call system in place.

All wards had access to outside space. However, patients on Akenside and Castleside could only access the garden with staff. Akenside was situated on the first floor and patients had to use the lift to access the garden. The door to the garden was locked and equipment in the garden was not stored safely. The manager was made aware of this during our inspection and the outside space had been made safe before we left. Gardens for the other wards were accessible, unlocked and well maintained.

Patients we spoke to were all positive about the food. All patients were able to have hot drinks and snacks at all times although on some wards they would have to request these. We saw that patient's dietary needs and preferences had been identified and staff were knowledgeable about the patient's needs. We observed positive interactions during mealtimes and when a patient needed assistance staff provided in a respectful way. Special diets were catered for and we saw evidence of patients following a high calorific diet.

Activity co-ordinators were included in the staff mix for each ward. The co-ordinators worked flexible hours; this meant that they often arranged their hours around significant events. The wards were preparing for Dementia Awareness week and Woodhorn ward was changing its communal area in to a local pub from a time the patients would remember. Other activities provided included; bingo, music, dancing, cinema nights, patients could have their hair done at the local salon or on the ward and pat-a-pet. We observed staff engaging with patients in one to one and group situations. The wards had a Reminiscence Interactive Therapy Activity computer and or hand held tablets. Patients were able to use it to recall memories; it could assist with conversations with family and staff. Patients could watch a movie; create a life story and play interactive games.

The 2017 Patient-led assessments of the care environment (PLACE) score for ward food at the locations scored better than to similar trusts with the exception of St George's Hospital which scored 88%.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Campus For Ageing and Vitality** | MH - Wards for older people with mental health problems | 99.2% |

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Monkwearmouth Hospital** | MH - Wards for older people with mental health problems | 92% |
| **St Georges Hospital, Morpeth** | MH - Wards for older people with mental health problems | 88% |
| **Trust overall** | | **94.8%** |
| **England average (mental health and learning disabilities)** | | **91.5%** |

## Patients' engagement with the wider community

Staff supported patients to maintain contact with families and carers. Carers were able to visit patients on the wards and patients also went on periods of home leave to spend time with their family and friends.

## Meeting the needs of all people who use the service

All staff had completed equality and diversity training and each ward had an equality and diversity lead. Staff spoken with understood their responsibility in providing support for patients with any of the protected characteristics.

The service made adjustments for patients with disabilities and specific communication needs. Each ward had accessible bathrooms and rooms to help accommodate patients with limited mobility. Where patients required additional adjustments, staff had accommodated these. We saw appropriate signage around the wards. This included a mixture of pictures and text and different coloured doors to aid a patient's orientation.

Staff ensured patients could obtain information on their rights, local services and other relevant information. Notice boards on the wards and around the sites included information about local services, patients' rights, how to complain and advocacy services. Staff told us they would be able to provide such information in alternative formats if necessary, for example if patients required easy read information, there were resources within the trust to accommodate this. Staff were able to access materials in other languages and a translation service for patients whose first language was not English.

Staff could accommodate patients' individual dietary requirements to meet their religious and cultural needs. Patients had access to spiritual support. The trust had a chaplaincy, spiritual and pastoral care team. All the wards had a faith box with provision for different religious texts so that people were able to practice their faith.

There were relaxation areas for female patients on the wards. However, on Castleside, we saw that male patients were also using the female lounge, staff swapped the male and female lounges around so that female patients still had their own lounge.

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

## Listening to and learning from concerns and complaints

This core service received 13 complaints between 1 January 2017 and 31 December 2017. Three of these were upheld, six were partially upheld and four were not upheld. None of the complaints were referred to the Ombudsman.

The number of either partially or fully upheld complaints reported during this was lower than the 11 reported at the last inspection.

| Ward name | Total Complaints | Fully upheld | Partially upheld | Not upheld | Referred to Ombudsman | Upheld by Ombudsman |
|---|---|---|---|---|---|---|
| **Akenside** | 3 | 1 | 2 | 0 | 0 | 0 |
| **Castleside** | 1 | 0 | 1 | 0 | 0 | 0 |
| **Hauxley** | 2 | 0 | 0 | 2 | 0 | 0 |
| **Mowbray** | 1 | 1 | 0 | 0 | 0 | 0 |
| **Woodhorn** | 6 | 1 | 3 | 2 | 0 | 0 |

Patients knew how to complain and raise concerns. There was information on display around the wards about how to make complaints, including contacting the Care Quality Commission where patients were detained. Most said they would speak to staff and feel comfortable in raising any issues. Carers also told us they knew how to make any complaints and would try to resolve any issues with staff locally in the first instance.

We saw evidence of staff acting upon patient complaints and concerns. Staff meeting minutes showed discussion about patient complaints. Staff tried to resolve any concerns locally if the circumstances were appropriate. They supported patients to make formal complaints if required.

This core service received 23 compliments during the last 12 months from 1 January 2017 to 31 December 2017, which accounted for 6% of all compliments received by the trust as a whole. Each ward had a ‘tree of hope’ where patients and relatives left positive comments about their experience of the service.

# Is the service well led?

## Leadership

Leaders had the skills, knowledge and experience to perform their roles. Ward managers had a good understanding of the services they managed. Staff told us that team leaders were visible on the wards and we observed this. All staff we spoke with felt well supported by their immediate managers and above. They reported senior managers were visible on the wards. All staff knew the service's care director and reported the chief executive had visited the service and met with staff.

Leadership development opportunities were available and all staff were encouraged to develop. The trust provided ward management and leadership courses for managers. There were opportunities for staff below this level to develop and managers had succession plans which took into account staff progression. Staff felt the ward managers provided leadership and were visible and approachable.

## Vision and strategy

The trust vision was to be a leader in the delivery of high quality care and a champion for patients. This vision was supported by the values, caring, compassionate, respectful, honest and transparent. Staff knew and understood the values and how they applied in their work and team. They had been able to contribute their views to decide on what the final trust values should be. The values and behaviours were included within the staff appraisal process so staff could demonstrate how they worked in accordance with these.

The trust's visions and values were evident throughout the wards. There were displays communicating what the values were. The values were included on the trust intranet. The trust used values based recruitment to help identify suitable staff to work within the trust.

Staff, patients and carers had the opportunity to contribute to discussions about the strategy for their service.

## Culture

Staff we spoke with felt part of the multi-disciplinary team. They reported feeling valued, supported, and respected by their colleagues. We observed staff's commitment to a culture that focused on providing patients with high quality care. Staff respected senior nurses and felt well supported by them.

Staff knew how to use the whistle blowing process and felt able to raise concerns without fear of retribution. They had a varied understanding about the role of the 'freedom to speak up' guardian. 'Freedom to speak up' guardians work with the trust to create a culture where staff speak up in order to protect patient safety, and empower workers.

Managers were able to deal with poor staff performance when necessary. There were processes and policies in place to support this and the trust had a human resources department who would be involved where necessary.

Teams worked well together and managers were able to appropriately deal with any difficulties. A number of staff we spoke with said they felt supported by their ward manager and felt they worked well to manage the team.

Staff had the opportunity to talk about their careers, personal development and objectives within their appraisals. Some individual staff were undertaking further courses to help their career progression and the trust was supportive of this.

Staff had access to support for their own physical and emotional health needs. The trust had an employee assistance programme which provided counselling and other support to staff and an occupational health service.

The trust had schemes to recognise and reward staff success. This included a monthly staff achievement and recognition award and an annual trust awards event.

## Governance

Overall, the trust had an effective governance structure in place to oversee the running of the older adult wards. The trust had recently changed the structure of the services and managers were now responsible for central, north and south inpatient services. This meant that services could develop new ways of working and focus on local populations and their needs.

There was a clear framework about what issues were discussed at senior management meetings. These included discussions about service feedback and ward updates, audits, training and development, safety and risk, feedback and complaints and safeguarding issues. Minutes showed staff discussed incidents and any learning from these and looked at actions and measures to improve the service.

Staff participated in local clinical audits. These included reviews of medication documentation, clinic room and equipment checks, environmental checks and other areas. The wards also participated in trust wide audits.

The associate directors had good clinical oversight and awareness of the challenges facing the service, which they were working to address. For example, high vacancy for qualified staff. The service was actively recruiting to vacancies and exploring ways to recruit and retain staff by looking at development, progression, and succession.

The trust has provided a document detailing their 12 highest profile risks. Each of these has a current risk score of 15 or higher. None relate to this core service.

## Management of risk, issues and performance

Staff discussed service risks at team level and could escalate concerns through line management if needed. Senior managers discussed risks in business meetings and could escalate concerns for inclusion in the trust risk register.

The wards had access to the trust emergency planning and business continuity arrangements.

## Information management

The trust had information management systems to collect data from wards about the service. This helped inform senior managers about the individual and clinical performance of the wards and where improvements were required.

Staff had access to the equipment and technology necessary to undertake their role. They had used computers and laptops to access patient records. Staff were supported by the information and technology unit. Information governance systems included confidentiality of patient records. Only staff with the appropriate authority from the trust by way of a personal log on and password could only access records. Paper records were kept in the main staff office in a back room. When staff were not present in the room, or were completing confidential information they locked the door so patients could not enter. The service reported information governance breaches as serious incidents.

The service made notifications to external bodies where required. This included notifying agencies such as local authorities, community teams and the police where necessary.

