Tees, Esk and Wear Valleys NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out an unannounced inspection of forensic inpatient wards because we were made aware of a number of issues including unsafe staffing numbers and poor culture within the service.

We also carried out short notice (24 hours notice) announced inspections of community mental health services for working age adults, crisis and health based places of safety and community child and adolescent mental health services because we received information giving us concerns about the safety and quality of these services.

We inspected the well-led key question for the trust overall.

Following this inspection, we issued a warning notice, under Section 29A of the Health and Social Care Act 2008, on 23 August 2021. This identified specific areas that the trust must improve and set an overall date for compliance of 1 March 2022. Some areas for improvement had a compliance date of 1 November 2021. The trust had taken steps to make the required improvements. For more information on action we have taken, see the sections on Areas for improvement

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regulatory processes.

At this inspection we rated one of the four services core services we inspected as inadequate, two as requires improvement and one as good.

Overall, we rated safe, responsive and well-led as requires improvement, effective and caring as good.

We did not inspect child and adolescent mental health wards because the trust no longer provided this service and we have removed this core service from our report.

Our findings

We did not inspect wards for older people with mental health problems, wards for people with a learning disability or autism, community based mental health services for older people, community mental health services for people with a learning disability or autism or specialist eating disorder services. We did not have information that meant we needed to visit these services this time.

We did not inspect acute wards for adults of working age and psychiatric intensive care units, because we had carried out two recent inspections of this service. The first inspection was in January 2021, in response to a significant incident which sadly resulted in the death of a patient. Following this inspection, we issued a warning notice under Section 29A of the Health and Social Care Act, which required the trust to make significant improvements in relation to assessing and managing patient risk.

We carried out a follow up inspection of this service in May 2021 and found that, whilst the trust had made significant improvements to comprehensively assess and mitigate patient risk on the wards, these had not been fully embedded at the time of our inspection.

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

- We rated safe, responsive and well-led as requires improvement, effective and caring as good. In rating the trust, we took into account the current ratings of the five services not inspected this time. As the trust no longer provided child and adolescent mental health wards, this was removed from the ratings aggregation.
- Two of the trust's services had worsened since the last inspection; we rated forensic inpatient services as inadequate and community mental health services for working age adults as requires improvement.
- The overall rating for specialist community mental health services for children and young people stayed the same as the last inspection, however the rating for safe went down to inadequate.
- The trust recognised that their organisational and governance structures were not fit for purpose. They had embarked on a significant change programme and were about to consult with staff on these changes. As a result, not all of these changes were in place or embedded at the time of our inspection.
- Whilst the leadership team displayed an open and honest culture, the culture across the trust was variable. Senior leaders had not ensured that action taken within localities had positively impacted to improve culture within services. There was a lack of oversight of the effectiveness of action plans to address poor culture. Not all staff felt able to raise concerns without fear.
- Systems to identify, understand, monitor and reduce or eliminate risks were not always effective and required further development. This meant there was a lack of oversight risk and adequate assurance at board level. Mechanisms to escalate performance and risk issues from ward/team level to board did not function effectively. The trust had started to develop an integrated performance and assurance framework, but this was not in place at the time of our inspection.
- Not all wards and teams had enough staff who knew patients well and were able to care for them safely. In forensic inpatient services, staffing levels negatively impacted on the quality of care provided to patients. In some community teams, staffing levels were not sufficient to meet the demands of the service.
- Patients were not always appropriately safeguarded from abuse. There was no trust-wide policy for safeguarding adults. The trust had a procedure for safeguarding adults, which did not clearly outline the governance and accountability at each level of the organisation. The trust did not have a named doctor for adult safeguarding. Staff did not always make safeguarding referrals when appropriate. In forensic inpatient services, staff did not always treat patients in a kind, respectful and dignified way. There were high levels of restrictions placed on patients' freedoms.

Our findings

- There were not always enough staff who knew patients well to keep patients safe. In some services this impacted on the safety and quality of care and meant that staff were not always meeting the needs of patients. In some services, this impacted on timely access to treatment.
- There were high waiting times in community mental health services for children and young people. There was a lack of oversight of the waiting list management process and risks to children and young awaiting assessment and/or treatment were not reviewed.
- Although overall compliance with mandatory training was good, there were pockets of poor compliance. This meant that some staff did not have the required essential skills needed to deliver safe care.
- Governance systems at a locality level were insufficient to ensure the quality and safety of the service. Local leaders did not always have oversight of appropriate performance measures to ensure good quality care.
- Staff did not always report and record incidents appropriately. Staff sometimes did not report incidents when they occurred and sometimes reported multiple incidents within a single incident record. This meant that there was not appropriate oversight of the scale and nature of incidents which were happening within services.
- The trust required continued improvement in its approach to equality and diversity. Staff with disabilities or from a black and minority ethnic background were more likely to experience harassment, bullying or abuse. Staff network groups identified a huge variation in approaches and level of support by middle-managers across the trust in relation to equality and diversity concerns.
- Investigations into complaints and serious incidents were not always carried out in line with trust policies. Systems and processes to identify and implement learning from serious incidents were not effective. Actions had not been taken to tackle common themes identified within serious incidents to embed learning and prevent future serious incidents.

However;

- The trust had established a new committee of the board (people, culture and diversity committee) and appointed an executive director for people and culture, to embed a more strategic approach to people and culture within the trust.
- Staff completed annual appraisals, which included discussions on development and career progression. Leadership development opportunities were available and some staff had worked for the trust for many years and had been promoted into more senior positions.
- There was good engagement with staff, staff side, governors and external partners. The trust had completed a significant consultation and engagement process to inform development of their new strategy.
- The trust had taken action in response to enforcement action following our inspection of acute and psychiatric intensive care wards. As a result, simplified and introduced more effective systems to assess and manage patient risks within inpatient services. The trust had extended these systems to include community mental health services. Work continued to embed these systems and ensure their effectiveness.
- The board had approved further workforce investment for inpatient services and there was an ongoing recruitment process in response to staffing challenges.

There were robust systems in place in relation to the effective management of medicines and controlled drugs.

How we carried out the inspection

During this inspection we;

Our findings

- talked to service users and their carers about their experience of using these services
- visited nine forensic inpatient wards
- visited crisis teams and three health-based places of safety
- visited community mental health services for adults of working age
- visited community child and adolescent mental health services
- spoke with a variety of staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, managers, executive directors, non-executive directors and governors
- reviewed a number of records relating to the care and treatment of patients
- reviewed a variety of documents relating to the management of the trust and the services it delivers
- held focus groups with; staff network groups, staff side and Hospital Managers
- reviewed a variety of information we already held about the trust
- sought feedback from a number of the trust's stakeholders such as Healthwatch, NHS England and clinical commissioning groups.

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

What people who use the service say

We spoke with over 100 service users and their carers across the four services we visited and also spoke with staff and governors who were users of trust services. We spoke with Healthwatch to obtain information about what people said to them about the trust's services.

Feedback from service users and their carers was mixed.

In community child and adolescent mental health services, most people described not feeling listened to in relation to their views on medication prescribed to them. They also spoke about a lack of medical reviews, a lack of medical oversight in relation to the side-effects of medication and a general feeling of not being supported. People described very long waiting times for autism assessments and not feeling supported whilst they were waiting. Communication was highlighted as a particular concern, with people telling us that staff did not always return telephone calls and some information was provided to children and young people in a format they could not easily understand. Other people told us that although they had waited a long time to access services, once they received treatment this was of good quality and staff had given appropriate and helpful advice.

In forensic inpatient services, patients told us that they were unhappy that leave off the ward did not always happen as planned due to staffing shortages. Some patients were unhappy that they had been seen by a number of different doctors, although patients did receive regular one to one time with their named nurse. Patients told us that some staff were disrespectful to them and used derogatory terms and we viewed one incident of abuse by a member of staff towards a patient on CCTV footage. Some patients told us their needs were not being met by staff, including some of their physical health needs. Carers of people who used the service said they did not receive sufficient contact and

Our findings

information from staff, including not receiving invitations to key meetings and not receiving information about the ward when loved ones had been admitted. Patients did tell us that they were able to provide feedback and suggestions on how to improve the service through community meetings which took place on the wards. During our observations of the care of people received, we saw some interventions which were not always respectful and kind.

In community mental health services for working age adults and community crisis services for adults, most people we spoke to who used the service were positive about their experience of care. Some negative comments related to waiting times and access to face to face appointments.

Feedback from patients through trust surveys indicated that at the end of 2020/2021, 90% of patients reported their overall experience of care as excellent or good. Eighty four percent of patients reported that staff treated them with respect and dignity, 89% of patients would recommend the trust service to friends and family if they needed similar care or treatment. The trust target for all of these indicators was 94%.

In inpatient settings, only 65% of patients reported feeling safe on the wards, against a trust target of 88%. Sixty eight percent of inpatients reported they were supported by staff to feel safe, against a trust target of 65%.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

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

Action the trust MUST take to improve:

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

Trust wide

- The trust must ensure that it continues to deliver its board development programme to strengthen the scrutiny and challenge by boards members. (Regulation 17)
- The trust must ensure that planned changes to the governance structure are implemented to provide assurance that patients receive safe, good quality care and treatment. (Regulation 17)
- The trust must ensure that fit and proper checks have been carried out as required by legislation. (Regulation 19)
- The trust must ensure there is a safeguarding policy which clearly outlines the governance and accountability at each level within the organisation. (regulation 17)
- The trust must ensure that work continues to develop the "Our Journey to change" strategy to clearly set out how it will achieve its strategic goals. (Regulation 17)
- The trust must ensure that it responds appropriately to allegations of bullying, discrimination, racial abuse or hate crimes. (Regulation 17)

Our findings

- The trust must ensure it reviews its freedom to speak up and whistleblowing policy and processes to ensure they are effective. (Regulation 17)
- The trust must ensure that learning from incidents and complaints is implemented effectively to improve the safety and quality of care patients receive. (Regulation 17)
- The trust must ensure that its corporate risk register is current, has clear actions and timescales. (Regulation 17)
- The trust must ensure that the revised board assurance framework is implemented, and its effectiveness reviewed. (Regulation 17)
- The trust must ensure they collect performance data relating to targets and quality standards so that senior managers can ensure there is appropriate governance and quality assurance. (Regulation 17)

In forensic inpatient services

- The trust must ensure that all patients are safeguarded from abuse; all patients are treated with kindness, respect and dignity and that safeguarding referrals are sent to the local authority when appropriate to do so. (Regulation 13)
- The trust must ensure that the use of restraint within the service is proportionate and used only as a last resort and that any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)
- The trust must ensure that the wards within the service are staffed in accordance with its assessed safe staffing numbers so that care and treatment is delivered in a safe way; patients have access to activities, psychological interventions, occupational therapy, escorted Section 17 leave and staff can take their breaks. (Regulation 18)
- The trust must ensure that all staff receive and are compliant with a mandatory training programme which meets the needs of all patients within the service. (Regulation 18)
- The trust must ensure that all staff receive regular clinical supervision. (Regulation 18)
- The trust must ensure that audits of care records identify any errors or omissions in relation to patients' risk management plans in order to ensure all risks are identified and mitigated in order to keep patients and others safe. (Regulation 17)
- The trust must ensure that all incidents within the service have been reported by staff using the trust's incident reporting procedure. (Regulation 17)
- The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff receive key information and have the opportunity to provide their own feedback on the service. (Regulation 17)

In community mental health services for working age adults

- The trust must have effective oversight of caseloads and case management within all community teams. (Regulation 17)
- The trust must ensure that they are delivering care and treatment that is appropriate and meeting the needs of all patients across the community teams. Assessments and treatment must be offered in a timely way. (Regulation 9)

In crisis services and health-based places of safety

- The trust must ensure the proper and safe management of medicines. (Regulation 12)

In community child and adolescent mental health services

Our findings

- The trust must ensure that there are enough staff in each team to meet the demands of the service. Staffing level must be reviewed and amended promptly at times of high pressure and demand. (Regulation 18)
- The trust must ensure that all staff are appropriately trained in the mandatory skills required to fulfil their roles. (Regulation 18)
- The trust must ensure there is clear oversight of the waiting list management process and that it is robust enough to ensure all children and young people and reviewed and any risk acted upon. (Regulation 12)
- The trust senior management team must respond promptly to address issues within the service to ensure effective service delivery without delay (Regulation 17)
- The trust must ensure that the service can be accessed promptly for all children who are referred (Regulation 9)

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider strengthening the range of experience and backgrounds of non-executive directors in future appointments.
- The trust should continue its focus on the recruitment and retention of staff to maintain safe staffing levels.
- The trust should strengthen its serious incident process, including clear terms of reference, how patients and families have been involved and how staff had been supported.
- The trust should ensure that complaints are responded to in line with trust policy and implement any learning that had been identified.
- The trust should consider appointing a named doctor for safeguarding adults.
- The trust should ensure that incidents are recorded accurately, and that further review or investigation is carried out to improve safety and quality of services.

