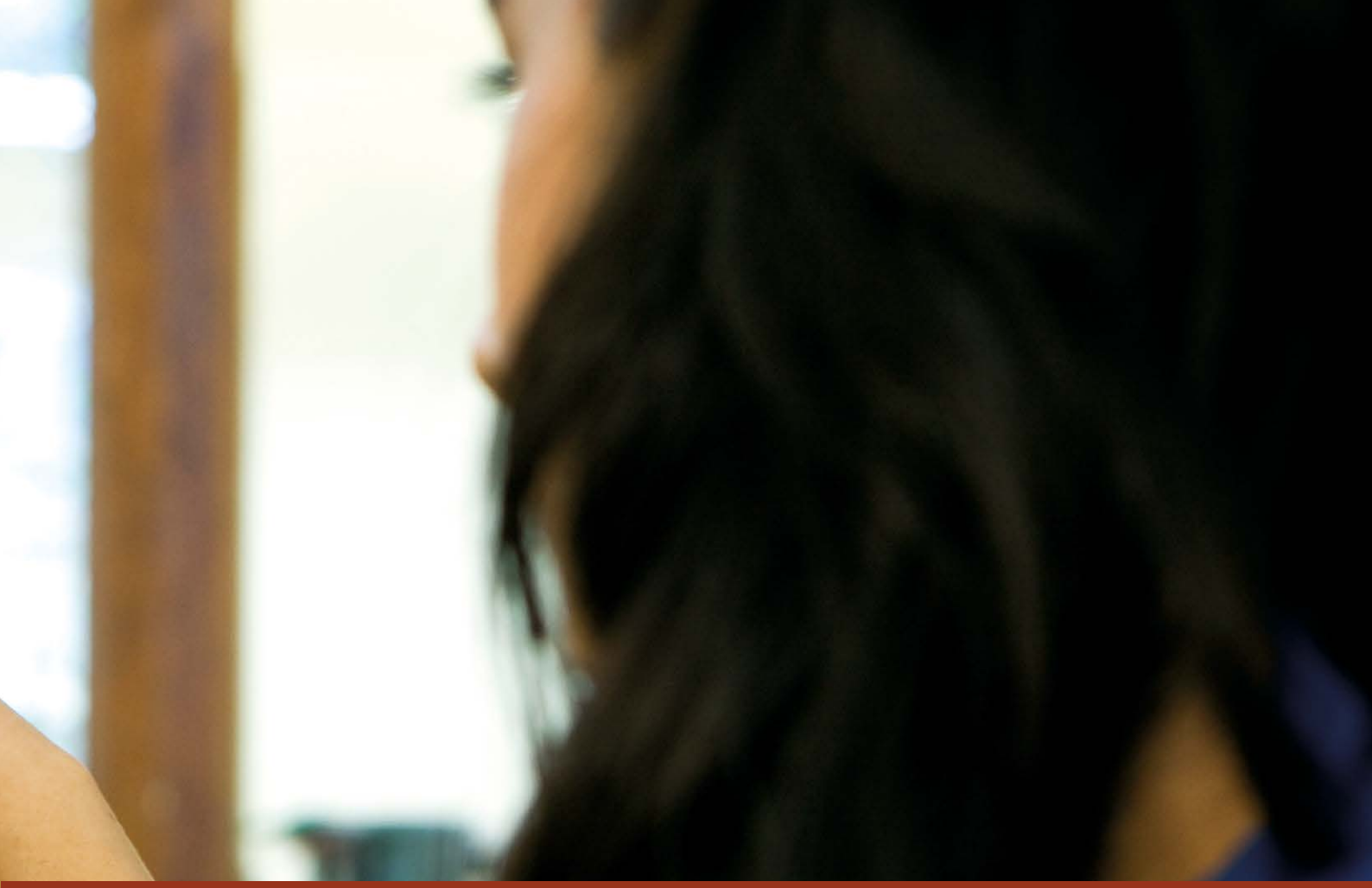
Care Quality Commission

The state of health care and adult social care in England 2016/17

Mental health

STATE OF CARE



Key points

- We rated 68% of NHS core services as good and 6% as outstanding. Among independent services, 72% of core services were rated as good and 3% as outstanding.
- Twenty-four per cent of NHS core services were rated as requires improvement as at 31 July 2017, as were 23% of independent core services. And a small number were rated as inadequate: seven core services (1%) in NHS trusts and four core services (2%) among independent services.
- We are concerned about the high number of people in 'locked rehabilitation wards'. Too often, these are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community.
- We are concerned about the very wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. Wards where the level of physical restraint was low had staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.
- Some mental health wards still accommodate patients in dormitories. Patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers. This arrangement does not support people's privacy or dignity. Also, a number of acute and rehabilitation wards still admitted both men and women to the same wards. Some of these do not comply with the requirement to eliminate mixed-sex accommodation.
- We found some excellent examples of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating. However, we also found community mental health services where staff did not ensure that patients had their annual physical health checks.

Introduction and context

This year we published *The state of care in mental health services 2014-17*, which gave detailed findings from CQC's initial programme of comprehensive inspections in specialist mental health services.