## Engagement

The trust worked closely with external stakeholders such as commissioners and NHS Improvement.

Staff had access to the trust's intranet through which they received emails, updates, and newsletters about the trust. They also received updates at team meetings and through supervision. All staff could access the dashboard; this meant they could keep up to date with their training and have an overview of the ward they worked on.

Staff, patients, and carers could access information about the service through the trust website.

Everyone had opportunities to give feedback about the service. This could be formal through staff, patient and carer surveys and comment cards or informal by attending various meetings. Patients told us that they were able to feedback about the service at their one to ones and following a stay.

## Learning, continuous improvement and innovation

Staff had the opportunity and time to consider and engage in opportunities for making improvements. This included personal development such as extra training and undertaking research initiatives.

They had joined the safe wards network and started to roll out some of the modules on the wards. Safe wards is a model that uses various interventions that aim to reduce conflict and containment in inpatient mental health settings.

All wards were members of 'Star Wards'. The following wards had also been awarded 'the Full Monty:

- Roker
- Cleadon
- Akenside
- Castleside

Someone who had experience of mental health services founded the Star wards organisation in 2006. They work in partnership with mental health wards to improve everyone's experiences and outcomes – patients, staff, family, friends and carers.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service would be accredited if they were able to demonstrate that they met a certain standard of best practice in the given area. An accreditation usually carried an end date (or review date) whereby the service would need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **Accreditation for Inpatient Mental Health Services (AIMS)** | Mowbray Ward | Until 21 March 2020 |
| **Accreditation for Inpatient Mental Health Services (AIMS)** | Roker Ward | Until July 2020 |
| **Accreditation for Inpatient Mental Health Services (AIMS)** | Akenside Ward | Until May 2020 |

# Specialist community mental health services for children and young people

## Facts and data about this service

Northumberland, Tyne and Wear NHS Foundation Trust provide specialist community mental health services for children and young people aged 0 – 18 across Gateshead, Newcastle, Northumberland, South Tyneside and Sunderland.

There are three teams providing specialist community mental health services and three teams providing intensive community treatment services for children and young people. Each team provides services across a geographical locality. The localities are:

- Newcastle and Gateshead
- Northumberland
- South Tyneside and Sunderland

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| **Benton House** | Newcastle and Gateshead Children and Young Peoples Service | 2012 | n/a |
| **Bensham Hospital** | Newcastle and Gateshead Children and Young Peoples Service | activity has been combed with Benton House | n/a |

| | | | |
|---|---|---|---|
| **Northgate Hospital** | Northumberland Children and Young Peoples Service | 3620 | n/a |
| **Monkwearmouth Hospital** | South Tyneside and Sunderland Children and Young Peoples Service | 2044 | n/a |
| **Chad House** | EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne | 176 | n/a |
| **Monkwearmouth Hospital** | EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne | 136 | n/a |
| **Monkwearmouth Hospital** | ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside | n/a | n/a |
| **Benton House** | ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle | n/a | n/a |
| **Northgate Hospital** | ICTS (Children and Young People's Intensive Community Treatment Service) - Northumberland | n/a | n/a |

The children and young people's service provides a single service to all children and young people aged 0-18 years who present with mental health difficulties, learning disabilities or neurodevelopmental difficulties. The intensive community treatment services provide intensive home based treatment for children and young people with complex mental health needs and urgent assessments for self-harm and acute mental health presentations.

This inspection was 'short notice announced', which meant staff did not know until the day before that we were coming to inspect the service. However, before the inspection visit, we reviewed information that we held about these services.

As part of this inspection we visited:

- Newcastle and Gateshead children and young people's service
- Newcastle and Gateshead intensive community treatment services
- Northumberland children and young people's service
- Northumberland intensive community treatment services

Newcastle and Gateshead children and young people's service provide services at Benton House and Bensham Hospital. The intensive community treatment services have an office base at Bensham Hospital where they can access interview rooms if required. However, the majority of patients are seen in the community.

The Northumberland children and young people's service and the intensive community treatment services have an office base at Northgate Hospital. However, there are no clinic or interview rooms on site. The children and young people's service provide services across five community hubs in Hexham, Alnwick, Morpeth, Blyth and Berwick, which the intensive community treatment service can access if required. The inspection included visits to the base at Northgate Hospital and the Blyth hub.

During this inspection the inspection team;

- Looked at the quality of the environment and observed how staff were caring for patients
- Spoke with 10 patients and 14 parents or carers of children and young people

- Received feedback from 14 patients, 8 carers and 16 staff members on comment cards left during the inspection
- Spoke with the managers of all four teams we inspected
- Spoke with 28 staff members including doctors, nurses, psychologists, social workers, occupational therapists and support workers
- Held a focus group with 18 associate directors responsible for the services
- Attended and observed two clinical case discussions, one risk management meeting and one multidisciplinary team meeting
- Observed four interactions between staff and patients
- Looked at 31 care records
- Reviewed medication records and reviewed physical health monitoring practises at each location
- Reviewed Mental Health Act documentation including consent to treatment records at each location
- Looked at a range of policies, procedures and other documents relating to the running of the service

We last undertook a comprehensive inspection of specialist community mental health services for children and young people in June 2016. At that inspection, we rated the services overall as outstanding. We rated the key questions safe, responsive and well-led as good and the key questions effective and caring as outstanding.

## Is the service safe?

### Safe and clean environment

In all the locations we visited, the trust completed regular environmental risk assessments including general health and safety and fire risk assessments. We found the assessments to be thorough with action plans for remedial works.

None of the interview rooms were equipped with call alarms. However, staff were provided with personal attack alarms whilst on site. Reception staff were responsible for signing the alarms out to staff and for completing regular checks on the alarms to ensure they were working appropriately. All staff were provided with a lone worker device which enabled them to raise an alarm both on site and in the community if they felt threatened.

Clinic rooms on the sites we visited were clean and had the necessary equipment to carry out physical observations, including equipment to measure height, weight and blood pressure. Records demonstrated equipment was calibrated and regularly cleaned following use. Staff followed infection control principles including handwashing and the use of hand sanitiser.

The locations we visited were clean and well maintained. Cleaning schedules were in place demonstrating the tasks that were regularly completed. Waiting rooms had appropriate facilities for children and young people including TV’s, toys and books. Administration staff took a lead on cleaning the toys and completed a regular audit to ensure this was happening.

## Safe staffing

### Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | 31 December 2017 | 328.46 | N/A |
| Total number of substantive staff leavers | 1 January 2017 – 31 December 2017 | 27.09 | N/A |
| Average WTE* leavers over 12 months (%) | 1 January 2017 – 31 December 2017 | 8.4% | N/A |
| **Vacancies and sickness** | | | |
| Total vacancies overall (excluding seconded staff) | 31 December 2017 | 5.64 | N/A |
| Total vacancies overall (%) | 31 December 2017 | 1.7% | N/A |
| Total permanent staff sickness overall (%) | 31 December 2017 | 5.7% | 5% |
| | 1 January 2017 – 31 December 2017 | 5.8% | 5% |

| **Establishment and vacancy (nurses and care assistants)** | | | |
|---|---|---|---|
| Establishment levels qualified nurses (WTE*) | 31 December 2017 | 178.28 | N/A |
| Establishment levels nursing assistants (WTE*) | 31 December 2017 | 36.80 | N/A |
| Number of vacancies, qualified nurses (WTE*) | 31 December 2017 | 40.16 | N/A |
| Number of vacancies nursing assistants (WTE*) | 31 December 2017 | 2.73 | N/A |
| Qualified nurse vacancy rate | 31 December 2017 | 22.5% | N/A |
| Nursing assistant vacancy rate | 31 December 2017 | 10.2% | N/A |
| **Bank and Agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 January 2017 – 31 December 2017 | 0 (0%) | N/A |

*WholeTime Equivalent

This core service has reported a vacancy rate for all staff of 1.7% as of 31 December 2017. The teams reported an overall vacancy rate of 23% for registered nurses at 31 December 2017 and 10% for nursing assistants. During the inspection managers explained this was due to the original establishment being allocated against nursing roles. However, the service now utilised the care practitioner role which comprised of staff from a variety of disciplines.

| | Registered nurses | | | Health care assistants | | |
|---|---|---|---|---|---|---|
| **Team** | **Vacancies** | **Establishment** | **Vacancy rate (%)** | **Vacancies** | **Establishment** | **Vacancy rate (%)** |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne** | -0.5 | 5.4 | -9.3% | - | - | - |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne** | -2.3 | 3 | -76.7% | - | - | - |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 0.13 | 8.8 | 1.5% | 0 | 1 | 0.0% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | 0.07 | 10.67 | 0.7% | 0 | 1 | 0.0% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside** | 1.48 | 11.21 | 13.2% | 0 | 1.5 | 0.0% |
| **Newcastle and Gateshead Children and Young Peoples Service** | 20 | 54.5 | 36.7% | 1.7 | 7.5 | 22.7% |
| **Northumberland Children and Young Peoples Service** | 7.32 | 35.6 | 20.6% | 1.23 | 9.5 | 12.9% |
| **South Tyneside and Sunderland Children and Young Peoples Service** | 13.96 | 49.1 | 28.4% | -0.2 | 6.3 | -3.2% |
| **Core service total** | **40.16** | **178.28** | **22.5%** | **2.73** | **26.8** | **10.2%** |
| **Trust total** | **152.1** | **1844.37** | **8.2%** | **67.01** | **1379.01** | **4.9%** |

NB: All figures displayed are whole-time equivalents

| | Overall staff figures | | |
|---|---|---|---|
| **Team** | **Vacancies** | **Establishment** | **Vacancy rate (%)** |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne** | -0.5 | 5.4 | -9.3% |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne** | -2.62 | 3 | -87.3% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 0.53 | 11.6 | 4.6% |

| | | | |
|---|---|---|---|
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | -0.23 | 12.87 | -1.8% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside** | 1.58 | 12.91 | 12.2% |
| **Newcastle and Gateshead Children and Young Peoples Service** | 7.78 | 104.86 | 7.4% |
| **Northumberland Children and Young Peoples Service** | 2.82 | 91.05 | 3.1% |
| **South Tyneside and Sunderland Children and Young Peoples Service** | -3.72 | 95.39 | -3.9% |
| **Core service total** | **5.64** | **337.08** | **1.7%** |
| **Trust total** | **200.44** | **3969.59** | **5.05%** |

NB: All figures displayed are whole-time equivalents

Between 1 January and 31 December 2017, no shifts were filled by bank or agency staff to cover sickness, absence or vacancy for qualified nurses or nursing assistants. No shifts were left unfilled.