In forensic inpatient services

- The trust should ensure that all seclusion reviews take place as scheduled and seclusion documentation is completed accurately.
- The trust should ensure that all patients receive a comprehensive mental health assessment on or soon after admission and that the related documentation is saved to its care records system.
- The trust should ensure that information and documentation within its care records system is easily accessible for all staff within the service and contains up to date information about each patient's physical health assessment requirements
- The trust should ensure that all patients' care plans are formulated with outcome measures.
- The trust should ensure that staff who are off sick are fully supported to return to work when they are recovered.
- The trust should ensure that all guidance relating to medicines management is up to date to ensure staff follow current best practice and legislation.

Our findings

- The trust should ensure that all staff involved in the delivery of patients' care and treatment are able to attend multidisciplinary team meetings, so they have the opportunity to provide feedback on the patient's progress and health status.
- The trust should ensure that staff within the service actively inform, involve and support family members and carers when the patient has consented for them to do so.
- The trust should ensure that there are sufficient numbers of rooms so that staff can change out of their personal protective equipment, activities can take place and multidisciplinary team meetings can take place.
- The trust should ensure that staff update all ward noticeboards so that patients and staff have easy access to the most up to date information about the ward and wider service.

In community mental health services for working age adults

- The trust should consider the accessibility of the service for those patients who are unable to attend in core working hours.
- The trust should ensure that they maintain patient confidentiality when patients are being seen on trust premises
- The trust should ensure that care plans are reviewed in line with the policy

In community child and adolescent mental health services

- The trust should ensure that all children and young people who require risk management plans have them in place
- The trust should continue to ensure that all environmental issues within its estates structure are fit for purpose. The trust should continue with its plan to improve and relocate buildings that are no longer suitable.

Is this organisation well-led?

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

Leadership

Leaders did not consistently have the skills, knowledge and experience to perform their roles. They had a good understanding of the portfolio they managed but were not always visible in services and approachable for patients and staff.

Since the time of our last inspection of the trust in September to November 2019, there had been significant changes to the executive leadership team, including the chief executive, executive director of people and culture and the executive director of finance. For the director of people and culture, this was their first executive role. The trust had also developed proposals to strengthen the leadership structures across the organisation. These plans were in the early stages but aimed to increase the capacity and accountability of leaders in the trust. It was anticipated that the new structures would be fully in place by April 2022.

The board had not ensured that actions being taken by senior leaders were effective in addressing issues and risks within the organisation within clear timescales.

Our findings

Leaders were aware of service level risks, however the impact of actions to address risks were not always assessed. As a result, improvements were not always achieved or sustained. For example, actions taken to improve the culture within the forensic inpatients service had been marked as completed on the service action plan. However, there had been no assessment or review into how the actions had influenced any change to the culture of the service. During our inspection we found evidence that there continued to be a concern regarding the culture within the forensic inpatient services.

The quality of forensic inpatient services had deteriorated since our last inspection and we rated this service as inadequate following this inspection. The overall rating for specialist community mental health services for children and young people stayed the same as the last inspection, however the rating for safe went down to inadequate.

The trust had eleven voting members of the board. This included the trust chair, and the executive and non-executive directors. The executive directors with voting rights were; the chief executive, the director of finance and information, director of nursing and governance (who was also the deputy chief executive), chief operating officer (this post was vacant at the time of our inspection), medical director, director for people and culture, director of planning, commissioning, performance and communications (who was also the assistant chief executive) and the executive medical director. All non-executive directors had voting rights.

The chief operating officer had left the trust shortly before our inspection. The responsibilities of this role were being carried out by other directors on weekly rotation until the interim chief operating officer was due to come into post in September 2021.

The trust was in the process of recruiting an executive director of corporate affairs and involvement. This was a new post, which would hold responsibility for bringing patient, carer and community involvement and engagement together across the trust.

The non-executive directors brought a range of skills and experience from their relevant backgrounds although these were mainly in the NHS and other public sector organisations. Non-executive directors chaired the sub committees of the board.

Our observations of two board meetings and one meeting of the Mental Health Legislation Committee and evidence from board and committee minutes and reports highlighted a lack of challenge, and a focus on operational detail rather than assurance and strategic oversight. These issues were also highlighted by the external review of the of the trust's governance systems, which had been commissioned by the trust in November 2020.

The trust recognised that there was a requirement to embark upon a programme of board development, both executive and non-executive directors reflected that they would benefit from greater board development opportunities. There was a lack of understanding of what measures needed to be in place to give the board the required assurance in relation to the quality, safety and performance of the trust. In May 2021, the board had approved a specification outlining the scope of the required elements of the board development plan and were commissioning external expertise to conduct this work.

To support the existing governance arrangements, a weekly trust quality improvement board had been established, chaired by the chief executive and attended by the executive team. This board had responsibility for and oversight of ward/team to board reporting on implementation of quality assurance standards including regular audits and direct observations on wards. It reported to the trust board, through the quality assurance committee, on actions being taken to improve patient safety.

Our findings

In February 2021, a monthly regional quality board was established, jointly chaired by the regional chief nurse from NHS England/Improvement regional team and the executive lead of the North East and North Cumbria integrated care system. The regional quality board was accountable to the regional quality surveillance group and joint strategic oversight group and was attended by system partners including representatives from local clinical commissioning groups, the Care Quality Commission, Health Education England and local authorities. The quality board was established to oversee and support continued improvements in patient safety, quality and performance in the trust. The trust was also accessing external capacity and support to assist with driving forward planned improvement and embedding sustainable change.

During our inspections, we generally observed staff treating patients with kindness and compassion. However, in the forensic service we were concerned about the culture where some staff had not always acted in line with the trust values. We observed incidents on CCTV footage of staff abusing a patient and using restrictive interventions unnecessarily. Staff in this service had not always reported concerns when patients had been subjected to harm. We were concerned that local leaders had failed to effectively respond to issues relating to safeguarding patients and the poor culture within this service and more senior leaders had not ensured that actions taken were effective in improving the quality of care to patients in this service.

Staff generally told us that the chief executive was visible within the trust, staff knew and recognised him. There was less awareness and visibility of other executive directors and non-executive directors. There was a programme of service visits by executive and non-executive directors. Between January and May 2021, there had been visits to adult acute admission and psychiatric intensive care wards, forensic services wards and community mental health teams. There had been no visits during March 2021 due to the impact of Covid-19. Some executive and non-executive directors reflected on the limitations of these service visits as whilst they provided an insight into services, they did not always accurately identify issues and challenges faced by staff within services.

The board of directors were open and honest about the challenges faced by the trust. They described the trust as being on a journey to improvement, particularly in relation to strengthening governance structures and systems to provide assurance.

The trust had a fit and proper persons policy. During the inspection we reviewed the personnel files of four members of the board who had joined the trust since the time of our last inspection. Not all files were in line with the requirements of the fit and proper persons regulation. We found no evidence of qualification checks in any of the files we reviewed, no evidence of professional body registration checks in the two files where this was a requirement. One file had no references and another had only one reference.

The trust had four operational directorates, one for each geographical locality (County Durham and Darlington, Teesside, North Yorkshire and York) and a separate forensic directorate. The four directorates operated a triumvirate structure led by a director of operations, head of nursing and deputy medical director, all accountable to the chief operating officer. Deputy medical directors were jointly accountable to the medical director, and heads of nursing were professionally accountable to the director of nursing and governance. Each directorate had a professional lead for psychology.

Each geographical directorate consisted of four clinical service lines:

- adult mental health
- mental health services for older people

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- children and young people's services
- learning disability services.

Each clinical service line within the geographical directorates were managed by a head of service, clinical director (some also had an associate clinical director) and locality lead for psychology. These were then supported by locality, ward or team managers.

The trust had a director of therapies providing leadership for all psychological professions. There were professional heads of dietetics, occupational therapy, physiotherapy, speech and language therapy and social work.

The trust had an associate director of nursing who was the operational safeguarding lead. The director of nursing and governance was the executive lead for safeguarding. There was a named doctor and two named nurses for safeguarding children. There were two named nurses for safeguarding adults, but no named doctor. The trust had a safeguarding procedure for staff but did not have a safeguarding policy in place outlining the governance and accountability at each level within the organisation.

At the time of our inspection, the trust was at an early stage of implementing significant changes to the organisational structure. The trust was embarking upon a consultation exercise on a proposed structure consisting of two care groups/ directorates each with its own managing director who would report directly to the chief executive. The Trust had also reviewed and agreed changes to the portfolios of the executive directors.

Leadership development opportunities were available, including opportunities for staff below team manager level. Some of the directors had worked for the trust for many years and had been promoted to senior positions within the trust.

Vision and strategy

Leaders knew and understood the trust vision and values and generally understood how they were applied to the work of their team.

Following the appointment of the new chief executive in June 2020, the trust had embarked upon an extensive consultation exercise, to inform the development of a new strategy for the trust. Through 'Our Big Conversation', the trust engaged with key stakeholders including people who used services, carers and families, staff, council of governors and external organisations. Over 2,100 people contributed to this listening exercise and the responses had informed the development of the new trust strategy 'Our Journey to Change'. The trust had summarised this strategy as a single page document, outlining the trust vision, values and strategic ambition.

The trust values were:

- Respect (listening, inclusive, working in partnership)
- Compassion (kind, supportive, recognising and celebrating)
- Responsibility (honest, learning, ambitious).

The trust vision was:

Our findings

“We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate, and responsible”

The vision was underpinned by three strategic goals:

- to co-create a great experience for our patients, carers and families
- to co-create a great experience for our colleagues
- to be a great partner

The trust had undertaken extensive consultation to inform the development of the new trust strategy. This had informed the development of the trust business plan, agreed in March 2021. The plan set out the actions that would be taken to implement ‘our journey to change’. Progress against the actions were reported quarterly to the resources committee. The trust had identified five working groups to take a collaborative approach to further developing each area of the strategy.

The trust had developed a set of patient safety priorities in ‘Our journey to safer care’ but there was no clear interface to the strategic goals set out in the trust strategy. It was unclear what actions needed to be put in place to achieve these priorities.

Staff within the services we inspected generally knew and understood the trust vision and values, although said that these were not always followed. This was raised as a particular concern within forensic services, where staff did not feel respected by managers above modern matron level.

Culture

Staff did not always feel respected, supported and valued.

The leadership team displayed an open and honest culture. They had an understanding of the challenges in creating a positive culture across the whole trust. However, culture across the trust was variable.