The landscape of specialist mental health care in England is complex. Care is provided by mental health NHS trusts and independent mental health providers for people with a wide range of mental health needs in a variety of settings and locations – both in hospital and in the community. Many of the NHS trusts that provide mental health care are very large and operate over a wide geographical area.

The independent sector manages a substantial proportion of national provision of mental health inpatient services for children and young people, long stay and rehabilitation wards, wards for people with a learning disability or autism, and medium and low secure forensic wards. The NHS funds much of the care provided in these independent hospitals through contracts with NHS England or clinical commissioning groups.

There has been a steady rise in the number of people in contact with mental health services over the last few years. This has contributed to a substantial increase in the maximum waiting times for routine appointments for children's and young people's community services in the NHS. The maximum wait for an appointment has risen from 11 weeks in 2012/13 to 26 weeks in 2015/16.

The total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16.[79] The fact that a high and increasing proportion of inpatients are detained under the Mental Health Act is evidence that only those people who need immediate, intensive treatment and care are admitted to a mental health ward. As a result, admission wards are a high risk environment. This is reflected in NHS Benchmarking Network data for NHS services in 2015/16 that show the high number of incidences of violence towards staff (538 per 100,000 occupied bed days), and of violence towards other patients (286 per 100,000 occupied bed days).

To provide safe care, mental health admission wards need a well-staffed team of experienced mental health workers who know the patients and work together well. To provide effective care, the team must contain staff from a range of disciplines who can provide the full range of treatments and interventions – physical, psychological and social. Future developments in community mental health services must not distract attention from the importance of improving the quality and safety of mental health wards.

The high and perhaps growing demand for mental health care has been accompanied by a steady decline in the number of NHS mental health nurses. From January 2010 to January 2017, the number of full-time equivalent psychiatry nurses fell by 12%, from 40,719 to 35,845.

The pressure on beds, and inability of community services to provide an alternative to admission, mean that too many people with mental health conditions are admitted to acute wards or psychiatric intensive care units some distance from their homes (known as 'out of area placements'). NHS Digital have reported that, at the end of May 2017, there were 857 such patients across the country counted as 'out of area'. Of these, 96% (821) were deemed 'inappropriate', although this is likely to under-estimate the true scale of the problem.[80]

A survey by the British Medical Association found that visits to people placed out of area entailed a four-hour drive or a six-hour trip by public transport. There is a government ambition to end inappropriate out of area placements in acute inpatient services for adults by 2020/21.[81]

CQC's ongoing review into children and young people's mental health services is finding a particularly complex and fragmented picture – care that is planned, funded, commissioned, provided and overseen by many different organisations, who frequently do not work together in a joined-up way. Some families felt this lack of joined-up working meant they had to wait till their child's mental health reached crisis point before they got any help.

Overview of quality

Core service ratings

We have now completed comprehensive inspections of all specialist mental health services in England. As well as rating the whole provider, we also rate certain 'core services' that we always inspect (see box).

Our inspectors have found many examples of good and outstanding care – but we also found too much poor care, and far too much variation in both quality and access across different services.

Overall, the performance at core service level of NHS trusts and independent providers was very similar. There were 68% of NHS core services rated as good as at 31 July 2017 and 6% were rated as outstanding (figure 2.13). Among independent services, 72% were rated as good and 3% as outstanding.

However, a substantial minority of NHS trust and independent services must improve the quality of care they provide. Twenty-four per cent of NHS core services were rated as requires improvement as at 31 July 2017, as were 23% of independent core services. And a small number were rated as inadequate: seven core services (1%) in NHS trusts and four core services (2%) among independent services.

Where we find poor care, we take action to make sure it improves. As we reported in *The state of care in mental health services 2014-17*, across the two-year period from April 2015 to March 2017, we issued 21 warning notices to NHS mental health trusts and 91 to independent mental health providers. Across the entire sector, we also issued one urgent notice to impose a condition, one non-urgent notice to impose a condition and two non-urgent notices to cancel registration.

Figure 2.14 shows the overall rating for each core service, across both NHS and independent providers. Some types of service performed particularly well, especially community mental health services for people with a learning disability or autism (81% rated as good and 8% as outstanding)

Core services for specialist mental health services

In specialist mental health services, we always inspect the following 11 core services where they are provided.

Inpatient mental health

- Child and adolescent mental health wards
- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Forensic inpatient/secure wards

Community mental health and crisis services

- Specialist community mental health services for children and young people
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism

and community-based mental health services for older people (75% rated as good and 10% as outstanding). It is difficult (and perhaps inadvisable) to make comparisons between the ratings for different types of services. However, it is striking that there is a 23 percentage point difference between community mental health services for people with a learning disability or autism and acute wards for adults of working age and psychiatric intensive care units, in terms of the proportion that we rated as good or outstanding (89% compared with 66%).

Ratings by key question

As well as the overall rating, we give all services a rating for each of the five questions we ask of all care services. These allow us to look into greater detail at the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led? Figure 2.15 shows how NHS trusts and independent locations were rated against the five key questions across all their core services. There are close similarities among the ratings given at key question level to NHS and independent core services.