This core service had 27.09 (8%) staff leavers between 1 January 2017 and 31 December 2017. This was higher than the 5.49% reported at the last inspection (from 1 January 2015 to 31 December 2015).

Three teams had no staff leavers during this period.

| Team | Substantive staff | Substantive staff Leavers | Average % staff leavers |
|---|---|---|---|
| **South Tyneside and Sunderland Children and Young Peoples Service** | 99.59 | 11.44 | 12% |
| **Newcastle and Gateshead Children and Young Peoples Service** | 97.18 | 8.40 | 9% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 11.07 | 1.00 | 8% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | 11.60 | 1.00 | 8% |
| **Northumberland Children and Young Peoples Service** | 88.19 | 5.25 | 6% |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne** | 5.30 | 0.00 | 0% |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne** | 4.80 | 0.00 | 0% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside** | 10.73 | 0.00 | 0% |
| **Core service total** | 328.46 | 27.09 | 8% |
| **Trust Total** | 3696.18 | 252.06 | 28% |

The sickness rate for this core service was 6% between 1 January 2017 and 31 December 2017. The most recent month's data (December 2017) also showed a sickness rate of 6%. This was similar to the sickness rate of 5.24% reported at the last inspection in 1 January 2015 to 31 December 2015.

Children and Young People's Intensive Community Treatment Service – Northumberland and South Tyneside and Sunderland Children and Young Peoples Service both had the highest annual sickness rate, both with 8%.

| Team | Total % staff sickness (at latest month) | Ave % permanent staff sickness (over the past year) |
|---|---|---|
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | 10% | 8% |
| **South Tyneside and Sunderland Children and Young Peoples Service** | 9% | 8% |
| **Newcastle and Gateshead Children and Young Peoples Service** | 4% | 6% |
| **Northumberland Children and Young Peoples Service** | 5% | 4% |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne** | 3% | 3% |
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne** | 1% | 2% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside** | 1% | 2% |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 2% | 1% |
| **Core service total** | 6% | 6% |
| **Trust Total** | 7% | 6% |

## Medical staff

Between January 2017 and 31 December 2017, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 7% of shifts. Six per cent of shifts were unable to be filled by either bank or agency staff.

Caveat: the number of shifts filled and unfilled does not add up to the total shifts available.

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne** | 9.28 | 0.00 | 0.00 | 1.27 |

| Ward/Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne** | 0.84 | 0.00 | 0.00 | 0.12 |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 48.76 | 0.00 | 0.00 | 6.66 |
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | 214.67 | 0.00 | 2.35 | 26.66 |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside** | 41.46 | 0.00 | 0.00 | 5.67 |
| **Newcastle and Gateshead Children and Young Peoples Service** | 2548.33 | 0.00 | 195.40 | 126.13 |
| **Northumberland Children and Young Peoples Service** | 1,055.35 | 0.00 | 0.00 | 144.21 |
| **South Tyneside and Sunderland Children and Young Peoples Service** | 1,556.85 | 0.00 | 175.19 | 13.61 |
| **Core service total** | **5,475.54** | 0.00 (0%*) | **372.95 (7%*)** | **324.33 (6%*)** |
| **Trust Total** | **7,1731.91** | 0.00 (0%*) | **5,599.55 (8%)** | **3,437.50 (5%)** |

***** Percentage of total shifts

At the time of the inspection all teams had a wide range of professionals including consultant psychiatrists, speciality doctors, psychologists, medical secretaries and administrators. Staffing structures also included the role of care practitioners who could be nurses, nursing assistants, social workers and occupational therapists. Managers told us this enabled them to recruit to the needs of the young people and the service rather than be restricted to the skills of a specific discipline. The service had been actively recruiting to fill vacancies and at the time of the inspection had over recruited to some posts.

At the time of inspection, the overall staffing for the teams inspected was:

| | **Overall staff figures WTE** | | |
|---|---|---|---|
| **Team** | **Establishment** | **Actual** | **Variance** |
| **ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle** | 11.60 | 14.71 | +3.11 |
| **ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland** | 12.87 | 14.91 | +2.04 |
| **Newcastle and Gateshead Children and Young Peoples Service** | 104.86 | 108.46 | +3.6 |
| **Northumberland Children and Young Peoples Service** | 91.05 | 95.17 | +4.12 |
| **Total** | **220.38** | **233.25** | **+12.87** |

At the time of the inspection the Newcastle and Gateshead service had 3500 open cases with an average of 50 cases per staff member. The Northumberland service had 2529 open cases with an average of 42 cases per staff member. Allocations varied across treatment pathways with the neurodevelopmental pathway having the highest average caseload of 60, although this could be as high as 200 cases for some staff. Managers explained that within this pathway some young people on the attention deficit hyperactivity disorder pathway would only be seen for an annual review so although appearing high, caseloads were manageable. Managers told us caseloads were regularly reviewed in supervision and that they used a caseload analysis tool which considered the number of cases an individual had and the frequency they were seen to ensure the caseload was manageable. Staff told us caseloads were reviewed regularly and that although they were high, if they had several complex cases that managers would support them to manage their caseloads.

**Mandatory training**

The compliance for mandatory and statutory training courses at 31 December 2017 was 89%. Of the training courses listed, three failed to achieve the trust target. One module scored below 75% which was medicines management training with 74% staff trained.

The training compliance reported for this core service during this inspection was higher than the 86% reported at the last inspection.

Key:

| Below CQC 75% | Between 75% & trust target | **Trust target and above** |
|---|---|---|

| Training course | This core service % | Trust target % | Trust wide mandatory/ statutory training total % |
|---|---|---|---|
| **Records and Record Keeping** | 99% | 85% | 99% |
| **Safeguarding Children** | 97% | 85% | 94% |
| **Safeguarding Children Level 2** | 97% | 85% | 94% |
| **Infection Prevention & Control - Inoculation Incidents – Hand Hygiene** | 92% | 85% | 95% |
| **Equality & Diversity Introduction** | 91% | 85% | 95% |
| **Fire** | 91% | 85% | 89% |
| **Dual Diagnosis Training** | 91% | 85% | 92% |
| **Moving & Handling Awareness Training** | 90% | 85% | 96% |
| **Health & Safety** | 90% | 85% | 94% |
| **Clinical Risk Training** | 89% | 85% | 92% |
| **Safeguarding Adults** | 89% | 85% | 94% |
| **Safeguarding Children Level 3** | 88% | 85% | 90% |
| **Mental Capacity Act 2005** | 88% | 85% | 82% |
| **Deprivation of Liberty Safeguards** | 88% | 85% | 82% |
| **Information Governance** | 88% | 85% | 90% |
| **Mental Health Act 1983** | 87% | 85% | 84% |
| **MHA MCA DoLS Combined** | 85% | 85% | 79% |
| **Clinical Supervision** | 84% | 85% | 86% |
| **PMVA Breakaway** | 78% | 85% | 81% |

| | | | |
|---|---|---|---|
| Medicines Management Training | 74% | 85% | 83% |

During the inspection, managers demonstrated the online dashboard used to monitor staff training. Managers could see the service and team compliance with all mandatory training. When training was due to expire this was highlighted and gave time for managers and staff members to attend the training. The dashboard demonstrated where training compliance was below the trust target, this was due to staff on long term absence whose training had expired. Managers explained that this would be addressed as part of the individuals return to work plan.

## Assessing and managing risk to patients and staff

**As**sessment **of patient risk**

We reviewed 31 care records all of which contained a current risk assessment. The duty team completed an initial triage and assessed the risk of all new referrals. Any high-risk referrals were allocated to the intensive community treatment service to be seen within 72 hours, managers told us this was often within 24 hours. Staff completed a Functional Analysis of Care Environments risk profile for all children and young people during the initial assessment. The Functional Analysis of Care Environments risk profile was included in the Department of Health's publication, 'Best Practice in Managing Risk' (March 2009). Risk assessments were found to be a 'live' document and were regularly reviewed and updated as patient needs and risks changed. We saw evidence of crisis plans within risk assessments which identified where risk may be increased and actions that could reduce the risk.