During the inspection we spoke with staff across a range of roles and grade. Staff feedback in relation to the culture of the trust was mixed. Staff working in mental health crisis services and health-based places of safety, community child and adolescent mental health services and community mental health services for working age adults were generally positive about the culture of the services in which they worked and the trust overall. Staff within forensic inpatient services described a ‘toxic’ culture. These staff did not feel respected, supported or valued. Staff were not always able to raise concerns without fear of retribution. The trust had commissioned an external review of the culture within the forensic service in November 2019. During our inspection, whilst recognising the impact of the pandemic, we found limited improvement and staff told us the culture within the service continued to be poor. Actions taken to improve culture within the service had not been effective and leaders had not sought sufficient assurance regarding the impact of action taken.

Staff in some community services we spoke to, did not feel that managers always appreciated and understood the pressures they faced, particularly in relation to high workloads in some teams.

Our findings

Pockets of poor culture or low staff wellbeing and a recognition that this could undermine the trust's ability to provide safe and sustainable services was included on the board assurance framework. Some actions/measures in the board assurance framework to address this issue were graded as only providing limited assurance.

The trust's staff survey in 2020 had a response rate of 38%, which had decreased from 45% in 2019. The median response rate from this type of organization in 2020 was 49%. The 2020 NHS staff survey was carried out between October and November 2020, as the second wave of the COVID-19 pandemic took hold. Of the ten themes from the survey, the trust results were the same as the benchmark average in four areas, just below the benchmark average in five areas and just above the benchmark average in one area.

There was a positive relationship between the board and staff side. Representatives from trade unions had been actively involved in 'our big conversation' and felt their contributions had been heard. The chief executive held monthly webinars attended by representatives from the seven trade unions. Trade union representatives said these were a useful forum to raise concerns directly with the chief executive.

The trust had an equality, diversity and human rights strategy (2020-2023) which had been approved by the board in January 2020. The strategy had been due for review in July 2021. The strategy set down the trust's ambition to be an inclusive employer and service provider in which diversity is welcomed and valued, where all staff are able to achieve their full potential and where service users are able to access person-centered care which supports them to lead meaningful and satisfying lives. The strategy included an 'outcomes scorecard' which detailed performance measures against which the strategic objectives of the strategy would be measured.

The trust had three staff network groups; black and minority ethnic network, long term conditions network and LGBTQ+ network. We facilitated focus groups for each of the staff networks as part of our inspection activity.

The black and minority ethnic network was relatively newly formed. The network met monthly and was well attended. Members of the network identified significant concerns across the trust including staff being victims of racial abuse and hate crimes. Members felt that responses to these issues were variable. There was a lack of consistency in how managers dealt with reports of this nature and the level and quality of support provided. Members were aware of the role of the freedom to speak up guardian but felt that staff from black and minority ethnic backgrounds were less likely to raise concerns. Staff felt that issues were less likely to be taken seriously and acted upon than those of their white colleagues.

The workforce race equality standard became compulsory for all NHS trusts in April 2015. Trusts are required to demonstrate progress against nine measures of equality in the workforce. In 2020, the percentage of the workforce, where ethnicity was known, from a black and minority ethnic background was 5%.

The metrics evidenced that a higher proportion of staff from a black and minority ethnic background (25%) had experienced harassment, bullying or abuse from staff than white staff (20%). Fifteen percent of staff from a black and minority ethnic background had personally experienced discrimination at work from their manager/team leader or other colleagues, compared with 6% of white staff.

The trust had an action plan in place to improve performance against the metrics.

The long-term conditions network had been established in 2020. The network was a confidential group to provide members with a safe space to speak openly and honestly about their conditions. Members of the network supported one another, and all members who participated in the focus group said they found this support invaluable. The

experiences of network members in relation to how well they had been supported by managers within the trust was hugely variable. Some members had been well supported but others had had very negative experiences. The network escalated issues to one of the locality director of operations and also had a nominated representative within employee support service to link in with. Members had escalated the variation in approach when supporting employees with long term health conditions and disabilities but felt that there was a long way to go within the trust to have consistency amongst managers.

The workforce disability equality standard is comprised of ten metrics, comparing the experiences of disabled and non-disabled staff in the NHS. In 2020, 6% of staff identified themselves as having a disability. The metrics in the workforce disability equality standard evidenced that a higher proportion of staff with a disability had felt pressure from a manager to come to work, despite not feeling well enough to perform their duties (26%) than non-disabled (17%). There had been a decrease of 13% in the proportion of disabled staff saying their employer had made adequate adjustments to enable them to carry out their work (76% at March 2020 compared with 89% at March 2019).

Members of the LGBTQ+ network were overall very positive about their personal experiences working within the trust. They spoke positively about the new executive director for people and culture, who they felt took any issues they raised seriously. Members said that, in their experience, the trust took a proactive stance in supporting employees from the LGBTQ+ community. Sometimes issues had arisen where patients had been abusive to staff, but managers had dealt with this quickly and appropriately. Members were generally positive about the equality and diversity training provided by the trust.

In 2020, 3% of staff identified themselves as lesbian, gay or bisexual (LGB). The metrics in the workforce sexuality equality standard evidenced that LGB staff were more likely to report higher levels of discrimination by their manager/team leader than heterosexual staff, with gay women reporting the highest levels (11.6%). LGB staff were 1.49 times more likely to enter disciplinary processes than heterosexual staff, although this level had reduced from the previous year (1.49 times more likely at March 2020, compared with 2.5 times more likely at March 2019).

The trust had a guardian of safe working hours who was allocated personal assistant time to support them in their role. The guardian provided annual and quarterly reports to the board in line with the requirements of the 2016 terms and conditions of service for Junior Doctors. Reports included data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern.

Between 1st April and 30 June 2021, the trust had received 90 exception reports. These generally related to excess working hours or not having five hours continuous rest while working between 10pm and 7am on a non-residential on-call rota.

Not all staff felt that they could raise concerns without fear. Staff were aware of the trust's whistleblowing policy and most knew how to access the freedom to speak up guardian. The trust's whistleblowing policy was out of date, having had reviews delayed on a number of occasions.

Staff in forensic services raised significant concerns about fear of speaking up. In September 2020 the trust conducted a survey of staff within the forensic service. The results highlighted a number of issues, including that staff felt unsafe at work and had experienced violence in the workplace, communication from senior managers was poor and staff were not involved in important decisions.

Our findings

The trust had a freedom to speak up guardian who had been in post since 2016. The freedom to speak up guardian had been a part time role, for 18.5 hours per week until just prior to our inspection when the working hours had been increased to full time. This increase in working hours had been agreed for an interim period of two months initially, to provide five day per week responses to concerns. There was a deputy freedom to speak up guardian who provided cover during periods of leave. The trust had recruited fifteen dignity at work champions from across the trust. The freedom to speak up guardian felt that more investment was needed to further develop the champion role. The freedom to speak up guardian was line managed by the chief executive and submitted a formal report to the board twice a year. Between September 2020 and June 2021, 145 cases had been lodged with the freedom to speak up guardian. Of these, 49% related to bullying, 26% to patient safety concerns, 13% to staff safety concerns and 6% to culture systems/processes. Almost half (46%) of cases were anonymous.

The trust employed around 7,500 people. There were not always enough staff who knew people who used services well to keep people safe and used high levels of bank and agency staff.

The trust monitored wards and reported where fill rates fell below 90% for both registered nurses and healthcare assistants. Between 1st December 2020 to 31st May 2021, 19 (30%) wards had fill rates of less than 90% for registered nurses on daytime shifts. The trust stated that this was largely due to the roster having an additional registered nurse aligned to it that was not essential. During the same period, eight (13%) wards had fill rates of less than 90% for registered nurses on night-shift. Average fill rates for health care assistants showed that there were eight (13%) wards with fill rates of less than 90% on daytime shifts and two (3%) wards on night shift. Forensic inpatient service highest number of red occurrences (on nine wards) across the reporting period for registered nurses on day shift and for healthcare assistants on day shift (five wards).

In July 2021, 31 wards had registered nursing fill rates below 90%, three of which had fill rates below 50%. Twelve wards had health care assistant fill rates below 90% for day shift, two had fill rates below 50%. For night shifts 12 wards had registered nursing fill rates below 90%, three of which had fill rates below 50% and three wards had healthcare assistant fill rates below 90%.

The staff sickness rate was 5.8% in February, reducing slightly to 5.2% in March 2021.

The board had approved further workforce investment for inpatient services. Increased staffing requirements had been considered for inpatient adult mental health wards and forensic inpatient wards to improve patient safety, patient experience and clinical effectiveness. In addition, an acuity-based roster software product was being piloted in forensic inpatient services to support the management of daily staffing levels, escalation of issues and the dynamic redeployment of staff within the service. This would be reviewed and could be rolled out across the trust.

The trust was working in partnership with four other mental health trusts, to carry out an international recruitment drive for qualified nurses, with a target of recruiting 20 staff. The trust had also recruited over 90 newly qualified registered nurses into the trust, who were due to take up posts in September 2021.

The trust had a process in place to address poor staff performance where needed, including a disciplinary policy, which had been reviewed in July 2021. The trust had undertaken 82 disciplinary procedures with staff since 1 June 2020, 22 of which were still ongoing at the time of our inspection. The trust policy did not clearly define a target for conclusion of disciplinary procedures. Of the 20 ongoing disciplinary procedures that were ongoing, seven had been ongoing for more than six months. The longest ongoing case was from June 2020. Staff absence and a police investigation had resulted in cases taking longer than six months to conclude.

Our findings

We reviewed six disciplinary cases as part of our inspection activity. We found in all cases the trust policy had been followed.

The trust had effective processes in place to verify that clinical staff had a current professional registration and to ensure staff had a valid check with the disclosure and barring service. The trust took appropriate action, for example placing staff on restricted duties pending receipt of a valid disclosure and barring service check, or while staff were awaiting registration renewals.

The trust provided opportunities for development and career progression. Some staff had worked for the trust for many years and had been promoted to more senior positions. Development opportunities were discussed as part of the annual appraisal process. The proportion of staff completing an annual appraisal was 96% in February 2021.

There was an annual programme of mandatory training for all staff. As of February 2021, overall compliance with mandatory training across the trust was 92%. However, compliance rates for completion of mandatory training was not consistent across all services, and in the four services we inspected, we found that staff were not always fully compliant with essential skills to fulfil their roles. In forensic inpatient services, staff were sometimes deployed into wards for people with a learning disability and/or autism who did not have the required skills to communicate effectively with patients.

The trust had created an director for people and culture, who was a non-voting member of the board, with the postholder taking up position in February 2021. The new executive director had worked in the trust for a number of years and had previously been employed as the director of therapies. This new post had replaced the previous post of director of human resources and organisational development. The aim was to take a more strategic approach to people and culture within the trust, with a drive to bring about cultural change through the trust's new values. The trust had also introduced a new sub-committee of the board, the people, culture and diversity committee to further strengthen oversight and governance.

The trust held an annual staff awards event to recognise staff and volunteers for their contributions in a variety of categories.

Governance

Our findings from the other key questions demonstrated that governance processes were not operating effectively across the trust.

There was a board sub-committee structure in place, with each committee chaired by a non-executive director, reporting to the board. The committees were:

- Audit and risk committee
- resources committee
- mental health legislation committee
- quality assurance committee
- nomination and remuneration committee
- West Lane project committee.

Our findings

The trust had commissioned an external review of its governance structure, systems and processes in November 2020. The findings report from this review included over thirty areas for improvement recommendations. The trust had accepted all the recommendations from the review and had developed an action plan in response to the findings them. This was at an early stage of implementation at the time of our inspection.