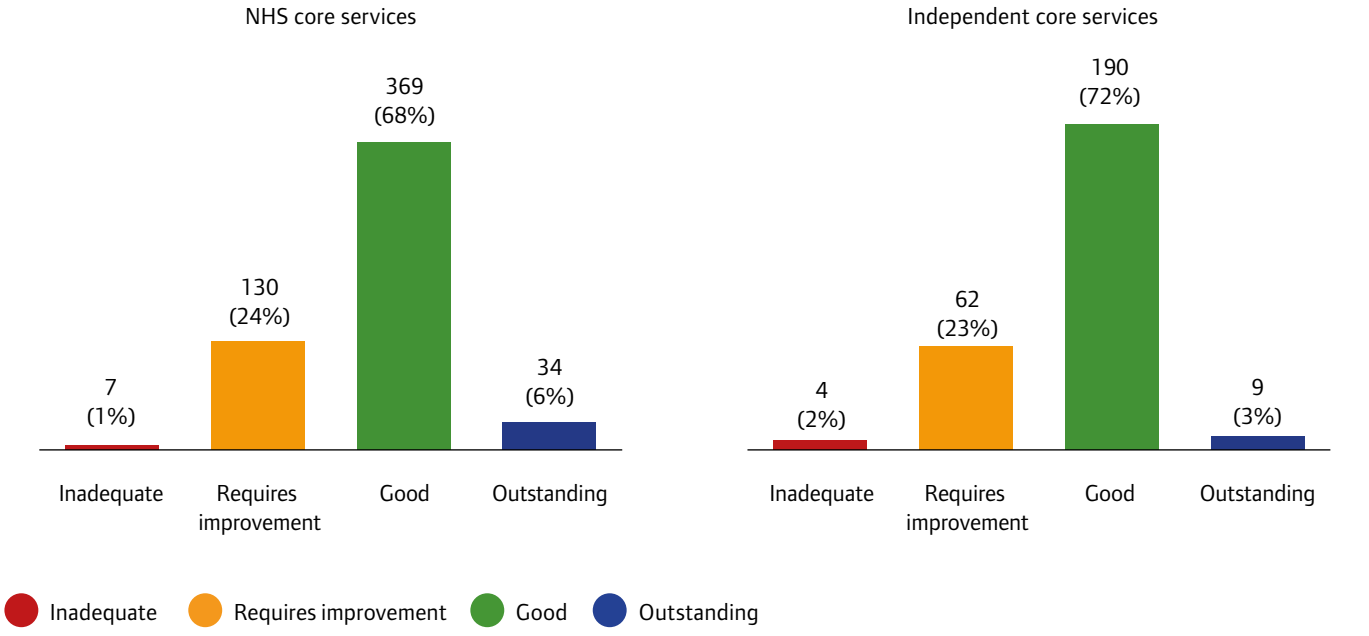
A number of themes contribute to this pattern of ratings for the key questions.

Safe: our biggest concern is about safety

Three per cent of NHS core services and 5% of independent core services were rated as inadequate at 31 July 2017. A further 36% of NHS core services and 32% of independent core services were rated as requires improvement. A number of factors contributed to these ratings:

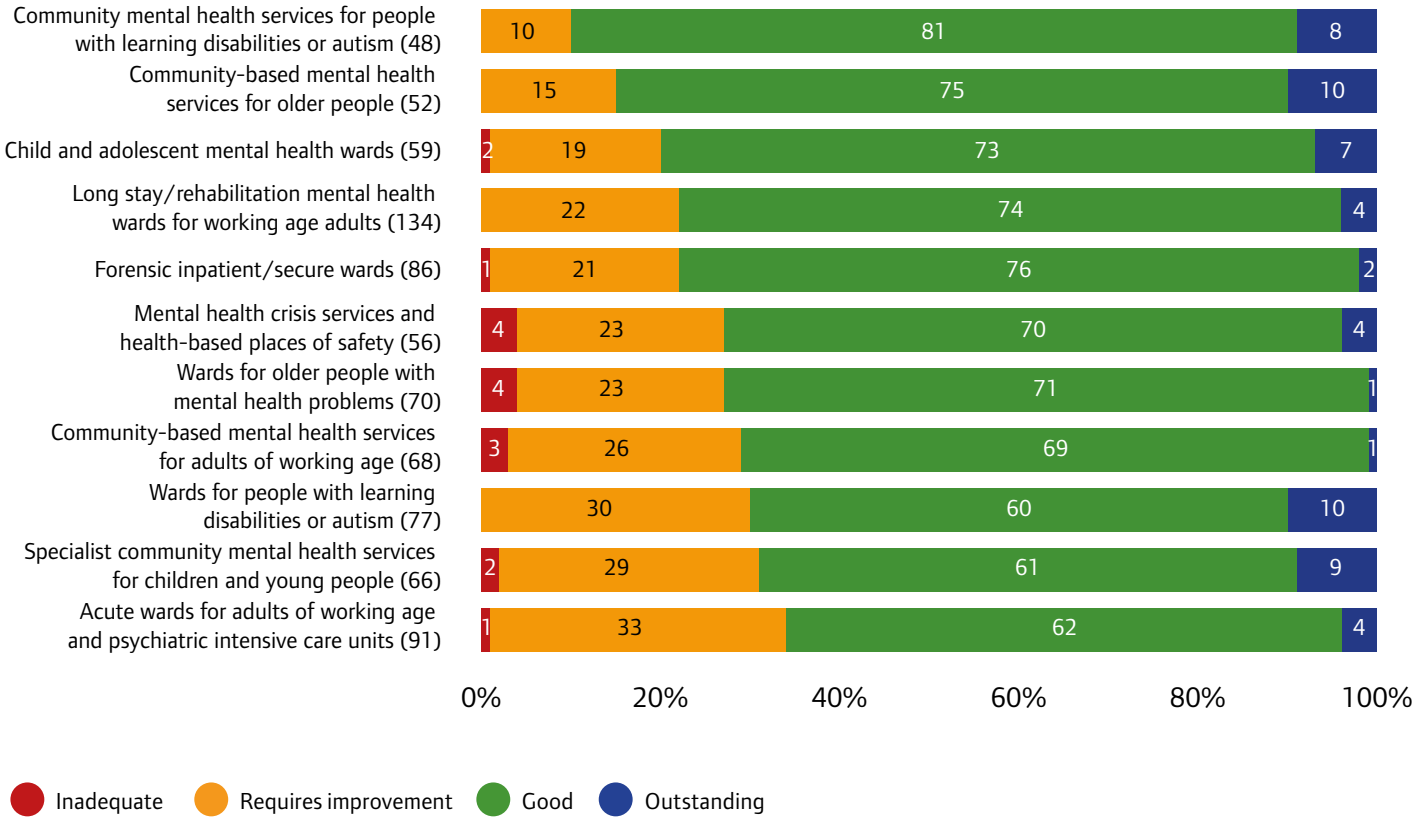
- The poor physical environment of many mental health wards. Many inpatient facilities were not designed to meet the needs of the group of patients that are admitted to acute mental health wards today. Their design does not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points.

Figure 2.13 Mental health core service overall ratings



Source: CQC ratings data, 31 July 2017, total 540 NHS core services and 265 independent sector core services.

Figure 2.14 NHS and independent combined overall ratings by core service



Source: CQC ratings data, 31 July 2017, total 540 NHS core services and 265 Independent sector core services.

Figure 2.15 Mental health core service overall ratings by key question

Source: CQC ratings data, 31 July 2017.

- Some services struggled to ensure that mental health wards are staffed safely at all times. The shortage of mental health nurses is greater in some parts of the country than others. The problem was worse in services that had high levels of sickness and high rates of staff turnover. The resulting negative effect on morale can create a cycle of increasing sickness and further staff turnover that can be difficult to break. Many providers used bank and agency staff to fill shifts. This can work well, provided the nurses who are filling in know the patients, their nursing colleagues and the ward routine. When this was not the case, it could affect patients' experience and continuity of care. In the worst cases, it could affect safety – our inspectors have reported medication errors made by staff who were not familiar with the service and who may not have had enough training or a proper induction to a ward. Even the basics, such as putting notes on care plans, had not always been completed by agency staff due to lack of training.
- Staff in both inpatient and community services did not always manage medicines safely. We found examples where staff did not store or transport medicines securely or keep them at the correct temperature, did not keep accurate records when they administered medicines and did not monitor patients' physical health necessary to keep them safe.

Our inspectors have seen some good initiatives to embrace a culture of safety. For example, in one NHS trust, wards had embedded a 'Safewards' approach. The seclusion room was rarely used as staff had improved how they talked and listened to patients to minimise incidents. When an incident did occur, they used reflective practice to understand the reason for the challenging behaviour and to consider how they could have handled it better. The inspector reported a much calmer and happier ward and that staff felt safer. The success was due to genuine staff engagement and buy-in to the idea of using the Safewards techniques all the time – not because someone had told staff to do it, but because they believed in it. Staff felt supported by the trust by making resources available and for training to happen.

Effective: care needs to be holistic and recovery-focused

When we look at whether care is effective, we want to find out whether the service is providing people with care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Staff need to take a holistic and recovery-focused approach to people's care and treatment. The majority of services provide care that is good or outstanding in this regards (71% of NHS trusts and 68% of independent services were rated as good, and 3% and 1% respectively were rated as outstanding).

However, a substantial minority need to improve, with 24% of trusts and 30% of independent services being rated as requires improvement. Services need to more to get the basics right consistently. We found examples of care plans that were not completed consistently, not holistic, not dated or missing from care records.

On pages 84 to 86, we highlight particular issues around services that need to ensure rehabilitation wards are geared towards people's recovery, and around the need to pay attention to people's physical health as well as their mental health.