**Management of risk**

Each location held a fortnightly risk management meeting where staff could take complex cases to discuss any risk issues and gain support in formulating risk management strategies. Staff told us if a patients' health deteriorated or there were concerns raised about a potential risk they would arrange to see the patient and develop a strategy to support the young person which could include additional support or contact with another agency for example the young persons' school. If staff felt it was necessary, the case could be referred to the intensive home treatment team who could provide additional intensive support to the young person.

After initial triage, the duty team allocated high-risk referrals to the intensive community treatment service. Lower risk referrals were allocated to the correct pathway within the children and young people's service. The service maintained a waiting list for young people referred into the service, there was no formal system in place to monitor or detect increases in the level of risk. This meant that once on the waiting list the service relied on young people and carers to highlight changes in risk rather than proactively monitoring people waiting for treatment.

The service had effective lone worker protocols in place. All staff had a lone worker device, which staff could use to record their location during a visit in the community. Staff could also use these devices to summon help discreetly if they felt threatened. Staff told us they were encouraged to use the devices out of work also and gave the example of staff using the device whilst feeling vulnerable when walking their dog after work.

Additional systems were also in place including an open team diary for staff to record visits and staff boards where staff could record where they were going and when they would be expected back.

## Safeguarding

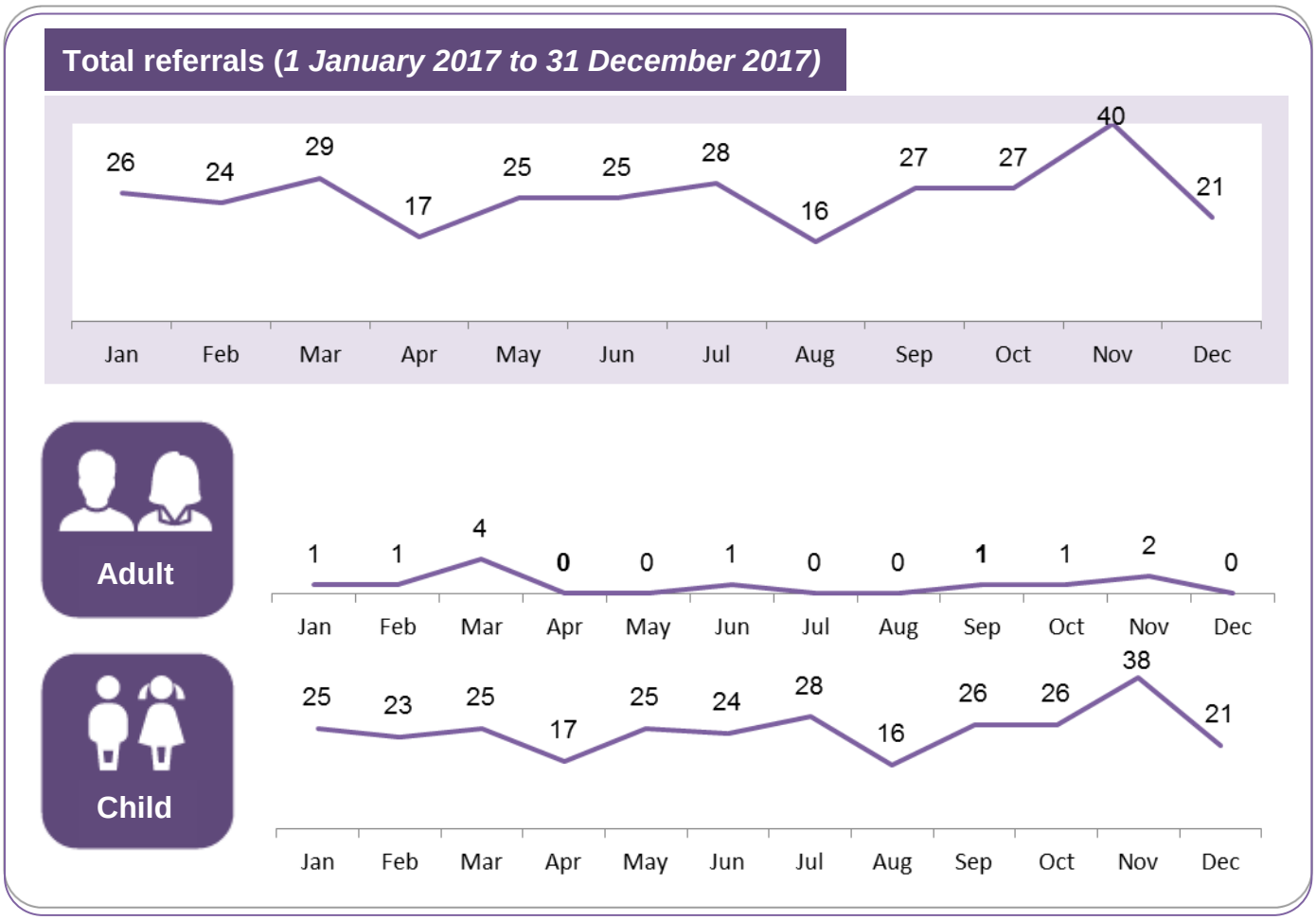
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 305 safeguarding referrals between 1 January 2017 and 31 December 2017, of which 11 concerned adults and 294 children.

| Referrals | | |
|---|---|---|
| **Adults** | Children | Total referrals |
| 11 | 294 | 305 |

Staff knew and could describe the safeguarding procedures. Staff were aware of the trust's own safeguarding team and the lead professional for children's safeguarding. Staff were able to demonstrate knowledge of the local safeguarding procedures and described having good links to the local authority safeguarding teams.




The trust submitted details of a serious case review commenced or published in the last 12 months that relate to this core service. This was in relation to the children and young people service in South

Tyneside and resulted in three recommendations being made. Details can be found in the table below.

| Recommendation | Actions Taken |
|---|---|
| **Safeguarding Children Supervision** | Trust staff reminded and requested to access safeguarding supervision |
| **Care Coordination** | Trust staff reminded of policy and instructed to ensure all appropriate documentation is completed |
| **CYPS staff to access training re sexual exploitation and complex needs** | CYPS staff to access training to underpin knowledge. |

## Staff access to essential information

The trust had an electronic patient record system. Staff told us they found the system easy to use and navigate and they could find all the relevant information they needed regards a patient. Where a patient was receiving services from more than one team or individual all staff were able to access the system and record entries in the patients' progress notes. Specific assessments for example positive behaviour support plans, which did not have a template embedded on the system could be scanned and attached to the patient record. If this was not possible due to copyright issues then a note would be made in the patients' record and the original assessment kept in a purple file. These files were stored in a lockable cabinet in the staff office.

## Medicines management

Medication was managed through a shared care agreement with a patients' own GP. Psychiatrists prescribed the patients medication and this was managed locally through the patients' GP and pharmacist. We reviewed medication records in all the locations we visited. Medication was prescribed in line with guidance from the National Institute for Health and Care Excellence and within British National Formula limits for children. Where patients were prescribed antipsychotics there was evidence in the patient's records of regular medication reviews with the psychiatrist and physical health monitoring being completed by the general practitioner.

## Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there was one STEIS incident reported by this core service. The incident reported was 'apparent/actual/suspected self-inflicted harm meeting SI criteria' and was an unexpected death.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS, however was not for the same incident.

The number of serious incidents reported during this inspection was lower than the four reported at the last inspection.

| | **Number of incidents reported** | |
|---|---|---|
| **Type of incident reported on STEIS** | Newcastle and Gateshead Children and Young Peoples Service | Total |
| **Apparent/actual/suspected self-inflicted harm meeting SI criteria** | 1 | 1 |
| **Total** | **1** | **1** |

## Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Northumberland, Tyne and Wear NHS Foundation Trust.

The trust used an electronic system to report incidents. All staff could describe how to complete an incident form and the circumstances, including near misses, in which a report was required. We found that the service had a process to learn from incidents and staff could give examples of when incidents had been discussed in team meetings.

Managers informed us the electronic system automatically sent all incident reports to the relevant people for example a safeguarding alert would go to the team manager, the community clinical manager and the safeguarding team. The clinical business unit also monitored all incident reports centrally and provided regular reports on themes and trends. Managers told us learning from specific incidents was disseminated through the services governance structure and shared in team meetings.

In February 2018 the findings from a Domestic Homicide Review of an incident which occurred in 2015 was published. At the time of the incident the perpetrator had some involvement with the Northumberland children and young people's service. The service had implemented some changes at the time of the incident including the introduction of the fortnightly risk management meetings. We were told by the manager that the publication of the review had been an opportunity to revisit the learning and the changes implemented to ensure they continued to be effective. Staff we spoke to were also aware of the incident and the changes which had taken place following the incident.

# Is the service effective?

## Assessment of needs and planning of care

The service used a goal based outcomes approach. Goal based outcomes compare how far a child or young person feels they have moved towards reaching a goal that they have set for themselves at the beginning of an intervention. We reviewed 31 care records and found that all records contained a comprehensive assessment of need covering mental health, physical health, environmental, educational and social needs. All records contained a personalised up to date care plan which reflected the needs and voice of the young person and where appropriate their parent or carer.