In light of recommendations from this external review, the trust was making changes to their governance structures. New sub-committees of the board were being established, including a people, culture and diversity committee, commissioning committee and strategy and resources committee (replacing resources committee). This new structure was not embedded at the time of our inspection, so we were unable to assess the impact and effectiveness of these changes.

The trust had a Mental Health Act legislation committee, chaired by a non-executive director who did not have a background in mental health. The chair reflected that they were still 'getting to grips' with the agenda but felt that reports coming to the committee provided the correct level of information and assurance.

The trust had a designated lead officer for Mental Health Act who was very experienced in the role. They were concerned that there was insufficient understanding of the Mental Capacity Act amongst staff and compliance with the act. There was a conference planned with a focus on mental capacity and Mental Capacity Act champions worked in services to improve understanding and compliance.

There was evidence of the effective administration of the Mental Health Act within the trust. However, that was no system to provide assurance that mental capacity assessments regarding consent to mental health treatment were undertaken by responsible clinicians, despite this issue being raised in Mental Health Act monitoring visits.

The trust had reviewed and updated their policy on long term segregation, with the updated policy coming into effect in April 2021.

At the time of our inspection, the trust did not have an integrated performance report. The four localities each produced a monthly quality and learning report which was presented and discussed at the quality assurance committee. A trust level quality and learning report was presented at trust board meetings. We reviewed a sample of the quality and learning reports. These contained an overview of key performance metrics, an overview of actions and key learning points. Areas of learning were not sufficiently detailed and the same learning duplicated in reports.. The quality committee received a 'positive and safe' report twice a year which reported on actions taken to address rising restrictive interventions.

There was limited evidence of learning from issues. We heard from executive and non-executive directors that the trust was moving towards becoming a 'learning organisation'. There was recognition that the trust had more work to do in this area. Work had commenced to develop an integrated board assurance report provide a more integrated approach to quality and performance assurance and improvement across the trust. This would encompass measures for each sub-committee and would be aligned to the board assurance framework.

The trust had an incident policy and Duty of Candour policy in place. We reviewed five serious incident reports during our inspection. All of the serious incident reports we reviewed included a background summary with a description of the incident and conclusions. All of the reports provided a detailed timeline of events and highlighted areas of good practice or areas the trust felt short of their expected standards. However, all five incident reports were missing basic information

including the incident reference number, patient date of birth, reviewer details and version control of the serious incident report. The safeguarding section of the report was not completed in one of the reports where appropriate, one report did not seek any feedback from the patient's carers, friends or family and there was no evidence in the reports identifying how staff were supported following each of the incidents.

There were no clear terms of reference provided to us with any of the serious incident reports, therefore it is not clear if they were in place or if there was family involvement for setting the terms of reference for the investigation. Lessons learned, where appropriate, had been identified in all of the serious investigation reports. In two reports, there were action plans present and in the other three reports there were assurance statements outlining how learning would be addressed and monitored.

The trust's duty of candour policy states that the patient or family should be sent a letter containing an apology with a detailed account of what happened within 10 days of the serious incident. The trust had identified duty of candour in three of the incidents we reviewed, however we could only find evidence of two letters being sent out, both of them were sent to the families six months after the incident, which is not in line with the trust policy. One of the serious incidents we reviewed stated that there had been learning identified and 'missed opportunities' by the trust, however the trust had not identified this as duty of candour.

The trust had a complaints policy, which was out of date at the time of our inspection. The trust had extended the review of the policy four times from April 2020 – July 2021. The last date for review was July 2021 and they had not extended the review past this date or reviewed the policy. The trust had a complaints procedure in place and a patient advice and liaison service which patients, carers and families could use to submit a complaint.

During 2020/21 the patient advice and liaison service dealt with 2,127 concerns or issues from patients and carers, 52% of which related to adult mental health services. During the same year 263 formal complaints were registered. The most common causes for complaints related to aspects of clinical care, communication and attitude. Responses to 174 were issued, 78% within the target timescale of 60 working days.

We reviewed five complaints during our inspection. We found only three of the complaints were sent acknowledgement letters within three days, in line with the trust's policy. There was a lack of supporting evidence to show that complaints were investigated and documented fully on four of the complaints. One of the complaints did not have any supporting documentation to clarify what investigations had taken place into the complaint, we made the trust aware of this and asked for further information, however this was not provided.

None of the complainants had received updates on their complaints since receiving their acknowledgement letter to the final outcome being sent. One of the complainants should have been responded to in June 2021 after an initial complaint was made in November 2020, however no update had been sent out to advise them of a delay in the response deadline.

We found three of the five complainants were provided with an outcome to their complaint within the 60-day deadline set by the trust. Areas of improvement had been identified in two of the complaints, with the trust detailing the action they would be taking. However, two complaints had passed the 60-day deadline for response and three of the outcome letters had not identified any learning or actions following the investigation into the complaint.

Staff used physical intervention including the use of mechanical restraint. Secure inpatient services had a policy for the use of mechanical restraint, however there was no trust wide policy. Between 1 September 2020 and 1 June 2021, trust data indicated that mechanical restraint was used on 54 occasions. This included eight times on non-secure inpatient

wards. Two of these related to the use of surgical mitts. One incident related to Police applying handcuffs whilst a patient was in an accident and emergency department and one related to Police applying handcuffs to a patient on an inpatient mental health ward. One incident related to the use of soft cuffs to transfer a patient from a psychiatric intensive care unit to a secure inpatient ward. The final incident related to the use of equipment to move a patient into a seclusion room.

Management of risk, issues and performance

Leaders used performance systems to identify, understand, monitor and reduce or eliminate risks. However, these systems were not always effective and required further development. Performance data in some services was not routinely collected and reported on. Whilst local managers had an understanding of performance against service targets, there was a lack of oversight by more senior managers in the trust. The board had acknowledged that these systems needed to be strengthened and had started work on a single, integrated performance and quality report. In order to develop a fit for purpose integrated board assurance report, discussions had taken place with each of the chairs and the executive lead for each sub-committee of the board. The focus was to identify appropriate measures that would provide appropriate assurance to the board. There was also work underway to establish a clear assurance flow, linked to the new governance framework, to provide a clear line of sight from ward/team to board.

At the time of our inspection, the trust had a performance management framework to provide oversight and management of key performance indicators. The four localities held monthly quality and assurance improvement meetings where issues of concern were reviewed and escalated. Performance dashboards included a range of performance measures including;

- Waiting times
- Out of area placements
- Patient experience
- New referrals
- Number of discharges
- Bed occupancy
- Length of stay
- Sickness absence rates

These performance dashboards (including the relevant indicators) were reviewed by:

- locality quality assurance groups
- locality management and governance boards
- senior leadership group and its sub-groups
- quality assurance committee
- the board

Our findings

The quality and assurance committee received a trust wide quality and learning report alongside a quality and learning report for each of the four localities. The trust recognised that existing performance and assurance arrangements needed to be strengthened to provide a system that was inclusive of all performance information, inclusive of all relevant sources of assurance including qualitative and quantitative measures.

The trust had systems in place to identify risks from incidents, complaints and safeguarding alerts and make improvements. However, these were not always effective. The trust recognised that it needed to review existing risk escalation processes and were considering how these could be streamlined to provide a more robust mechanism for escalating risks from ward to board.

We carried out an inspection of acute and psychiatric intensive care services within the trust in January 2021, following a serious incident involving a ligature, which sadly resulted in the death of a patient. We found that systems and processes to identify and manage patient risks were not sufficient to ensure patient safety. The board were not aware of these significant failings in the oversight of patient risk assessment and risk management processes prior to our inspection.

Following this inspection, we took enforcement action, requiring the trust to make significant improvements in their systems and processes to identify and manage patient risk. We re-inspected acute and psychiatric intensive care wards in June 2021 and found that the trust had made improvements. The trust was continuing to further embed their streamlined risk assessment and risk management process across the whole organization, in both inpatient and community services.

The trust had implemented a two-phase programme of estates works to reduce potential ligature points within inpatient services to address learning from inpatient deaths and an increase in fixed ligature incidents. Phase one of the programme focused on the replacement of fixtures and fittings in ensuite bathroom with anti-ligature fittings. The programme was established following a previous death of a patient involving a ligature in 2019. At the time of our inspection, phase one of the programme had been completed, although progress had been delayed due to COVID-19. Phase two of the programme was expected to be completed by the end of 2021/2022, improving the safety of bedroom doors and windows.

The trust had commenced installation of a ‘digital care assistant’, which detects movement in bedroom and seclusion rooms through the measurement of patient’s vital signs and sends alerts to staff where any risks to patients are identified.

There was a lack of learning following serious incidents in the trust. For example, there had been a number of serious incidents involving fixed ligature points, including five inpatient deaths since May 2019. Reviews of these incidents all highlighted issues with the risk assessment and risk management processes. Following a serious incident where a patient ligatured using a fixed ligature point, the trust issued an inhouse safety notice. However, no inhouse safety notice was issued following subsequent serious patient safety incidents involving different fixed ligature points. At the January 2021 board meeting, members questioned why processes to embed learning from serious incidents had not been effective. It was acknowledged that complex procedures and high volumes of activity and acuity contributed to a lack of learning.

The trust target for completing investigations into serious incidents was 60 working days. This target was not always met, and the trust had a backlog of serious incidents which had not been completed within the 60-day target. At the end of July 2021, there were 208 open incidents, some dating back to 2017. The trust was working closely with

commissioners and NHS England and Improvement to develop a standard and consistent approach to evidence for assurance to review and close these incidents. At the beginning of August 2021, there were 67 serious incidents, 24 of which had not been allocated to an investigating officer, and 32 were overdue. We reviewed serious incident investigations throughout the 12 months preceding the inspection.

Staff used an electronic system to report incidents. The trust upload incidents to the National Reporting and Learning System, which is a central database of patient safety incident reports. We reviewed incident data for the period 1 January 2021 to 31 July 2021. During this time the trust reported 6,485 incidents. Of these 4,321 were categorised as no harm. These included incidents where patients had tied ligatures. Some of these incidents had resulted in patients being found unresponsive and having to be transferred to acute hospital settings. We found that sexual safety incidents occurring on the ward were all categorised as low or no harm. This meant these types of incidents were not subject to investigation for action and learning. We also found that some incidents of were grouped together in a single incident report, including sexual safety incidents. This meant that incidents were being under reported. These issues meant that leaders had limited assurance about risks within services.

The trust learning from deaths policy and mortality review process were under review at the time of our inspection. Mortality reviews were completed in-line with guidance from the Royal College of Psychiatrists. The mortality review tool used consists of two stage review process; part one is a review of the care records, where any concerns are noted a part two (structured judgement review) was carried out. Mortality reviews and structured judgement reviews, including themes and trends, would normally be discussed and reviewed at the trust's patient safety group. This group had been stood down as a result of the coronavirus pandemic. An interim mortality review panel was established to review the back log of structured judgment reviews that had been completed. Reports on the outcomes and findings of mortality reviews were presented to the board. Between April to June 2021, 301 cases met the criteria for a mortality review. Of these, 78 reviews have had a part one review and 12 cases were selected for a more detailed structured judgement review. 29 community deaths of patients with learning disabilities were reported. All were reviewed via the trust mortality review process and were reported to the Learning Disability Mortality Review Programme. The four most common themes found from serious incident reviews of deaths were risk assessment, care planning, inadequate record keeping and poor communication. These themes had been ongoing for some time and it had been acknowledged that there was more work to do to strengthen assurance processes to tackle these common themes and embed learning to prevent future serious incidents.