Caring: mental health services can be proud of their staff

Across all services, the vast majority of staff genuinely cared about the people who used their services. The overwhelming majority of NHS and independent services were rated as good or outstanding for having caring and compassionate staff (NHS: 88% good, 9% outstanding; independent: 93% good, 5% outstanding). With very few exceptions, staff formed relationships with their patients that were respectful and compassionate and they treated patients with dignity and respect.

We have also seen many examples of staff involving carers and families, and of services providing specific support for carers. Families have complimented the attitudes of staff and the support that they have received, with staff making sure that families were involved with care planning and received regular updates.

The one area where mental health staff could do better as caring professionals is by engaging patients as true partners in their care. This issue has been flagged up by our Mental Health Act reviewers as well as by our inspectors. In too many services, care plans do not truly reflect the patient's voice. We will pay closer attention to this issue in future inspections.

Responsive: people often cannot access the service best equipped to meet their needs.

Our inspectors found community child and adolescent mental health services with very long waiting times, a mental health crisis team that did not provide 24-hour cover and patients whose discharge had been delayed because of the unavailability of suitable accommodation or a community care package.

Well-led: services need good leadership to become outstanding

Overall, 21% of NHS core services and 17% of independent services needed to improve in terms of their leadership. The influence of good leadership on staff cannot be overestimated. The NHS Staff Survey provides invaluable information on the views and experiences of people working in the NHS. Compared with the acute sector, those who work in mental health and learning disability trusts report poorer levels of overall satisfaction, and they are less likely to recommend the organisation as a place to work or receive treatment. On the other hand, they report better experiences of staff support, team working, line management and working practices. Worryingly, a higher proportion of mental health staff also reported experiencing harassment, bullying, abuse or physical violence from patients, relatives or the public in the 12 months prior to the survey.

When we analysed a number of inspection reports, we found six key themes that contributed to a rating of good or outstanding for well-led: leadership, a clear vision and set of values, a culture of learning and improvement, good governance, quality assurance, and engagement and involvement.[82]

In part 1 of this report, we highlight that the best services collaborate at a local level to deliver care that is centred on the needs of individuals. Our inspectors have seen examples of services identifying an issue or a need for patients and then working together, at times across sectors, to solve that need.

Sometimes, this is about bringing better physical health to those with mental health conditions For example, at one NHS trust, GPs came twice a week to provide care for mental health inpatients, and at an independent mental health hospital, there was a GP clinic next to an acute mental health ward.

At the acute adult inpatient and the psychiatric intensive care unit wards of one NHS trust, a registered nurse had been recruited to focus on the physical health of patients. Our inspector reported that this had a positive impact – the physical health care of patients was better monitored and deterioration was spotted quicker. This had been recognised by ambulance services and A&E, who had noticed that the notes accompanying the patient were of better quality and, as a result, they had a better understanding of the person's presentation.

Another example of services coming together was in South London, where trusts, police, ambulance and voluntary organisations were building a framework to identify places of safety for people who had been detained under section 136 of the Mental Health Act. The aim was to share information about availability of places of safety to provide support for a person in crisis and avoid them being detained in a custody cell, police car or ambulance.

Aggregated ratings

We also provide overall trust level ratings (in the NHS) or combined location level ratings (in the case of independent services) by aggregating the ratings of key questions awarded across all the core services provided by that trust or independent location. For example, if we have rated three out of the 11 core services as requires improvement for an individual key question (such as safe), then we would normally rate the NHS trust as requires improvement for safe.

The size and complexity of NHS mental health trusts, and the variability between core services, means that it is possible that in some hospitals a few poorer performing core services may affect their overall rating.

Fifty-nine per cent (32 out of 54) NHS trusts were rated as good overall as at 31 July 2017 (figure 2.16). We have rated two trusts as outstanding – Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust. Both trusts provide care in hospitals and round-the-clock care in the community that are world-class. They have leaders, both at a provider and ward level, who shape the care they deliver around the people who receive it.

However, 35% of NHS trusts (19) were rated as requires improvement overall. There was also one NHS trust (2%) rated as inadequate at 31 July 2017.

For the independent mental health locations, there were 73% (166) rated as good as at 31 July 2017, and 4% (eight) rated as outstanding. However, a substantial minority of locations need to improve: 22% (49) of independent locations were rated as requires improvement and 1% (three) as inadequate.

Key issues

Locked mental health rehabilitation wards

More than 50 years after the movement to close asylums and large institutions, we were concerned to find examples of outdated and sometimes institutionalised care. We are particularly concerned about the high number of people in 'locked rehabilitation wards'.

The Royal College of Psychiatrists does not recognise locked mental health rehabilitation wards as a service model. The purpose of these wards is poorly defined. Also, patients are often admitted to a rehabilitation ward a long way from their home. This risks the person becoming isolated from their friends and families and can make it difficult for staff in local community services, that should facilitate discharge and provide aftercare, to maintain regular contact.

We were surprised at how many beds there were in hospitals of this type. From the information available to us, we identified 357 mental health rehabilitation wards. Of these, 248 were locked and 109 were unlocked. Rehabilitation wards provided a total of 4,936 beds, of which 3,587 (73%) were in a locked ward. The independent sector provided more than two-thirds of the rehabilitation beds that were on a locked ward.