Staff completed basic physical health monitoring including height, weight and blood pressure on assessment. Where more specific monitoring was required for example if a patient was prescribed antipsychotic medication this would be done through the general practitioner. Patient records contained evidence of requests for physical health screening and blood tests being made to general practitioners and of the results received. Some clinics in Newcastle and Gateshead had introduced a process where patients saw a support worker prior to their appointment with their consultant so that basic health screening could be completed and provided to the clinician during the appointment.

## Best practice in treatment and care

In line with the recommendations made in the 2015 Department of Health publication 'Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing', the service provided treatment pathways. Children and young people entering the service were triaged as requiring support of one of three pathways;

- learning disability
- complex mental health
- neurodevelopmental.

We found that the service had introduced clear evidence based pathways for a range of mental health problems including anxiety, attachment disruption, challenging behaviour, depression, eating disorder, obsessive compulsive disorder, post-traumatic stress disorder, and relational trauma.

Within these pathways, the service could offer an extensive range of therapies approved by the National Institute for Health and Care Excellence. Therapies were offered on both an individual and group basis and included both the young person and the parent/carer if appropriate. Data provided by the trust demonstrated the range of therapies offered on an average week.

The Newcastle and Gateshead children and young people's service provided an average of 80 specific therapy sessions alongside routine clinical sessions:

- Cognitive Behavioural Therapy sessions
- Dialectical Behavioural Therapy sessions
- art therapy sessions
- play therapy sessions
- interpersonal Psychotherapy for Adolescents sessions

- Eye Movement Desensitisation and Reprocessing sessions
- family and systemic therapy sessions
- parenting sessions
- sensory sessions.

Additionally, the service provided five weekly and three monthly group sessions.

The Northumberland children and young people's service provided an average of 80 specific therapy sessions alongside routine clinical sessions:

- five, two hour group sessions per week
- three parenting groups for parents with children on the neurodevelopmental pathway per month
- 80 specific therapy appointments including
    - Cognitive Behavioural Therapy sessions
    - Dialectical Behavioural Therapy sessions
    - art therapy
    - Positive Behaviour Support
    - interpersonal Psychotherapy for Adolescents sessions
    - Eye Movement Desensitisation and Reprocessing sessions
    - family and systemic therapy sessions
    - parenting sessions
    - sensory sessions.

The intensive community treatment teams in each locality provided treatment to children and young people in their own homes, the service based interventions predominantly around a Dialectical Behavioural Therapy approach. Behavioural reactivation, psycho education and systemic therapy approaches were also used on a smaller scale. Due to the nature of the service provided the trust were unable to provide figures for the average number of interventions provided per week.

We saw evidence in observations and care records that treatment was provided in line with National Institute for Health and Care Excellence recommendations that children and young people should be offered a course of psychological therapy prior to the consideration of a medical intervention. Where medication was considered this was following a multidisciplinary review and in consultation with the young person and their parent/carer. Where medication was used this was in alongside a psychological therapy and within British National Formula limits for children; appropriate physical health checks were conducted prior to medication being prescribed and ongoing monitoring was completed by the young persons' general practitioner.

Staff used a range of outcome measures to assess the effectiveness of treatments including:

- goal based outcomes ratings
- the Children's Global Assessment Scale

- Children and Young. People's Improving Access to Psychological Therapies
- Health of the Nation Outcome Scales for Children and Adolescents

The service used the Health of the Nation Outcome Scales for Children and Adolescents as one way of measuring outcomes and reported the compliance with these quarterly to local commissioners. The trust set a target of 80% of children and young people would have the rating completed on initial assessment and discharge. The compliance with this outcome was available on the managers online dashboard and all teams were above the trust target.

This core service participated in 12 clinical audits as part of their clinical audit programme 2017 which are detailed in the table below:

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| **CA-15-0062: Audit of pharmacological therapies policy Practice Guidance note 17- Melatonin in Paediatric sleep disorders** | (Medicines Management) | MH: Specialist Community mental health services for children and | Clinical | 19.04.17 | Raise awareness and provide training for prescribers and clinical teams of the requirements in PPT-PGN 17 when prescribing melatonin for children and young people. |
| **CA-16-0019: NICE CG72: Audit of Transition of Young People with ADHD to Adult Services Against NICE Guidelines** | (North CYPS) | MH: Specialist Community mental health services for children and young people | Clinical | 26.04.17 | 'Opt-in' letters sent to DNA patients (those aged 17 years and over). |
| **CA-16-0021: Audit of team meeting documentation on RiO to ensure contemporaneousness of entries, actions following decisions or documented new decisions and changes to risk are recorded in the risk assessment document** | (North CYPS) | MH: Specialist Community mental health services for children and young people | Clinical | 12.09.17 | RiO masterclasses to remind staff about requirements. |
| **CA-16-0065: An audit of annual physical health monitoring of children and adolescents on anti-psychotic medication attending ADHD clinics in Northumberland.** | (North Community) | MH: Specialist Community mental health services for children and young people | Clinical | 27.11.17 | 1. E-mailed Trust guidelines on physical health monitoring in children and adolescents receiving antipsychotics to team members of CYPS neurodevelopmental team, Northumberland.<br><br>2. Distributed audit findings to team members and wider CYPS services.<br><br>3. Presented audit report to Northumberland CYPS neurodevelopmental team meeting as well as NTW CYPS consultants meeting.<br><br>4. Explored options and provided a consistent and reliable process/ pathway for blood sample collection, transportation to laboratory and accessing test results for those children and adolescents on antipsychotics |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | | | | attending neurodevelopmental clinics in Northumberland. |
| **CA-16-0069: Melatonin prescribing practices in Newcastle / Gateshead Tier 3 CYPS team** | (North Community) | MH: Specialist Community mental health services for children and young people | Clinical | 28.06.17 | Email sent to CYPS team highlighting audit findings. This highlighted the importance of a non-pharmaceutical approach as first line. This included a copy of the NTW leaflet on Melatonin. Leaflet made available to patients following appointment and attached to clinic letter.<br><br>Presentation of Audit at consultant meeting on 12th July.<br><br>Audit presented to new CYPS trainees as part of induction. |
| **CA-16-0085: Management of weight loss in ADHD patients in Newcastle CYPS.** | (North Specialist CYPS) | MH: Specialist community mental health services for children and young people | Clinical | 28.06.17 | A single paper growth chart introduced to follow patients longitudinally between appointments which should gather all of the required information. |
| **CA-16-0023: Clinical Supervision** | CYPS | CHS - Community mental health services for people with learning disabilities or autism<br>MH - child and adolescent mental health wards<br>MH - specialist community mental health serves for children and young people | Clinical | 21.06.17 | The need for separate safeguarding supervisors in training has been disseminated to staff. Also liaising with safeguarding regarding capacity to deliver regular training. Increased awareness promoted on the differences between management and clinical supervision. Increased training on both types of supervision to raise awareness and to identify separate people within the workforce in the service area to deliver both types of supervision. Procedural clarification of holding site/storage and ownership of Clinical Supervision Contracts in order that Supervisors can have access and contracts can be audited/accessed appropriately if necessary. Trust examining the possibility of the development of individual e-learning courses for core clinical refresher and training of trainers to improve access to mandatory training. |
| **CA-16-0088: Learning Disabilities Transformation** | Trustwide | CHS: Community mental health services for people with learning disabilities or autism<br>MH: wards for | Clinical | 15.11.17 | CDT identified to undertake the role of a Programme Board for this project. Governance structure considered and to put in place in advance of future transformation projects. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | people with learning disabilities or autism<br>MH: Child and adolescent mental health wards<br>MH: Specialist Community mental health services for children and young people | | | |
| **CA-15-0120: NICE (Baseline) CG128,CG70,QS51: Autism in Children and Young People** | Trust - CYPS | CHS: Community mental health services for people with learning disabilities or autism<br>MH: wards for people with learning disabilities or autism<br>MH: Child and adolescent mental health wards<br>MH: Specialist Community mental health services for children and young people | Clinical | 19.07.17 | Team Managers / CCM's developed a 'throughput' model of assessment in each locality to manage the backlog of referrals waiting to start assessment.<br>Team Managers developed a standardised letter to GP/Paediatrician to request medical information current and past history.<br>Team Managers ensuring that diagnostic reports will be completed within 3 weeks of the MDT diagnostic formulation meeting.<br>Parents will be provided with a diagnostic report within 3 weeks of completion of the written report.<br>Team Managers ensuring that all staff have access to the CYPS Foundation Training Programme and attend relevant modules – identified within PDP.<br>Diagnostic report now includes statement about co-existing conditions.<br>Team Managers ensuring that diagnostic reports will be completed within 3 weeks of the MDT diagnostic formulation meeting.<br>Parents will be provided with a diagnostic report within 3 weeks of completion of the written report. |
| **CA-15-0084: Blood Pressure and Pulse monitoring in children with ADHD on medication in adherence with NICE guidance** | (SCG- CYPS) | CHS: Community mental health services for people with learning disabilities or autism<br>MH: Child & Adolescent mental health wards<br>MH: Specialist Community mental health | Clinical | 22.01.17 | Disseminated information to the clinical team and charts for BP centile and instruct they are used 100% of the time.<br>Education provided to staff on the importance of recognising centile for clinical interpretation. |

| Audit name | Audit scope | Core service | Audit type | Date completed | Key actions following the audit |
|---|---|---|---|---|---|
| | | services for children and young people | | | |
| **CA-16-0003: NICE CG72: Adherence to NICE Guidance for ADHD in the Adult ADHD Service** | (SCG- Adult ADHD Service) | CHS: Community mental health services for people with learning disabilities or autism<br>MH: Child & Adolescents mental health wards<br>MH: Specialist community mental health services for children and young people | Clinical | 22.02.17 | Dissemination of audit findings to the ADHD Team. Training provided to ADHD Team on cardiovascular risk factors.<br>Review of minimum expected standards of review documentation. |
| **CA-16-0015: 5-a-Day: Are young people with a learning disability supported to meet this target? A re-audit following improvements** | (SCG-CYPS Inpatient and Regional Service) | MH: Child & Adolescents mental health wards<br>MH: Specialist community mental health services for children and young people | Clinical | 22.02.17 | Ongoing review of menu Education of staff with relation to diet and exercise Continue with healthy breakfast group, healthy tuck shop and healthy cooking sessions. Considered provision of Wake up and Shake up on the wards as opposed to the ARC. Review access to cake every supper time. |