At the time of our inspection, three services were operating in business continuity arrangements due to staffing pressures. These were forensic inpatient services, Durham and Darlington crisis and intensive home treatment team and Tees learning disability inpatient services. In North Yorkshire & York locality there was an increase in adult mental health teams requesting support through "stop the line" process due to inability to deliver service expectations due to staffing issues and increase in referrals.

Due to increased levels of staff sickness and services operating in formal business continuity arrangements, in July 2021 the trust set up an incident room and made formal requests to the wider system for support in line with NHS procedures. All non-essential work had been assessed, for example non-essential meetings, training and projects were stood down to reduce the pressure on services. The trust was working to return to normal operations as soon as it was safe and practicable.

In response to the COVID-19 pandemic, the trust invoked its emergency and service continuity plans to maintain delivery of critical services. Command and control structures were put in place to provide executive oversight of these arrangements. Technology including videoconferencing was used to facilitate remote appointments and remote working to reduce transmission of the virus.

Our findings

The trust had a financial plan in place, which included workforce investment. There was an appropriately qualified and experienced director of finance who had been in post since October 2020 with associate/deputy director and board-level experience from roles within commissioning and community and mental health provider organisations.

At the time of our inspection, the trust was in segment three of the NHS England and Improvement's system oversight framework. This was due to significant quality concerns, with no concerns in relation to the trust financial performance of the trust.

The trust had a chief pharmacist in post who was the controlled drug accountable officer. There was good oversight of controlled drugs within the trust. Medicines optimisation within the trust was well led. The Medicine Optimisation and Pharmacy Framework 2021-2025 had been developed with pharmacy staff and revised to align with trust business plan. There was a clear workforce plan in place to address vacancies and plan for future recruitment. Multidisciplinary attendance at key medicines committees was in place and there was good representation.

The medicines safety officer role was well established and fully integrated into trust governance processes.

The Drugs and Therapeutic group had a clear structure and was an established committee with multidisciplinary representation. Locality medicine management groups were part of the new trust structure and pharmacy representation was present in all localities. These groups had a clear remit but were not fully embedded at the time of our inspection and had not been reviewed for effectiveness.

Patients in services were provided with pharmacy medication information to enable patients to make informed decisions in relation to medicines.

The trust used the board assurance framework as a means of providing assurance to the board that the strategic risks were being effectively managed across the trust. A recommendation from the external governance review was to strengthen the board assurance framework. At the time of our inspection the trust had commenced this work, and a working draft of a refreshed board assurance framework was in place. This was scheduled to be reviewed by the audit committee in October 2021.The board assurance framework detailed 14 risks, each aligned to the strategic goals of the trust. Some of the risks within the BAF had no specified actions or timescales.

The trust had an organisational risk management policy, which was due for review in September 2021. As of 30 June 2021, there were 43 risks recorded on the corporate risk register. These covered a range of issues including workforce, service delivery, quality, compliance, patient safety, reputation and safety/security. Some risks had been open for a number of years, for example, safe staffing levels in forensic services had been on the risk register since 2015 and occupancy levels in the Teesside locality had been on the risk register since 2016. Not all risks had mitigating actions identified, some had no action owners and dates for completion of actions identified. For some risks, mitigation control measures were not robust. A patient safety risk in one community CAMHS team linked to significant staffing issues stated in mitigating controls that no scheduled medical cover was in place and that local leaders were 'working on this'. The mitigating action to increase capacity in the team was due for completion by March 2021 but this had not been achieved.

The corporate risk register was presented and discussed at the senior leadership group but not routinely presented at assurance committees of the board. The first and only report of the corporate risk register at the Audit & Risk Committee was at the meeting in March 2021.

Information management

Our findings

Staff in the community mental health services we inspected said they found electronic patient records easy to update and navigate. However, in forensic inpatient service staff did not always have easy access to clinical information and did not always maintain high quality clinical records. Staff in forensic inpatient services could not always easily locate important patient information quickly.

The trust was aware of the limitations of the electronic patient record system. The trust had been developing an information technology system which would overly the patient record system to make it easier to record and view the patient records. However, this project, which had started in 2018, had been significantly delayed and had not been fully implemented at the time of our inspection.

The director of finance and information was the senior information risk owner at board level. The trust had a network of information asset owners and administrators, which had increased information governance awareness, training and understanding of standards and responsibilities. The network was consulted when there was significant change to information governance process, for example implementing the new requirements under the Data Protection Act 2018 (GDPR).

Staff completed a cyber security training e-learning programme, which was launched in August 2020.

The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. There were 13 incidents reported in the Data Security and Protection Toolkit during the period 1 April 2020 to 31 March 2021. Six incidents were privacy breaches (inappropriate staff access to local or national patient information systems) affecting one person. Seven incidents were confidentiality breaches with a variety of causes. All incidents were investigated appropriately. No cases resulted in regulatory action by the Information Commissioners Office.

There was a risk relating to lost records on the corporate risk register. This risk had been on the risk register since October 2019. There were no mitigating actions identified.

Engagement

Following his appointment in June 2020, the new chief executive carried out an extensive consultation exercise with staff, patients and carers and external stakeholders, called ‘The Big Conversation’. The board were preparing to consult with staff on significant changes to the organisational structure and governance arrangements.

The trust had a council of governors, made up of 54 governors including publicly elected governors, staff governors and governors appointed from key stakeholders including local authorities and local universities. During the pandemic, arrangements were put in place to ensure the board was kept informed of the views of governors and members. This included regular meetings between the chairman and governors and attendance at the board by videoconferencing arrangements.

During the inspection, we held a focus group with trust governors, who generally said that relationships between the governing body and the board were good. They described the non-executive directors as supportive and engaging. Governors felt that they felt comfortable raising issues and gave examples of involvement in task and finish working groups to improve services in response to issues.

The trust had introduced a new executive director of corporate affairs and involvement post, who would be the executive lead for patient, carer and community involvement and engagement.

Our findings

The trust had a programme of service user and carer involvement, which had been managed virtually using relevant technologies during the COVID-19 pandemic. The trust had around 300 service users and carers registered to participate in a variety of engagement and involvement activities.

Staff in forensic services had been invited to participate in Schwartz Rounds and this was being expanded across the trust. The first trust wide Schwartz Round took place in June 2021, facilitated via video conferencing. The trust was considering other methods for staff engagement including 'pop-up' rounds for groups such as inpatient staff/ people working night-shifts, and 'Team Time', to facilitate reflection for individual teams.

The chief executive was chair of a green social prescribing group across the Humber, Coast and Vale integrated care system. This was one of six national test and learn partnerships focusing on green social prescribing. The aim was to work in partnership with a range of statutory and non-statutory partners to develop plans across Humber, Coast and Vale to identify activities, support and resources to promote nature based activities to help people with mental health issues reduce symptoms, activate self-management approaches and improve physical health. This project involved the co-creation of opportunities with service users and voluntary and community organisations.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify improvements in how the trust engaged with families. Following the event, the trust appointed a Family Liaison Officer to support families through the serious incident investigation process. The Trust was due to hold its second annual family conference in March 2020, however this was put on hold due to COVID-19.

The trust had an annual clinical audit programme, which included both national and local audits. During 2020/21, the trust participated in four national clinical audits and two national confidential inquiries. In the same year the trust carried out 130 local clinical audits which were reviewed by the quality assurance committee and clinical effectiveness group.

The NHS Long Term Plan outlined plans to implement integrated care systems across England. Integrated care systems are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. The trust footprint incorporates two integrated care systems (ICS); North East and North Cumbria ICS and Humber, Coast and Vale ICS. Since April 2021, the trust had entered into two provider collaboratives with a neighbouring mental health trust who were the lead provider and were responsible for the commissioning of children and young people's mental health inpatient services, adult low and medium secure services and adult eating disorder services.

Learning, continuous improvement and innovation

The trust conducted 52 clinical research studies during 2020/21; 43 of which were supported by the National Institute for Health Research.

The trust had an active research department and had opened a new research unit at Foss Park hospital. The trust had sponsored and contributed to national Covid-19 research programmes.

In 2021, the Trust launched a free-phone service for those in mental or emotional distress. The service was available 24 hours a day, seven days a week, providing an alternative to traditional crisis care and offering local people the opportunity to talk to trained mental health support workers.

Our findings

Adult Learning Disabilities services in the Durham and Darlington locality had secured additional funding to assist with the completion of annual health checks for people with a learning disability. The agreed protocol and model were being shared with teams within the Tees locality to extend the provision of this project.

During the pandemic, the trust used remote physical health monitoring devices to monitor patients who used antipsychotic medication.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement →← Dec 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
367 Thornaby Road	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Jubilee House	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Overall trust	Requires Improvement → ← Dec 2021	Good → ← Dec 2021	Good → ← Dec 2021	Requires Improvement → ← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement → ← Dec 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for 367 Thornaby Road

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018

Rating for Jubilee House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Aug 2021	Good Mar 2020	Good Mar 2020	Good Mar 2020	Requires improvement Aug 2021	Requires improvement Aug 2021
Wards for older people with mental health problems	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Requires improvement Mar 2020	Requires improvement Mar 2020
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Good Oct 2018	Requires improvement Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Inadequate ↓ Dec 2021	Inadequate ↓↓ Dec 2021	Inadequate ↓↓ Dec 2021	Requires Improvement ↓ Dec 2021	Inadequate ↓↓ Dec 2021	Inadequate ↓↓ Dec 2021
Community-based mental health services of adults of working age	Good →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement ↓ Dec 2021
Specialist community mental health services for children and young people	Inadequate ↓ Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement →← Dec 2021
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good ↑ Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Requires Improvement ↓

Is the service safe?

Good →←

Our rating of safe stayed the same. We rated it as good.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.

Staff working in the services had alarms which they could take into interview rooms and staff were available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. The psychosis teams had a range of equipment within clinic rooms and staff had access to all of the equipment to meet the needs of patients.

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning staff were on duty during the inspection.

Staff followed infection control guidelines, including handwashing. Managers prompted visitors to wear appropriate personal protective equipment and use hand sanitiser before entering premises. Posters were displayed around buildings to advise staff and patients of good hand hygiene and masks were being worn inside the premises. Signs were on office doors indicating the maximum numbers of people who could use the area at any one time.

Safe staffing

The service usually had enough staff, who knew the patients. Most staff had received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams had increased and was high in some teams.

Nursing staff

The service usually had enough nursing and support staff to keep patients safe. Some members of staff had gained promotion or secured places at university for further training. In total there were 77.45 vacancies across the core service from a total staffing number of 998.76. This equated to a 7.7% vacancy rate and most teams were able to manage this. There had been some difficulty recruiting to posts in North Yorkshire and York locality and these posts had been out to advert several times.

Managers made arrangements to cover staff sickness and absence. In some teams managers had picked up a small case load to assist staff when needed.

Managers supported staff who needed time off for ill health.

Average sickness levels were 7%. Durham and Darlington access team had a 22% sickness rate at the point of a service restructure. Issues had been raised with managers who had worked with staff and the sickness rate had dropped significantly in subsequent months. Some staff said that patients' needs were not always being met. The Stockton Affective Disorder team had 10% sickness rate. Managers said that they were managing this within the team but that waiting times had increased slightly over the last three months.

Medical staff

The service had enough medical staff and most teams had at least one dedicated consultant psychiatrist. The affective disorder team in Derwentside did not have a full-time psychiatrist as this post had been unable to be filled after being out to advert. The team had psychiatry cover over five days, but staff felt that a dedicated post would benefit the team to ensure consistency for patients.

Most teams within the service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The compliance rate for basic life support was 72% overall with four teams achieving below the trust target of 75%. Immediate life support was 78% with five teams below 60%. All other courses were above the trust target.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Most managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. The trust had introduced a new, streamlined process to assess and manage risk. Staff had worked hard to ensure that most patients had been moved across onto new risk management plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 61 records and found that risk summaries had been updated with only one exception where a patient had not had their risk summary updated after a significant incident. The records we looked at had risk management plans in place where appropriate.