We concluded that, too often, these locked rehabilitation hospitals are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community. In the 21st century, a hospital should never be considered 'home' for people with a mental health condition. This principle underpins the drive to transform care for people with a learning disability. It applies equally to those with severe and enduring mental health conditions.

In a number of cases, we found that these hospitals did not employ staff with the right skills to provide the high-quality, intensive rehabilitation care required to support recovery. This could result in people using these services feeling hopeless and powerless, and failing to fulfil their potential to regain control of how they live their lives.

These hospitals must more actively support patients to acquire the skills they need to live more independently and be more proactive in planning discharge. At the same time, health and social care commissioners must ensure that suitable accommodation and intensive community mental health support is available in the person's home area.

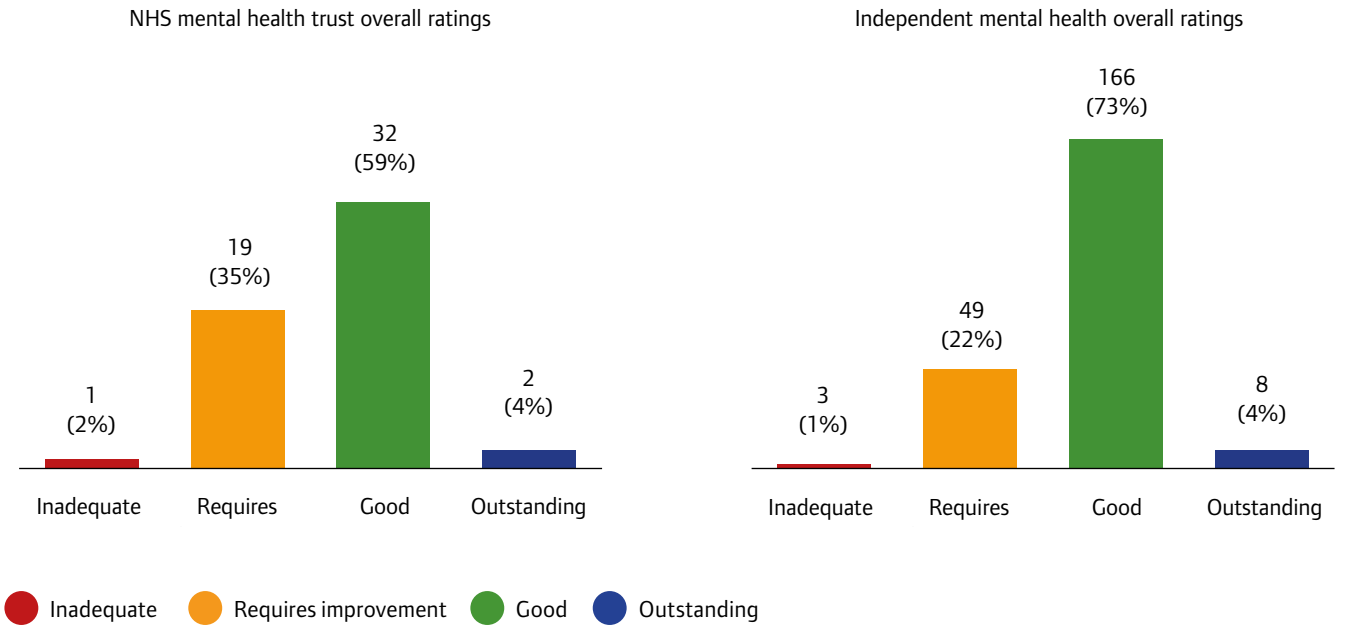
High secure hospitals

In 2016/17, our inspections of the three high secure hospitals in England found that all three had a shortage of nursing staff. At Broadmoor Hospital and Rampton Hospital, this restricted patients' access to therapies and activities. The low staffing levels at Rampton Hospital sometimes increased the risk to patients. One effect of the staffing shortage at Broadmoor Hospital and Rampton Hospital was that patients who were subject to night-time confinement also had restricted access to day-time activities. We were also concerned that staff at Broadmoor Hospital and Rampton Hospital did not monitor and review patients in seclusion and long-term segregation in line with guidance in the Mental Health Act Code of Practice.

The combination of night-time confinement and restriction on day-time activities is unacceptable – the 2013 guidance to the security directions sets out arrangements for general night-time confinement that "should only be put in place where it is considered that this will maximise therapeutic benefit for patients, as a whole, in the hospital. For example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day".

We will monitor the response of the trusts that manage Broadmoor Hospital and Rampton Hospital closely. We have shared our concerns with the Secretary of State and discussed our findings with NHS England Specialised Commissioning and the National Oversight Group for High Secure Services.

Figure 2.16 Mental health NHS trust and independent service overall ratings



Source: CQC ratings data, 31 July 2017, total 54 NHS trusts and 226 independent locations.

We have recommended that all three high secure hospitals work more closely together to share best practice and to address the concerns that we have identified.