## Skilled staff to deliver care

All staff undertook a mandatory trust induction programme and a local induction. The teams we visited comprised a wide range of professionals including consultant psychiatrists, speciality doctors, psychologists, medical secretaries and administrators. Staffing structures also included the role of care practitioners who could be nurses, nursing assistants, social workers and occupational therapists. Managers told us this enabled them to meet the needs of the young people more effectively. The service had access to physiotherapists and dieticians if required to meet the needs of an individual. These staff were employed by the trust although did not work specifically work in the core service.

Staff could access specialist training if required and told us that they had either completed, been offered, or were about to start additional training courses. Specialist training that staff could access included training in leadership both within the trust and at masters level, positive behavioural support, cognitive behavioural therapy, dialectical behaviour therapy, systemic therapy, interpersonal psychotherapy training for adolescence, and eye movement desensitization and reprocessing therapy.

The trust's target rate for appraisal compliance is 85%. As at 31 December 2017, the overall appraisal rates for non-medical staff within this core service was 78%.

The teams failing to achieve the trust's appraisal target were 'Newcastle and Gateshead Children and Young Peoples Service' (73%), 'South Tyneside and Sunderland Children and Young Peoples Service'(74%), 'EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne' (80%), 'Northumberland Children and Young Peoples Service'

(83%), ‘ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland’ (83%) and ‘EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne’ (83%).

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 81.9% reported at the last inspection.

| Team name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside | 11 | 11 | 100% |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle | 12 | 11 | 92% |
| EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne | 6 | 5 | 83% |
| ICTS (Children and Young People's Intensive Community Treatment Service) – Northumberland | 12 | 10 | 83% |
| Northumberland Children and Young Peoples Service | 90 | 75 | 83% |
| EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne | 5 | 4 | 80% |
| South Tyneside and Sunderland Children and Young Peoples Service | 100 | 74 | 74% |
| Newcastle and Gateshead Children and Young Peoples Service | 103 | 75 | 73% |
| **Core service total** | 339 | 265 | 78% |
| **Trust wide** | **3922** | **3228** | 82% |

The trust did not provide appraisal data for medical staff for this core service in their submission of data.

During the inspection managers told us appraisals were taking place for all staff and were in line with the trust targets. Data provided by the trust demonstrated that appraisal rates for medical staff were at 100%.

The trust has informed us a clinical supervision target rate is not specified in their policy.

Between 1 January 2017 and 31 December 2017 the average clinical supervision rate across all eight teams in this core service was 88% for non-medical staff.

Clinical supervision for medical staff has not been broken down by core service. The trust has informed us “As per Royal College of Psychiatry requirements, our medical staff all engage in a process of peer supervision, which occurs at least 4 times a year within their peer group. Clinical work and performance, along with peer supervision notes, are also reviewed annually, through the appraisal process, and ultimately the GMC revalidation process every five years. The trust medical appraisal rates are shown above as a proxy for clinical supervision.”

**Caveat:** there is no standard measure for clinical supervision and trusts collect the data in different ways, so it’s important to understand the data they provide.

The rate of clinical supervision reported during this inspection is higher than the 81% reported at the last inspection.

| Team name | Clinical supervision sessions required | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| South Tyneside and Sunderland Children and Young Peoples Service | 352 | 352 | 100% |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle | 111 | 106 | 95% |
| Newcastle and Gateshead Children and Young Peoples Service | 402 | 370 | 92% |
| EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) North of Tyne | 48 | 44 | 92% |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside | 84 | 76 | 90% |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Northumberland | 84 | 74 | 88% |
| EDICT (Children and Young People's Eating Disorder Intensive Community Treatment Service) South of Tyne | 44 | 33 | 75% |
| Northumberland Children and Young Peoples Service | 456 | 332 | 73% |
| **Core service total** | 1581 | 1387 | 88% |
| **Trust Total** | **29957** | **26917** | **90%** |

Each team we visited had a supervision log identifying when staff had received their managerial or clinical supervision. Managers told us that they were aware some pathway teams had not received supervision as regularly as they would like, for example, the Newcastle and Gateshead learning disability team had a new team manager. This had been identified and the manager had started to ensure staff who had not received supervision recently were prioritised. This was evidenced by the logs we saw on site and the staff we spoke to.

Managers described the systems in place to manage performance issues. The service had a range of support mechanisms available to staff including counselling and occupational health referrals. Managers said where performance issues were identified they would always try to support the member of staff to resolve these through identifying the issues and adjusting workloads where possible. However, if this was not possible managers were aware of the formal procedures available if necessary.

## Multidisciplinary and interagency team work

All the teams we visited had regular meetings including allocation meetings, business meetings and case discussion/formulation meetings. Each service also had a fortnightly risk management meeting. The team meeting minutes we sampled demonstrated there was a multidisciplinary attendance at all the meetings. During the inspection we observed four meetings. We saw these had a multidisciplinary representation including medical staff, psychology staff and care practitioners. Meetings were seen to have a clearly defined purpose and agenda. Staff were encouraged to take part and to share experience. Meetings offered an opportunity for staff to raise concerns and to collaboratively explore solutions.

The staff we spoke to told us they had good links with other organisations including schools, local authority, drug and alcohol services, youth offending and voluntary sector organisations. Staff and managers told us they would often provide support to a young person alongside another organisation for example a local school or college. Managers told us how relationships with third sector organisations were improving and in the Newcastle and Gateshead team work was ongoing towards developing a single point of access service which would be staffed by both the trust and voluntary sector organisations to ensure young people could be directed to the most appropriate service(s) from point of entry in to the service.

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

As of 31 December 2017, 88% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

We found that staff had a basic understanding of the Mental Health Act. Staff told us it was rare for the Mental Health Act to be used in the community services and that they focussed on working towards recovery with young people so that detention under the Mental Health Act was not required. Staff said the consultant psychiatrists would take the lead if the Mental Health Act was needed and that they were aware of where to seek support if required.

Care records showed evidence of informed consent to treatment which included the discussion of treatment options with young people.

## Good practice in applying the Mental Capacity Act

As of 31 December 2017, 88% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The Mental Capacity Act 2005 applies to young people aged 16 to 18 years old.

For young people under the age of 16, care and treatment can be provided under parental consent. However, the capability of the young person to be involved in decision making should be determined through the concept of the Gillick competence. This concept recognises that some children will, at a young age, have a level of maturity and understanding sufficient to make decisions regarding their care and treatment.

Managers and staff could describe the circumstances where Gillick competence would be assessed and demonstrated an understanding of the interface between capacity and Gillick competence. Staff were aware that the trust had a Mental Capacity Act policy and most cited the Mental Health Act office as where they would go if they had any queries regarding mental health legislation.

We found evidence of treatment options being discussed with young people and their parent/carer in care records and clinical letters. Where young people had been prescribed medication we saw evidence of the assessment of capacity to consent to treatment. We also found consent to share information forms in all files we reviewed. However, despite the trust consent to examination or treatment policy dated 2016, stating when Gillick competence had been considered the conclusion should be recorded in the progress notes; we could not find any reference to Gillick competence in any of the records we reviewed.

In some of the care records we reviewed we saw a new consent form which demonstrated both consent to share information and consent to treatment which was signed by both the young person and their parent/carer. Managers informed us the new form was being introduced and that staff had been asked to update the current forms in the care records. This was also evidenced within the team meeting minutes we reviewed.

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These include the existing powers of the court, particularly those under Section 25 of the Childrens Act 2004, or use of the Mental Health Act 1983.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

During the inspection we observed six appointments and other interactions between staff and young people visiting the service. Staff interactions with young people demonstrated that care was provided in a sensitive and thoughtful way. Care was delivered in a way that focussed on goals, recovery and building resilience.

We saw staff adapt their approach to interact with young people of different ages in a way that was appropriate and at the right level. We saw staff engage with young people in a professional way that respected the individual that they were working with.

Staff were kind, respectful and creatively explored difficult subjects with young people in an open and non-judgemental way. Staff demonstrated an in-depth knowledge of the young people in the service and could recall small details about young people. Staff were passionate about their work and we observed genuine ‘warmth’ in their work with young people.