The trust had implemented a new risk assessment tool in February 2021 and staff had reviewed all high and medium risk patients to ensure that they had either an adequate old style plan or if not to transfer them to the new style safety summary and safety plan by the end of March 2021. This assessment had been completed. Staff were currently working to transfer all remaining patients onto the new style documentation by August 2021.

Community-based mental health services of adults of working age

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. There were close links with the crisis team who would notify teams of anyone who had contacted them out of hours. We saw an example of a patient awaiting an autism assessment been giving support when their mental health had deteriorated.

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Most teams did not have waiting lists but those that did were due to staffing issues. Staff could discuss patients they were concerned about in daily huddles and discuss patients who were disengaging or not progressing in treatment. Patients awaiting an autism assessment were reviewed every six months and staff dealt with any mental health issues.

Staff followed clear personal safety protocols, including for lone working. Working practices had changed and some staff continued to work from home and using phone or video conferencing appointments, while most some staff has returned to the office and were doing a mix of home and office working.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received up to level three safeguarding training if appropriate to their role and safeguarding training compliance was above 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** Teams were either integrated with local authority social work teams or worked very closely together.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. All records were electronic and easily accessible to staff. However, staff said it was sometimes difficult to navigate the system and locate specific documents.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff in the psychosis team administered medication and stored medication appropriately. Staff also had access to locked cases to administer medications in the community.

Community-based mental health services of adults of working age

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We observed staff discussing the effects of medications during review meetings. Patient leaflets were available and handed or posted to patients to describe side effects of medications.

Staff carried out physical health monitoring with patients who were prescribed anti-psychotic medication in line with guidelines produced by the National Institute for Health and Care Excellence. We observed good monitoring within the psychosis teams we visited. Staff completed a baseline physical health check prior to initiating patients on antipsychotic medication. These checks included blood pressure, height, weight body mass index, electrocardiogram and blood tests, for example, blood glucose and cholesterol levels. Teams had robust lithium monitoring processes whereby a physical health lead was responsible for ensuring patients were having their regular reviews by the GP.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service usually managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) between June 2020 and June 2021 and found that out of the 136 incidents there were 98 incidents where the patient had involvement with adult community services. Most of these incidents were categorised as apparent/actual/suspected self-inflicted harm.

The trust was using a deaths dashboard to ensure mortality and serious incident reviews were being completed. Reports included a breakdown of the themes of all the learning identified and included areas such as, Care Records, Harm Minimisation, Policy Compliance, Referrals, Transfers, Communication and Intervention Planning.

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.

Community-based mental health services of adults of working age

In the last year, there had been one 'prevention of future death' reports sent to Tees, Esk and Wear Valleys NHS Foundation Trust relating to this service. The trust had investigated this incident, and this was ongoing. We did not find evidence during the inspection to suggest ongoing harm to other patients.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. We saw evidence that staff were supported after serious incidents. Staff were able to describe how they supported each other after patients had self-harmed in the community and discussed what they could have done differently.

Managers investigated incidents thoroughly and usually involved patients and their families where appropriate. Although most patients and families were happy with the process those who were not satisfied were often the most significant in terms of harm to patients and their families.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. A 12-week formulation process was in place where patients were seen weekly during the initial 12 weeks of treatment to get to know them and plan their care and treatment.

Due to the number of patients open to the community teams care coordinators worked within cells. Each cell was made up on several care coordinators who had a collective overview of patients within each cell. This meant that care coordinators had a basic understanding of all patients within that cell. This meant that if a member of the team was absent then the other staff in that cell would understand the patients' needs and could continue care and treatment.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Community-based mental health services of adults of working age

Staff generally reviewed and updated care plans when patients' needs changed. We reviewed 61 care plans and found that most patients had an up to date care plan in place. There were six care plans that had not been updated for a couple of years and one patient did not have a care plan in place as they had not engaged. This was raised with managers during the inspection who agreed to follow this up.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Care coordinators were from a range of different backgrounds including nursing, social work and occupational therapists. Patients could access psychological therapies, and this ranged from individual sessions to group work with online sessions were taking place. The access to psychological therapies varied across teams as the number of psychology staff varied between teams. For example, the Darlington team had therapy workers who worked with the psychologist and psychology assistants which meant patients had access to more psychological interventions. Each team had a small waiting lists for access to therapies. Group online sessions were also been offered.

Staff made sure patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Healthy eating and stop smoking services were available.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff used technology to support patients and some patients continued to access support online. Staff had improved online working over the last year as face to face appointments had reduced due to coronavirus restrictions. Patients were also able to access group sessions online.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

Most teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Most teams within the services had a full range of specialists to meet the needs of each patient. Teams were made up of managers, consultant psychiatrist, psychologists, occupational therapists, therapy staff, nurses and support workers. In some areas the teams were integrated with local authority social workers and where they were not there were close working relationships**.**

Community-based mental health services of adults of working age

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff were supported to attend training courses to increase their skills with different members of teams sharing their expertise with staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work and 94% of required sessions had taken place.

Managers supported staff to access clinical supervision of their work. Staff were responsible for ensuring that they identified a clinical supervisor and kept up to date.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meeting minutes were emailed to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had completed or were in the process of completing autism training. This was in response to the number of people awaiting an autism assessment.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each community team was broken up into small teams which were called cells. Staff met within their individual cells to discuss patients and the cells were clearly displayed on white boards in staff areas. Each cell met in their respected groups every morning for a huddle. We observed huddles taking place in each of the teams we visited and found them to be, short, effective and comprehensive. The huddles offered the opportunity for each cell to review their caseload, share any work, cover absences, review risk and review any key dates for physical health checks.

The management team, which comprised of the team leader, consultant psychiatrist, clinical psychologist, advanced practitioner and social care manager led daily meetings where staff could discuss any complex cases. Staff booked sessions using a board in the staff room for discussion that day.

Staff had effective working relationships with other teams in the organisation including the inpatient wards and crisis teams.

Staff had effective working relationships with external teams and organisations including drug and alcohol services and third sector support organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Community-based mental health services of adults of working age

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff had completed Mental Health Act training level one and two with over 95% completion rate.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The compliance rate for training was 98%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

We saw some evidence that staff assessed and recorded capacity to consent in the records.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when were necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Community-based mental health services of adults of working age

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We saw good interactions between staff and patients during the inspection. Most patients said that staff were meeting their needs.

Staff gave patients help, emotional support and advice when they needed it. We spoke to 48 patients and 10 carers and reviewed information we had received from patients and families before the inspection. Although most patients said that they were happy with the service we did receive some negative feedback. Three patients said that they did not feel listened to and that the support they got did not help to deal with trauma. Some patients said that they had complained to the service and that these had been acted upon and were now happy with their care and treatment.

Staff supported patients to understand and manage their own care treatment or condition. We observed meetings between staff and patients where staff explored patients' current presentation and what they could do to support them.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate.

Community-based mental health services of adults of working age

Patients could give feedback on the service and their treatment and staff supported them to do this. Electronic devices in waiting areas had been disabled to prevent the spread of infections. In response staff had portable devices which were made available to patients and families after appointments and were wiped down after use.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff usually supported, informed and involved families or carers. We spoke to 10 carers who said that they were happy and felt involved and that some patients attended appointments with a family member. A small number did say that they did not feel supported, informed and involved and although small numbers this had caused a significant amount of distress to those families.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment. We saw evidence of carers support and signposting within teams.

Is the service responsive?

Requires Improvement 

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

Access and waiting times

The service was not always easy to access, and some teams were not meeting the trust target of 28 days for an assessment and/or to start treatment. Teams had been developed to support patients who did not meet the criteria for secondary care, and both had significant waiting times due to staffing issues. The service had a clear referral criterion which did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Access teams were the first point of contact for all patients. Triage and initial risk assessments identified which service patients would be referred into. All referrals to the community adults' teams came through the access team. An access plus service had been developed in Durham and Darlington to meet demand and bridge the gap between primary and secondary services. York and Selby had an access and wellbeing team. However, both teams had staffing issues and a stop the line meeting had been initiated for the North Yorkshire wellbeing service. The trust used the stop the line process to review teams. This could include a review of staffing, operational issues and offers additional expertise and support to identify issues and solutions.

The service was not always meeting trust target times for referral to assessment and assessment to treatment. There were variations in how long people were waiting for treatment across the core service. The trust supplied data showing

that 10 out of the 32 teams were not meeting the 28-day target for referral to initial assessment. The longest wait was 127 days in the South Durham Psychosis team. Half of the teams were not meeting the target were in the North Yorkshire/York locality. The waiting time for the Attention deficit hyperactivity disorder service was 286 days. A further seven teams were not meeting the target for second contact after assessment.

There was an 18 month waiting lists for autism assessments, with 1,308 people waiting across Durham, Darlington and Teesside. This was due to an increase in referrals which had been triaged by the access team and passed to care coordinator caseloads. These people were reviewed every six months and had any mental health issues addressed while they waited. The trust did not supply waiting times for North Yorkshire and York as the assessments were the responsibility of another provider. However, during our inspection staff said that they did have people waiting for an autism assessment from the other provider on their caseloads.

Patients had some flexibility and choice in the appointment times available. Most teams offered some out of hours appointments, but the service was predominately 9-5pm.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff sometimes had to cancel or move the appointments times due to a lack of availability of suitable rooms. Where possible staff used online facilities to support appointments. Staff followed up patients who missed appointments and the teams had a 7% did not attend rate. Staff were able to discuss patients that they had concerns about during daily huddle meetings.

Appointments ran on time and staff informed patients when they did not.

The service monitored people on waiting lists within the team cells and through huddle meetings. People waiting for an autism assessment were monitored by individual care coordinators.

Staff supported patients when they were referred, transferred between services, or needed physical health care. If a patient needed to access the service again within 12 months of discharge, then they could refer themselves directly back into the service.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Staff said that they sometimes struggled to book rooms but that they used a combination of home visits and online facilities to support patients.

Interview rooms in the service were not always soundproof to protect privacy and confidentiality. We saw posters up notifying people of this.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and adjust for people with disabilities, communication needs or other specific needs. Most premises had disabled access and patients could be seen at home or through online facilities. Staff gave examples of where advocates had been used to help people raise complaints.

Community-based mental health services of adults of working age

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had the facility to request information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could access interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. We received mixed feedback and spoke to patients and carers who had raised concerns and had felt listened to and some that were still not satisfied with the service. Complaints information was contained within packs giving to patients. Managers dealt with complaints where they could or there was access to the trust patients advise and liaison service.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. These were fed back to staff in team meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Some complaints had related to individual staff and managers had responded by changing the patients care coordinator. We also saw an example of staff changing the location of the patient's appointment after a concern was raised.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Community-based mental health services of adults of working age

Most staff spoke highly of team managers and said that they were available and visible. The team managers we spoke to were knowledgeable and supported staff daily. They felt able to escalate concerns to locality managers and felt supported to increase staffing levels when needed. The three Heads of Services understood the pressures and demand on the service in their areas.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

There were posters and intranet posts that detailed the trusts values and staff were also able to explain what they were and relate them to the work they were doing. Staff told us that they received regular communications which included information about the trust vision and strategy.

Teams were structured differently in different areas and the Durham and Darlington teams were going through a restructure to increase the teams from seven to ten in response to variations in caseload sizes and workload.

Culture

Generally, staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Most staff could raise any concerns without fear.