Physical restraint

We have found examples, in all types of inpatient core service, of good practice in managing behaviour that might put patients or staff at risk of harm. Those wards where the level of restraint was low or where it was reducing over time had staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm. Staff on some wards made excellent use of positive behaviour support plans to anticipate and defuse situations that might have resulted in challenging behaviour. On many inspections, our inspectors have concluded confidently that staff used physical restraint or seclusion only as a genuine last resort.

However, more than three years after publication of the Department of Health's guidance 'Positive and Proactive Care: reducing the need for restrictive interventions', we are concerned about the very wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. We have also found a number of instances where staff were not recording all incidents of restraint and not documenting or recording seclusion or long-term segregation as required by the Mental Health Act Code of Practice.

We are committed to improving how we assess the use of restrictive interventions. In future, we will pay much closer attention to whether services have in place an active programme to reduce and minimise the use of restrictive interventions; and the extent to which they are able to demonstrate the impact of this programme.

Use of dormitories on mental health wards

We identified a number of wards that had dormitory accommodation. In the 21st century, patients—many of whom have not agreed to admission—should not be expected to share sleeping accommodation with strangers, some of whom might be agitated. This arrangement does not support people's privacy or dignity.

Sexual safety on wards for people with a mental health condition or a learning disability

Seven years after the NHS issued guidance to eliminate mixed sex accommodation in all hospitals, we identified a number of acute and rehabilitation wards that still did not comply. This is a particular concern in mental health wards, where the patient group might include a mix of those who are disinhibited and those who are vulnerable to sexual abuse. When this is the case, staff have a heightened responsibility to ensure that patients are safe from sexual harassment and sexual violence. We have taken action against services that did not follow NHS guidance on eliminating mixed sex accommodation. We will explore the issue of sexual safety on mental health wards more closely.

Physical health of people with a mental health condition a learning disability

One of the goals of the Five Year Forward View for Mental Health is that "by 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met". Our inspectors found a mixed picture. We found some excellent examples, particularly in forensic wards, of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating in response to the growing numbers of patients at risk of obesity and associated conditions such as diabetes. However, we also found community mental health services where staff did not ensure that patients had their annual health checks, and where they failed to monitor the effects of medication and services for older people where there was lack of integration of physical and mental health care.

Clinical information systems

Too many of the clinical staff we talked to voiced their frustration about the clinical record systems that they have to work with. Staff sometimes have to work with a confusing combination of electronic systems and paper, or with a number of different electronic systems because these systems 'do not talk to one another'. Clinical staff often spent a high proportion of their working time entering information into electronic records. Because of the

nature of the information entered, this problem often affected qualified nurses more than healthcare assistants. Despite this effort, too often staff were unable to locate or retrieve information that others had recorded.

This problem had a real impact. It consumed staff time that could have been better spent in face-to-face contact with patients, increased the likelihood that essential information about risk was not communicated to staff who needed to know, and might have led to sub-optimal care plans that did not reflect the contribution of all members of the multiprofessional team or sometimes the voice of the patient.

Residential substance misuse services

We inspect, but currently do not rate, independent sector services that provide structured drug and alcohol treatment where people have to be resident at the service in order to receive treatment. This includes medicine-assisted recovery programmes (and prescribing to prevent a relapse), such as detoxification or stabilisation services.

In 2016, in response to early inspections under our new comprehensive inspection approach, we wrote to all registered residential treatment providers to make them aware of our concerns about the quality of care being provided to people undergoing withdrawal from drugs and/or alcohol. We have now completed more inspections of these services, and we are in the process of reviewing these, to bring the picture up to date before the end of 2017.

Services for people with a learning disability or autism

Sixty per cent of wards for people with a learning disability or autism were rated as good at 31 July 2017, and 10% as outstanding; 81% of community services were rated as good, and 8% as outstanding. Many services worked well with other health and social services to build partnerships to meet the needs of people using the service and carers.

Although we found examples where staff had achieved a marked reduction in the use of physical restraint and seclusion, we remain concerned about the high use of restrictive interventions in some inpatient services.

The Transforming Care programme is tasked with ensuring that people in England with a learning disability or autism are only admitted to a mental health hospital when that is the intervention most suited to their needs at that time. Hospital must never be considered 'home' for people with a learning disability; they have a right to live in settled accommodation of their choice in their local community. This requires robust multidisciplinary community services, including 24/7 access to crisis care services, improved access to mainstream health care and the embedding of positive behaviour support across the health and care sectors.

Progress with Transforming Care has been patchy across England to date. Contrary to the aims of the programme, some patients have been in hospital for a long time and their care plans lacked evidence of active discharge planning.

Although we do not penalise providers for any lack of progress that is not within their control, we are increasingly checking that the Transforming Care 'building blocks' are in place. These include active participation by hospitals in care and treatment reviews, the implementation of positive behaviour support in both hospital and community services, and care in hospitals that is clearly discharge-oriented. We have also taken action to ensure that new providers who apply to register learning disability services are adhering to the model of care advocated by the Transforming Care programme. Our publication, *Registering the Right Support*, outlines our new approach.