Managers allowed staff to push boundaries where there was a clinical need, for example we were informed by one member of staff they had arranged an appointment with a young person whilst they were on holiday out of the area, managers allowed them to facilitate the visit to support the young person and their family to take a holiday. We also heard how young people reaching 18 years old would continue to receive involvement from the teams if the service felt that a successful outcome within a specific period could be achieved reducing the need to transfer the young person to adult services. We observed a member of staff take a call from a parent of children who had been discharged from the service. Staff listened and supported the parent taking time to offer reassurance and identify appropriate actions with them. Staff explained that despite their children being discharged the parent would occasionally contact the service if needs had changed and staff felt by providing support informally it helped reduce the need for the children to access services unnecessarily.

Staff recognised the risk that young people may become dependent on the service and they described how this risk was reduced by working with young people in partnership with other services, reducing the reliance on children and young peoples services.

Young people who used the service and their parents/carers were universally positive about the care they received from the service. Young people and their parents and carers praised the service and could provide real examples of how using the service had led to genuine and positive outcomes.

We saw that there was a culture of caring and support within staff teams. Staff told us how the support from their colleagues enabled them to support the young people. Staff felt that teams worked together to support young people and that discussion was encouraged within teams especially when staff were supporting a difficult or complex case. Newer staff told us how the teams had been welcoming and supportive during their induction to new roles.

Staff and managers appeared to genuinely care about the well-being of the team, recognising and adapting to the pressures the team faced.

## Involvement in care

### Involvement of patients

We reviewed 31 care records all of which demonstrated the young persons' involvement in their care. Young people set the goals they wanted to achieve and were involved in planning how to achieve them. They were involved in discussions about risk and risk management. All care records demonstrated the young persons' voice and there was evidence that young people had been offered a copy of their care plan.

We saw evidence of discussions about treatment options and young people being given a choice of the treatment they wanted. We saw leaflets about treatment options which were aimed appropriately at children and young people to help them understand the treatment. Staff told us if a young person had communication difficulties they could use appropriate resources including picture boards and social stories to explain treatments to them.

Following all clinical sessions young people revisited their goal based outcomes and rated the progress they believed they had made on each goal. Staff described how this was used to demonstrate a young persons' progress and to guide the direction of the sessions with the young person. This was evidenced in all the care records we reviewed.

The trust used a 'points of you' survey to gather feedback from patients on the service they had received. The results of the survey were accessible to managers and staff and could be used to identify themes within patient feedback.

In the period of 31 April 2017 to 31 March 2018 a total of 627 'points of you' surveys were completed for the services inspected. Of these the majority provided positive feedback with 405 responses stating they found the service had helped them 'a lot' and 506 people said they would be very likely or likely to recommend the service to friends or family.

In the same period only three surveys were completed for the intensive community treatment teams of the three surveys received one indicated they would not recommend the service to family and friends however all other results were positive.

Staff told us they could access advocacy support for young people if it was identified as a need and would work with the young person to identify how best to access advocacy to best meet their needs, this could be through the trusts advocacy or the young person's school or other service working with the young person.

**Involvement of families and carers**

We spoke with 14 parents and carers all of whom said they had been involved in the care of their child. Parents told us they were included in discussions about treatment options, care planning and risk assessments. Some parents told us they had been offered sessions with the clinicians without their child present. Whilst others told us the service had provided training in the therapeutic intervention the young person was receiving to enable them to support the young person outside of clinic sessions.

One parent told us how the staff had provided them with letters for their employer to support their request for time off work to care for their child at home when they had been unwell.

Staff told us if the young person had given consent they would share care plans with their parent/carer and would involve them in the care and treatment of the young person. Staff told us they tried to adopt a whole family approach and would offer support to parents where possible or to signpost them to appropriate services or to the local authority to access a full carers assessment.

# Is the service responsive?

## Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'. The core service met the assessment to treatment target in two of the targets listed.

The trust has not provided data for days from referral to initial assessment for this core service.

| Name of hospital site or location | Name of team | Service Type | Days from referral to initial assessment | | Days from assessment to treatment | | Comments, clarification |
|---|---|---|---|---|---|---|---|
| | | | Target | Actual (mean) | Target | Actual (mean) | |
| **Bensham Hospital** | Newcastle and Gateshead Children and Young Peoples Service (Bensham Hospital) | Not Provided | Not provided | Not provided | 18 weeks standard referral to treatment | 9 weeks | Complete waits to treatment 1.1.17-31.12.17 |
| **Northgate Hospital** | Northumberland Children and Young Peoples Service | Not provided | Not provided | Not provided | 18 weeks standard referral to treatment | 12 weeks | Complete waits to treatment 1.1.17-31.12.17 |
| **Monkwearmouth Hospital** | South Tyneside and Sunderland Children and Young Peoples Service | Not provided | Not provided | Not provided | 18 weeks standard referral to treatment | 17 weeks | Complete waits to treatment 1.1.17-31.12.17 |

The children and young people's service had moved away from the process of offering young people an initial choices appointment, followed by an internal waiting list to access their preferred treatment to a system of goal based outcomes. This meant that when a young person was referred to the service they would be placed on a waiting list for assessment based on the most appropriate care pathway and their level of need. Following their initial assessment young people would enter in to treatment immediately. Managers told us that the service had been struggling to meet the local demand under the previous system and that the service had struggled to reduce waiting lists. Under the new system young people could be assessed and begin to access support earlier. Managers advised there were some more specific therapies which still had a waiting time. However, a young person could continue to access treatment from their allocated worker until a member of staff trained in that therapeutic intervention was available.

The service had a target of 18 weeks from the point of referral assessment/treatment. At the time of the inspection the trust informed us there were a total of 97 people who had been waiting over

18 weeks to access the children and young people's service. Of these 92 were for the Newcastle and Gateshead service with the longest wait been 28 weeks from referral.

| CYPS Service | Current Waiters | Number of Referrals over 18 weeks | Mean Length of Time on Waiting List (days) | Maximum Length of Time on Waiting List (days) |
|---|---|---|---|---|
| **Northumberland CYPS** | 268 | 5 | 55 | 182 |
| **Newcastle/Gateshead CYPS** | 608 | 92 | 71 | 196 |

Managers in both locations were aware the service continued to have waiting lists and informed us they were actively working to address these and by the end of the month there would be no young people on the waiting list over the 18-week target. Managers attributed this to the move away from the choices appointment to the goal based outcomes approach. Managers had developed local action plans in consultation with commissioners to address waiting lists further, action plans included reviewing current care pathways, referral criteria and therapies provided, staff had begun reviewing their caseloads to ensure young people were receiving the most appropriate support and ensure they were on the most appropriate pathway. Managers told us in line with the national picture the neurodevelopment pathway had the longest waiting lists due to young people being required to complete the full assessment process before diagnosis was confirmed. The service had begun to look at alternative ways to address this and was in the process of redesigning the assessment pathway and training staff to complete some of the assessments therefore reducing the pressure on medical staff and shortening the pathway.

The intensive community treatment service had a target time of 72 hours from the point of referral to assessment. However, managers told us this was usually within 24 hours. We saw evidence of this at both locations we visited where young people who had been referred to the service that morning were seen by a member of staff on the same day.

The children and young people's service operated 8am – 8pm Monday to Friday and 9am – 5pm on a Saturday. The community intensive treatment service operated 8am – 9.30pm Monday to Friday and 10 am – 6pm at the weekend and Bank holidays.

Staff in all the teams we visited told us they were flexible in where and when they would meet young people and could see them for a clinic appointment, in their home or community. We observed one member of staff visit a young person at their college for a pre-arranged appointment. We also saw staff respond to text messages they received from young people throughout the course of the day. Staff told us many young people liked to text staff to confirm appointments or sometimes for reassurance if completing a task in line with their care plan.

Managers reported they did not have many people who did not attend appointments. However, managers and staff said there was no rigid discharge policy in the case of young people not attending appointments, each case would be addressed on individual circumstances. Where a patient did not attend or withdrew from the service each situation would be reviewed and appropriate actions agreed which could include making telephone contact or rescheduling appointments. If a patient was believed to be in need of treatment and was refusing to engage they may be referred to the intensive community treatment team or their records 'flagged' so that future referrals could be 'fast tracked'.

## The facilities promote comfort, dignity and privacy

The locations we visited had a range of rooms available including clinic rooms, therapy/interview rooms including separate rooms for art therapy and play therapy. Each room had a privacy screen on the window of the door and appropriate facilities including tables, chairs and toys for children and young people were available. Clinic rooms had equipment to take basic health measurements including height, weight and blood pressure.

Reception and waiting areas were clean and well maintained. Chairs, toys and books were available in all waiting areas. Although, we noted the waiting room at sextant house was small and could easily become overcrowded if more than one family attended for an appointment at the same time.

Clinics were held in a range of locations some of which were owned by the trust and some were leased by the trust. Managers were aware of the various contractual arrangements and the process in place to raise concerns if there were any maintenance issues with the buildings. The managers told us facilities based in acute hospital settings were more responsive to maintenance requests than facilities leased from private landlords. However, the trusts estates department supported managers in completing regular health and safety audits and checks. Managers told us they were confident the facilities all met the required standards of health and safety.

Parking difficulties identified at Benton House in the previous inspection were not found to be an issue during this inspection. The manager told us that the company who used to lease the floor above had moved out which had created more parking, although recognised this may only be a temporary solution to the issue and said the trust were exploring alternative solutions.