Some staff said that there had been previous problems in some teams, but that culture had recently improved. Staff knew of the freedom to speak up guardian and we saw examples of where this had been used. An issue had been escalated to senior managers of the Durham and Darlington access team which was ongoing at the time of the inspection.

Staff felt that they had worked well over the last year and had been supported to adjust to new ways of working. Patient contact had not stopped during the pandemic although face to face contacts had reduced and been replaced with online or telephone support. Staff felt that some of the new ways of working had improved practices especially in relation to online working.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level. Teams were not using a standard case weighting management tool. The trust had made improvements to the patient risk assessment and risk management process.

We found variations in how teams monitored and managed caseloads. Although systems were in place at team level to support effective case management, there was no agreed process for consistent oversight of caseloads across the trust. This meant that the trust could not be assured that all staff in the core service had manageable caseloads. Demands on the services had increased over the last year including an increase in autism assessments which meant that caseloads were high in some areas. The absence of the weighting tool meant that some managers did not have clear oversight of workload within teams.

The trust had introduced a new system to assess and manage patient risk and was monitoring the completion of risk summaries through the quality improvement board. The trust was on target to meet the completion of this work by August 2021. All patients rated red and amber had been completed with green rated patients due to be completed by August 2021.

The trust has also introduced a new assurance system to review and assess the quality of risk assessment and risk management processes and documentation. Managers were able to describe how they had implemented this system.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and staff had access to a trust wide performance system which allowed them to monitor performance. The system allowed managers to monitor key performance indicators relating to the service around mandatory training, supervision, staffing and waiting times. The system also allowed them to monitor patient contacts and was used as a tool in supervision with staff.

The service operated a risk register and managers were able to escalate risks to senior managers when required. The main risks for the core service were around staffing pressures and posts which the trust had been unable to fill in North Yorkshire. We saw evidence that this was on the trust corporate risk register. Staff wellbeing and increasing demands on the service was also on the local registers. Quality assurance and governance meetings took place and heads of service for each of the three localities met regularly to discuss issues and concerns.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Patient information was stored on a secure electronic record system and all staff including agency staff could access the system. This system was used throughout the trust which helped teams to effectively communicate and manage a patient's treatment journey.

Staff had access to the equipment and information technology needed to do their work. Staff working in the community had access to a laptop or a mobile device where it was needed. Staff had been supported to improve access to online facilities for patient contact and to keep in touch with team members. Staff had welcomed these changes.

Staff were required to undertake information governance training as part of their mandatory training, 98% of staff had undertaken this training.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Complex commissioning arrangements existed across the trust with several clinical commissioning groups in operation. This meant that teams did not always operate the same. In some areas extra funding had been secured but this was dependant on commissioning arrangements. The trust also worked with several different local authorities. We saw that regular meetings took place and managers had regular communication. There were close relationships with GPs and some teams were split into GP practice areas.

Forensic inpatient or secure wards

Inadequate ↓↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Blind spots were mitigated by the use of closed-circuit television in the nurse offices on the wards.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We looked at environmental risk assessments on the wards and these included the location of ligature anchor points on the wards and how the risk was mitigated such as supervised access and doors to rooms with ligatures being kept locked.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. We saw evidence that the wards were regularly cleaned, and staff, patients and visitors were encouraged to use hand sanitising gel before they went onto the wards. Staff complied with Covid-19 prevention measures such as donning personal protective equipment, including wearing face masks.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication, had a toilet and a clock.

Forensic inpatient or secure wards

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and support staff and did not always receive basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. During our inspection, we saw evidence that staffing numbers on wards fell short of the assessed numbers of staff needed to keep patients safe. These included:

- Nightingale ward (14 June 2021) - two staff were on shift out of an assessed safe level of four staff to meet the needs of 14 patients.
- Nightingale ward (12 June 2021) - two staff were on shift out of an assessed safe level of four staff to meet the needs of 14 patients.
- Hawthorn/Runswick Ward (14 June) - five staff were on shift out of an assessed safe level of eight staff to meet the needs of nine patients.
- Swift ward (17 June 2021) - two staff and one trainee were on shift out of an assessed safe level of six staff to meet the needs of nine patients.
- On Swift ward (12 June 2021) - three staff were on shift out of an assessed safe level of six staff to meet the needs of nine patients.

However, between 22 March to 22 June 2021 only two incident reports were made in relation to wards having staffing levels that had fallen below the trust's assessed safe staffing levels.

During our inspection, 16 patients, five carers and 26 staff members all referred to staff shortages on the wards.

The trust reported on 18 June 2021 that there were 6.94 whole time equivalent nurse vacancies and 14.91 healthcare assistant vacancies within the service.

Staff reported they were not always able to take a break or go to the toilet during 12-hour shifts due to staff shortages. During our inspection, we saw a message that had been left for a staff member to inform them that their break could not be covered because of a colleague reporting in sick.

The service had high rates of bank staff usage. The trust reported that in April 2020 to March 2021 the percentage of shifts covered by bank staff was 68.16% and from March 2021 to May 2021 was 65.96%. However, 75% of bank staff used had substantive contracts with the trust.

The service had low rates of agency staff usage. The trust reported that in April 2020 to March 2021 that the percentage of shifts covered by agency staff was 1.27% and from March 2021 to May 2021 was 5.98%. However, the trust also reported that during this period, over 30% of shift vacancies had not been covered. This meant that staffing levels required to meet patients' needs were not maintained.

Forensic inpatient or secure wards

Although managers limited their use of agency staff, permanent staff who were deployed to work on the wards from other areas within the trust were not always familiar with the needs of the patients. For example, staff on the mental health wards were moved to the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group.

The trust reported that between 1 April 2020 and 31 March 2021, the staff turnover rate within the service was 9.64%.

Managers supported staff who needed time off for ill health. Staff we spoke with during our inspection said managers were supportive, allowed staff to return to work on a phased basis and provided staff with updates on any changes on their return. However, the results of a staff survey conducted in 2020 indicated that staff felt under pressure to attend work when they were unwell.

Levels of sickness were not reducing. The trust reported on 18 June 2021 that the average staff sickness over the previous 12 months within the service was 9.83%. This was higher than the average sickness absence across the trust which was 5.6%. Figures for January to May 2021 showed that sickness rates were high and were as follows:

- January 2021 – 14.20%
- Feb 2021 – 13.42%
- March 2021 – 11.56%
- April 2021 – 10.44%
- May 2021 – 10.69%.

Managers calculated the number and grade of nurses, nursing assistants and healthcare assistants to enable each shift to be staffed safely. However, staffing levels often fell short of these calculated numbers.

Ward managers could not always adjust staffing levels according to the needs of the patients. Ward safety reviews, numbers of planned and actual staff who worked on 14 June 2021 night shift and staffing rotas over the month prior to our inspection evidenced that staffing shortages were not always filled to meet the needs of patients.

Patients did not have regular access to escorted leave or activities due to low staffing numbers. Activities for patients were cancelled on 1, 11 and 14 June 2021 due to staff shortages, affecting between 28 and 36 patients a day. Staff on the wards could not plan activities in advance as they could not guarantee enough staff would be in on the day to deliver them. The trust reported that between May 2020 and May 2021, 257 instances of escorted leave were cancelled due to having insufficient staff at the start of shift. The trust also reported that 17,861 leave sessions went ahead. Patients and staff also reported that Section 17 escorted leave was cancelled due to staff shortages on the wards.

The service did not always have enough staff on each shift to carry out any physical interventions safely. On Sandpiper ward, an incident was reported on 26 May 2021 in relation to a staff member sustaining an injury whilst physically restraining a patient. Insufficient numbers of staff had attended the ward in a timely manner for this to be done more effectively and safely.

However, we spoke with 27 patients and despite poor staffing levels, patients told us they had regular one to one sessions with their named nurse. We also saw evidence of one to one sessions in care records.

Staff shared key information to keep patients safe when handing over their care to others.

Forensic inpatient or secure wards

Medical staff

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

Six patients told us that they had been seen by numerous different doctors rather than a regular doctor and felt it was affecting their progress.

Managers could call locums when they needed additional medical cover.

Mandatory training

Managers did not adequately monitor or alert staff when they needed to update their mandatory training.

Staff had not completed their mandatory training. The trust's target for mandatory training compliance was 90%. Eleven wards were not compliant with training in relation to safeguarding level three, raising concerns/whistleblowing, medicines management, rapid tranquilisation and manual handling; all of which fell below 75% compliance.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they did not always use restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on or soon after admission, and reviewed them regularly, including after any incident.

Staff used the HCR 20; a recognised structured risk assessment tool used to assess the risk of violence. The trust had introduced a new process to assess and monitor patient risk. This was in response to our finding systemic failings in risk assessments and risk management plans during our inspection of its acute and psychiatric intensive care units service in January 2021.

Management of patient risk

Staff could observe patients in all areas with the use of closed-circuit television.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff did not always know about risks to each patient or act appropriately to prevent or reduce risks. We looked at 33 care records and seven contained risk management plans that were not appropriate for the risk identified or lacked management plans at all. Examples included:

- records not being updated following an experience of trauma and sexual safety incidents or concerns.
- inconsistencies in relation to documentation around patients' suicidal ideation
- observation levels for a patient being recorded incorrectly

- no reference in relation to concerns around the financial exploitation of a patient in their safety summary or safety plan despite it being logged as an incident
- a patient's risk assessment not being updated following incidents of choking and a fall
- a patient's risk history and risk assessment not being completed until three months after they were admitted to the service.

The trust had recently introduced a quality assurance schedule in relation to ensuring information within care records was accurate and up to date. However, this was still in the early stages of implementation and was yet to be fully embedded within the service.

Use of restrictive interventions

The trust reported in the 12 months prior to our inspection, there had been 1573 incidents of restraint within the service; of which 149 were in the prone position. The trust had a restraint reduction programme and was hopeful this would eliminate avoidable prone restraint.

Staff did not always make attempts to avoid using restraint by using de-escalation techniques. On review of an incident on closed-circuit television footage, we noted that the events that led up to the multiple uses of restraint and seclusion were not a proportionate response given the low risk posed by the patient.

We noted a second incident of inappropriate restraint whilst reviewing closed circuit television and an incident report. Mechanical restraint with the use of belts was used as a threat to make a patient go into seclusion. Again, this was disproportionate given the low risk posed by the patient.

Staff did not understand the Mental Capacity Act definition of restraint. There were high levels of restrictions placed on patients' freedom on the wards. On Thistle ward, patients could only attend their room for one hour a day, at other times bedrooms were kept locked. There was no clear rationale, recording or evidence of reviews for this decision. One patient told us they had no understanding of why the restriction was in place or whether that restriction would ever end. Wards placed patients on restrictions passports with bronze, basic silver, silver, and gold categories of which bronze contained the most restrictions and gold the least. Staff did not understand the use of the passports as there was no guidance in relation to their use and could not explain how regularly they were reviewed nor how they were individualised to the patient.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. In the 12 months prior to our inspection, there had been 195 instances of rapid tranquilisation within the service. The patients concerned had diagnoses of emotionally unstable personality disorder, schizophrenia and post-traumatic stress disorder; had exhibited violent and aggressive behaviour towards others or had made threats to harm themselves.

In the 12 months prior to our inspection, there had been 79 instances of seclusion within the service.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. We looked at a seclusion record on Thistle ward for 22 June 2021 which contained no narrative from a review by the doctor when the patient was brought out of seclusion. There was no evidence of the observations scheduled for 6:30pm having taken place and the rationale for the patient remaining in seclusion was unclear and not recorded.

There was one patient in long-term segregation at the time of our inspection and they had been segregated since May 2019.

Forensic inpatient or secure wards

Safeguarding

Staff understood how to protect patients from abuse but did not always work with other agencies to do so. Not all staff had received training on how to recognise and report abuse.