Improvement

As at 31 July 2017, we had re-inspected and reconsidered the overall rating of 126 NHS mental health trusts and independent mental health locations (figure 2.17).

Providers that needed to improve have made real progress when they have taken on board our findings and committed to tackle problems proactively and learn from others.

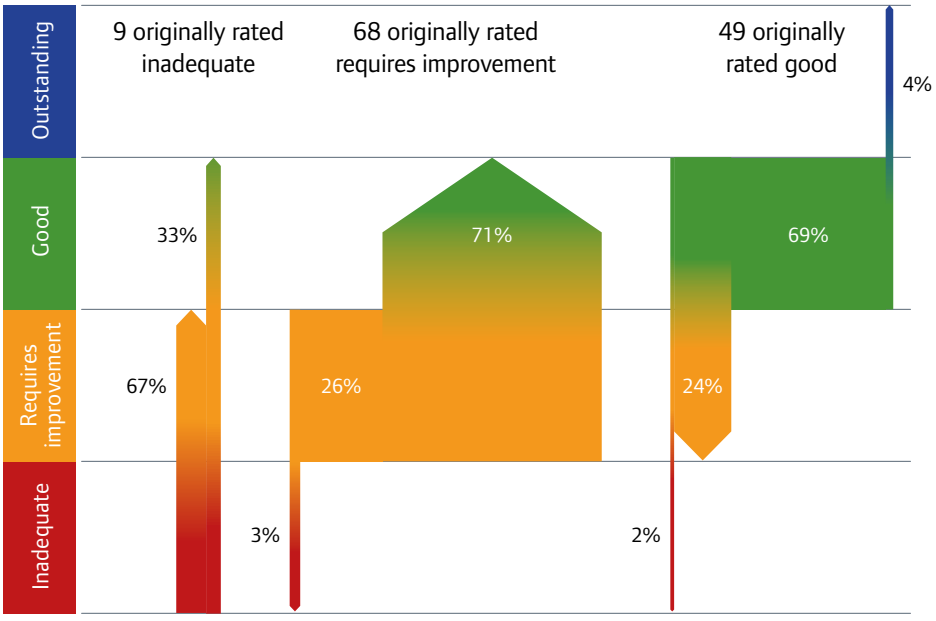
All of the nine services that were originally rated as inadequate and we re-inspected improved their rating – three to a rating of good and six to requires improvement. In addition, of the 68 services that were rated as requires improvement and were re-inspected, 48 (71%) improved their rating to good.

These improvements were testament to good leadership and strong determination to improve, at both board and ward level, the development of close links between leaders and front line staff, and those staff feeling part of a culture that delivers high-quality care.

We have seen a large number of providers that are actively seeking to learn and improve, and many have approached the outstanding trusts and others in a spirit of collegiate learning and a willingness to work together to improve the quality of mental health care.

However, we have also seen the quality of care in some services deteriorate – including some previously rated as good. Of the 49 services originally rated as good and re-inspected, 12 (24%) were re-rated as requires improvement and one went down to inadequate. In addition, two of the 68 services originally rated as requires improvement also deteriorated to a rating of inadequate.

Figure 2.17 NHS and independent mental health re-inspection overall ratings



Source: CQC ratings data as at 31 July 2017, total 126 re-inspections.

We reported in *The state of care in mental health services 2014-17* that the NHS core services with the most improvement (up to 31 May 2017) were forensic inpatient/secure wards, long stay/rehabilitation mental health wards for working age adults and wards for people with a learning disability or autism.

The independent core services that had improved the most up to 31 May 2017 were forensic inpatient/secure wards, child and adolescent wards, and community services for working age adults.

Northamptonshire Healthcare NHS Foundation Trust – quality improvement in action

This mental health and community trust was rated requires improvement in August 2015.

The quality of care at the trust was found to be inconsistent, particularly in community health services. For example there were worrying staff shortages, particularly community nursing staff and therapists. There were safety issues in a number of wards and in the gardens of one of the hospitals. There was also not enough training for staff or adequate supervision.

Despite the issues, we did see some outstanding practice in specific areas, such as older people's mental health. We also felt the trust had a strong leadership team capable of moving the trust forwards and improving.

In early 2017 we returned to inspect and found significant improvement. We rated the trust as good. The senior leaders had been instrumental in delivering the vision of quality improvement in the trust. The board were role-modelling the vision and values, and this was reflected in the high level of commitment to continuous improvement from staff at all levels. The trust was now meeting the target of 95% of patients being followed up within seven days of discharge.

People using the services of the trust were actively involved in helping with activities such as recruitment. There were very robust safeguarding policies in place and the trust was working collaboratively with partner agencies and to protect vulnerable adults and children.

We continue to monitor the trust as it completes further recommended improvements.

Care Quality Commission

How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter > @CareQualityComm

Read the summary and download this report in other formats at > www.cqc.org.uk/stateofcare
Scan this code on your phone to visit the site now.

Please contact us if you would like this report in another language or format.

CQC-388-560-102017