## Patients' engagement with the wider community

Staff told us they worked closely with partners in education settings and when a young person gave consent they would work with the school to support the young person. Staff told us they often visited young people in school to provide support if identified by the young person within their goal setting. We saw evidence of staff working in partnership with schools and colleges in the care records we reviewed and our observations. Staff told us they would always encourage children and young people to involve their family within the treatment they were receiving and would encourage young people to consent to information being shared with their parent/carer.

## Meeting the needs of all people who use the service

All the locations we visited were compliant with the Disability Discrimination Act 2005. The buildings had a ramp for wheelchair access, mechanically assisted doors and lift access if clinic rooms were on a different floor. Leaflets about the service were available at both sites. Whilst some leaflets were seen to be age appropriate for the service, we did not see leaflets in any language other than in English. Managers told us that leaflets in alternative languages could be provided by the trust's patient information service and that where necessary interpreters were available through the trusts contract with the interpretation service.

We saw a discussion between staff about an internet site which contained resources on sexuality and transgender. One member of staff made a note of the website and was seen to later phone a carer and pass on the details.

We were told the support for patients dealing with gender identity was better since the introduction of the trusts gender dysphoria service which had introduced a local pathway and reduced the need to refer patients to a clinic out of area. Staff told us the electronic patient record system was flexible and enabled them to change a patient's gender to their preferred gender on the system and also allowed staff to put a note on the system that would 'flag' any specific requests such as preferred names to staff.

## Listening to and learning from concerns and complaints

This core service received 58 formal complaints between 1 January 2017 and 31 December 2017. Nineteen of these were upheld, 16 were partially upheld and 11 were not upheld. Five were awaiting completion, four were withdrawn and two were unable to be investigated. An outcome was not provided for one complaint.

The number of either partially or fully upheld complaints reported during this was higher than the 17 reported at the last inspection.

| Team name | Fully upheld | Partially upheld | Not upheld | Awaiting Completion | Withdrawn | Unable to Investigate |
|---|---|---|---|---|---|---|
| ICTS (Children and Young People's Intensive Community Treatment Service) - Gateshead and Newcastle | 1 | 0 | 0 | 0 | 0 | 0 |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Northumberland | 1 | 0 | 0 | 0 | 1 | 0 |
| ICTS (Children and Young People's Intensive Community Treatment Service) - Sunderland and South Tyneside | 0 | 1 | 0 | 0 | 0 | 0 |
| Newcastle and Gateshead Children and Young Peoples Service | 6 | 4 | 3 | 3 | 1 | 1 |
| Northumberland Children and Young Peoples Service | 7 | 3 | 4 | 0 | 1 | 0 |
| South Tyneside and Sunderland | 4 | 8 | 4 | 2 | 1 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Children and Young Peoples Service | | | | | | |
| **TOTAL** | 19 | 16 | 11 | 5 | 4 | 2 |

This core service received 48 compliments during the last 12 months from 1 January 2017 to 31 December 2017 which accounted for 12% of all compliments received by the trust as a whole.

Staff told us they believed young people and their parent/carers were aware of how to raise concerns and that the complaints process was included in the service welcome pack. However, most of the young people and carers we spoke with said they would feel comfortable to raise a concern to their allocated worker, but were unaware of the trusts formal complaints process. Parents and carers did tell us however that they were confident, should they need to raise a concern they would be directed to the complaints process by staff.

# Is the service well led?

## Leadership

Managers we spoke with had the experience and capability to deliver sustainable care. They could explain how the different roles within the teams they managed contributed to providing holistic care for patients. Managers had undergone management skills training and some had management qualifications.

Managers were inspiring and strove to motivate staff to succeed. There was a system of leadership development opportunities available for staff and we saw that some team managers had been promoted from non-managerial roles.

When we interviewed associate directors, we found they had a thorough understanding of issues and challenges the service faced. Associate directors told us the new structure enabled them to work with the commissioners and local partners to address the challenges and meet the needs of the local population. Associate directors described how systems were in place to ensure consistency across the business units to share experience and learning.

Staff spoke positively about their local managers including their service managers, describing them as supportive and accessible. We saw examples where managers provided additional support to staff, for example, by limiting an individuals' caseload when they had more than one complex case.

## Vision and strategy

The trust vision 'to be a leader in the delivery of high quality care and champion for those we serve' was developed in 2017 and was underpinned by three values refreshed in 2013 in consultation with stakeholders including patients, staff and carers:

- Caring and compassionate
- respectful
- honest and transparent

Staff could describe the values in their own words and how they were relevant to the service and themselves in their work.

## Culture

The staff we spoke to told us they felt respected and valued by their managers. Staff were proud to work for the service and spoke highly of the culture of strong collaboration, team-working and support. Staff were universally positive about local managers and local managers were in turn positive about their relationships with senior management. Staff told us they felt able to raise concerns and understood the whistleblowing policy. Staff were aware of the role of the freedom to speak up guardian and although not many were able to name them they were all aware of the posters in the office bases which had a photograph and their contact details.

The sickness rate for this core service was 6% between 1 January 2017 and 31 December 2017. This was the same as the trusts overall sickness rate and similar to the sickness rate of 5.24% reported at the last inspection.

Managers told us staff could access support through the trusts independent counselling service if they were having difficulty at home or work, staff could also be referred to the occupational health service if this was highlighted as a need by either the manager or the individual. Where staff had been of sick for a long period, managers told us they would be supported to return to work through a phased return.

## Governance

The service had recently restructured in to a clinical business unit model. There was a clear governance structure for each of the business units which demonstrated a clear channel from staff up to the board. Staff across pathways could meet in pathway specific meetings to share experience and learn from each other. The governance structure also included a community children and young people's forum to ensure learning could be shared across the clinical business units.

Staff told us learning from incidents was fed back within team minutes and supervision. Staff could provide examples of learning from incidents for example the introduction of the risk meeting to review high risk cases with peers and develop management plans.

The dashboard used by managers for measuring and reporting on performance management and outcomes were available to all staff and the use of key performance indicators was embedded in the service, all staff understood their individual and team performance objectives.

The trust has provided a document detailing their 16 highest profile risks. Each of these has a current risk score of eight or higher. None of these related to this core service.

## Management of risk, issues and performance

There was a visible commitment to focusing on improving the quality and sustainability of care and people's experiences through delivering best practice, performance and risk management systems and processes. Each service had a local risk register detailing risks specific to the location or team. Managers told us these were developed through the discussions held in team meetings where staff could raise concerns. The local risk registers fed into the business unit register which in turn could be incorporated in the overall trust register for risks identified as high.

We saw contingency plans in place at each location we visited detailing the actions necessary to ensure business could continue in adverse events for example the loss of access to electronic patient records or telecommunications.

## Information management

Staff were provided with encrypted laptops which enabled them to work from the office base or remotely in the community if required. The electronic patient record required staff to be registered on the system and have a password to access any patient records. It was possible for the trust to complete an audit of any staff members activity to ensure staff were only accessing records necessary to perform their role.

All staff could access a 'dashboard' system through the trust intranet which provided an overview of their teams performance and key performance indicators. The system enabled managers to review data on appraisal and training compliance, live key performance indicator data, staff registration and revalidation dates and staff absence figures. The dashboards showed the overall team rates and could drill down to individual staff to identify where issues were within a team. Managers explained this was useful as sometimes a figure might flag as an issue at team level for example poor compliance with a mandatory training course. However, on closer investigation this could be attributed to staff absence.

## Engagement

Managers had an understanding of the challenges and priorities of the local population and commissioners, strategies and plans are fully aligned with commissioners and local stakeholders demonstrating a commitment to system-wide collaboration.

The trust had an up-to-date website with information for patients and carers including a comprehensive directory of services, news and events and support and advice. The trust sent regular communication emails to all staff letting them know about service changes, policy development and other relevant information.

Staff told us they encouraged patients to provide feedback through the 'Points of you' system which allowed them to provide written feedback or through an on-line portal.

Staff also asked all children and young people to review progress of their goal based outcomes at the end of each session and rate them from zero to ten.

## Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **Quality Network for Community CAMHS (QNCC)** | Newcastle CYPS | Accredited until 2019 |

| | | |
|---|---|---|
| **Quality Network for Community CAMHS (QNCC)** | Northumberland CYPS | Accredited until 2020 |
| **Quality Network for Community CAMHS (QNCC)** | South of Tyne and Wear CYPS | Accredited until 2020 |
| **Quality Network for Community CAMHS (QNCC)** | North Tyneside CYPS Member | None provided |

Managers told us how the service had moved to a process of collaborative leadership and sought to utilise the skills and experience of the staff to identify solutions to problems. Managers told us this had been the basis for the work on reviewing the neurodevelopmental assessment pathway and listening to how staff felt this could be improved.

Staff were encouraged to take part in audits and research, for example care plan audits, eye movement desensitisation and reprocessing timeline audit, sleep difficulty and the effects of melatonin use. In response to the green paper on children and young people's mental health the service was looking to identify opportunities to work more closely with schools, an example of which was a pilot to employ a member of staff to work in a school for twelve months, providing training to staff and early intervention support to young people. Managers told us the hope was that this would encourage early identification and intervention within a school setting reducing the need for young people to access the service formally. The service had also managed to secure some funding for a university professor to complete a research project on the outcomes of the pilot that would hopefully be published in the future.