Staff were meant to receive training on how to recognise and report abuse, appropriate for their role. However, not all staff were up to date with their mandatory safeguarding training. The trust reported compliance rates for safeguarding level three for the following wards at the time of our inspection which fell below the trust's target of 90% mandatory compliance:

- Kingfisher ward – 50%
- Harrier/Hawk ward – 70%
- Linnet ward – 50%
- Hawthorn/Runswick ward – 67%
- Sandpiper ward – 73%

Although the trust did not have a safeguarding adults policy; it did have a safeguarding procedure which contained guidance for staff, including the different categories of abuse. However, staff within the service did not always make safeguarding referrals to the local authority when appropriate to do so. For example, safeguarding referrals had not been made for:

- an incident involving a patient being verbally and physically aggressive towards a peer and staff
- threats made to a patient from a former patient that they would come to the hospital and assault them, which was received via text message and,
- an incident in which a patient attempted to assault a peer.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, patients could be moved if there were concerns that there would be friction between them and the person they had complained about.

Staff followed clear procedures to keep children visiting safe. Child visits were held in a room away from the wards near to the service's main security control centre.

Staff access to essential information

Staff did not always have easy access to clinical information and did not always maintain high quality clinical records.

Staff reported that the care records system could be very slow, sometimes froze and power cuts within the service sometimes resulted in any information not yet saved being lost.

There were templates within the system that could not be saved with a name to make finding them easy in the future. For example, positive behaviour plans were saved as 'blank letter template' because the drop-down list for naming files was so limited. This made it time-consuming for staff to easily find information needed to inform safe and effective care, as they had to access several documents before finding the correct one.

Staff also found difficulty locating specific documentation on the wards. For example, staff on Harrier/Hawk were unable to locate positive behaviour support plans for patients with a learning disability and/or autism. The ward manager later found them in the patients' interventions section on the care records system.

When patients transferred to a new team, there were no delays in staff accessing their records. The care records system allowed staff to access information from any ward within the service.

Records were stored securely, and staff were required to use a login name and password to access them.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Most staff followed up to date systems, processes and guidance when safely prescribing, administering, recording and storing medicines. However, on Nightingale ward, we found a copy of the British National Formulary and other pharmacy related guidance was out of date. A medication error happened on this ward on 11 June 2021 due to a prescription chart being misread by staff. The reason for the error was recorded as being due to 'demanding patients' on a safety review form.

We saw evidence in patients' care records that the multidisciplinary team reviewed patients' medicines regularly and staff provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Notes within patients' care records also evidenced that staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health and Care Excellence guidance. This also enabled staff to ensure patients' behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the side effects of medicines on patients.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The service had a controlled drugs accountable officer who was the chief pharmacist.

Track record on safety

The service did not have a good track record on safety.

In the 12 months prior to our inspection, there were four serious incidents within the service. Two were in relation to patient deaths and the others in relation to incidents which had led to permanent or long-term harm to the patients. Lessons learned as a result of these incidents included:

- embedding medication processes in nursing teams
- issuing a patient safety alert in relation to ensuring staff carried out care rounds in a safe manner
- delivering training in relation to reporting an incident in which harm did not take place immediately after a planned intervention
- the need to ensure that if formulation meetings are cancelled, that another is booked soon afterwards to ensure staff are aware of any risks associated with the patient.

Forensic inpatient or secure wards

We found staffing on the wards was below assessed safe numbers and risk management plans were not always appropriate for the risks identified. Staff had sustained injuries due to incidents of violence and aggression on the wards. These included a chair being thrown at a staff member and a staff member sustaining an injury due to there being insufficient staff to safely restrain a patient.

Staff gave limited examples of safety improvements within the service that were not as a direct result of our taking enforcement action against other services within the trust. One staff member told us that motion detectors in patients' bedrooms were being trialled within the service.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents or report them appropriately. Managers did not always investigate incidents or share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always know what incidents to report and how to report them.

During our inspection, we identified between 12 and 17 June that staffing numbers on some of the wards had fallen below the trust's assessed safe staffing levels on numerous occasions. However, between 22 March to 22 June 2021 only two incident reports were in relation to wards having staffing levels that had fallen below the trust's assessed safe staffing levels.

The trust notified us of an incident involving a member of staff tipping a patient out of a chair. We reviewed the closed-circuit television footage of this incident. Other staff who witnessed the incident did not intervene or report the incident.

A member of staff raised a concern through the freedom to speak up email address, which indicated staff did not always feel they could raise concerns about abusive behaviour towards patients. This incident was not logged until ten days after the incident occurred which meant that patients were at risk of further abusive treatment.

The results of a staff survey in 2020 showed that 40% of respondents would not feel safe in speaking out about anything that concerns them and 43% were not confident in raising concerns about unsafe clinical practice.

On Thistle ward, incident reports had not been made in relation to a patient's sexualised behaviour or an incident in which they were strangled by another patient on the ward.

On Mallard ward, the safety summary of a patient stated that they were at significant risk of sexual assault and continued to engage in sexually inappropriate behaviour; the last incident of which was in August 2018. However, the last recorded incident in the patient overview in relation to this was in 2017.

Staff reported serious incidents clearly and in line with trust policy. The trust reported that there had been four serious incidents within the service in the last 12 months and these were in relation to two patient deaths and two incidents of severe self-harm. The trust's investigation into one of the instances of serious self-harm identified that incidents had not always been logged in relation to this patient.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Forensic inpatient or secure wards

Staff told us that they did not have a debrief from management following the death of a patient on Nightingale ward. However, the trust was able to provide evidence that debriefs had been offered to staff on the ward on 30 April and 4 May 2021. The trust told us that managers were not always the staff members responsible for debriefs and psychologists or the trust's trauma lead organised and led the majority of debriefs following serious incidents.

Staff did not always receive feedback from investigation of incidents. One of the mechanisms for receiving feedback was via team meetings but six of the nine wards we inspected were not holding team meetings.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

Assessment of needs and planning of care

Staff assessed the physical and mental health of most patients on admission. They developed individual care plans for patients. Care plans did not always include suitable safety and security arrangements.

We looked at 33 care records during our inspection.

Staff completed most comprehensive mental health assessment of patients either on admission or soon after. However, staff were unable to show evidence of a comprehensive mental health assessments for two patients and a third patient's assessment was carried out two months after they had been admitted.

Most patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We found one out of the 33 records we looked at contained no evidence of a physical health assessment taking place. There was also a second record which stated that the patient's physical health was checked every two days when staff actually checked it once a week.

Seven of the records we looked at contained risk management plans that did not reflect all relevant risks recorded in the patients' care records.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. They did not always ensure that patients had good access to physical healthcare or support them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Forensic inpatient or secure wards

Staff provided a range of care and treatment suitable for the patients in the service. These included dialectical behaviour therapy and cognitive behaviour therapy. However, occupational therapists and psychologists had been deployed to work on the wards to cover staff shortages which resulted in patients having limited access to psychological or occupational therapy interventions throughout the 12 months prior to our inspection.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients could be referred to dietetics and speech and language therapists to meet their needs.

Staff were not always able to help patients live healthier lives by supporting them to take part in programmes. Physical activities were not always able to happen due to staffing issues. During our inspection, most patients were sat watching television or engaging in sedentary activities on the wards. We spoke with a carer who was concerned about their loved one's obesity; particularly given that access to the gymnasium had been problematic due to staffing issues and social distancing guidance in relation to COVID-19, limiting the patient's ability to exercise**.** Staff did provide advice about healthy eating choices.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included national early warning scores and HCR 20.

Staff used technology to support patients. Patients' access to mobile phones and the internet was dependent on ward security levels and whether access was supervised or not was based on the findings from patients' risk assessments.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits were not always effective as we identified issues with risk management plans, incident reporting, safeguarding issues not being reported and out of date pharmacy guidance, which audits had not picked up.

Skilled staff to deliver care

Although the ward teams included a range of specialists, they were not always available to meet the needs of patients on the wards. Managers did not always ensure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals but did not always ensure staff received supervision or the appropriate training for their roles. Managers provided an induction programme for new staff.

The service had access to a range of specialists to meet the needs of the patients on the ward. These included speech and language therapists, psychiatrists, dieticians and social workers. There were occupational therapists and psychologists within the service, but they had been deployed to work on the wards to cover staff shortages which resulted in patients having limited access to psychological or occupational therapy interventions.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. At the time of our inspection, 99% of staff had been appraised.

Forensic inpatient or secure wards

Managers did not always support staff through regular, constructive clinical supervision of their work. Data supplied by the trust in relation to the nine wards we inspected showed that only 74% of staff were compliant with their supervision for the July to September 2020 period. Compliance was 53% for the January to March 2021 period but managers attributed this to an outbreak of COVID-19 cases within the service.

Managers did not ensure staff attended regular team meetings. Staff on Harrier/Hawk, Sandpiper, Swift, Nightingale, Mandarin and Lark wards told us team meetings rarely or never took place due to low staffing levels.

Managers did not always ensure staff received any specialist training for their role. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group. However, staff members we spoke with gave examples of specialist training they had undertaken. These included diabetes, epilepsy, personality disorders, positive behaviour support plans, learning disabilities, palliative care, wheelchair users, leadership, electrocardiograms, dialectical behaviour therapy and, external training courses in autism and trauma.

Managers dealt with poor performance. The provider had a performance management system in place which included a process for addressing staff performance issues.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients and ensure patients had no gaps in their care. The ward teams did not always have effective working relationships with other relevant teams within the organisation. There were effective working relationships with relevant services outside the organisation and staff engaged with them to plan discharge.

Occupational therapists and psychologists had been deployed to work on the wards to cover staff shortages which resulted in patients having limited access to psychological or occupational therapy interventions throughout the 12 months prior to our inspection. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, healthcare assistants on Swift, Nightingale, Lark, and Harrier/Hawk wards told us they were not invited to multidisciplinary meetings and on Hawthorn/Runswick ward, it depended on what staffing levels were on the day.

Staff shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams did not always have effective working relationships with internal teams. However, staff did have effective relationships with external organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection, 96% of staff had completed their Mental Health Act training.

Forensic inpatient or secure wards

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from a Mental Health Act office onsite.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff did not always ensure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Staffing shortages meant that escorted Section 17 leave was sometimes cancelled so patients were unable to leave the ward.

Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under Section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, 97% of staff had completed their Mental Capacity Act training.

There was a clear policy on the Mental Capacity Act which staff could describe and knew how to access.

Staff had access to support and advice on implementing the Mental Capacity Act from a Mental Health Act office onsite.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Forensic inpatient or secure wards

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Inadequate 

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

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. They did not always respect patients' dignity or treat them with respect. They did not always understand the individual needs of patients and or support patients to understand and manage their care, treatment or condition.

Staff were not always kind, caring or respectful towards patients.

The trust made us aware of an incident involving a member of staff tipping a patient out of a chair. We reviewed the closed-circuit television footage of this incident and saw that other staff present who observed the incident did not challenge the actions of the staff member, nor provide any support to the patient. Two patients who spoke with us gave examples of how staff were disrespectful towards them and called them derogatory names. Another patient told us that staff threatened to place them in restraint if they attempted to light a cigarette at a family event they had attended.

Staff did not always give patients help, emotional support and advice when they needed it. Six patients told us that their own or other patients' needs were not being met. One of these patients needed access to sensory stimulation but was unable to due to staffing levels on their ward. Another said a patient on their ward needed to change their own catheter bag when staff were meant to do it for them and a member of staff on the ward we spoke with confirmed this had happened. Some patients told us that due to staffing shortages, they sometimes had to accompany staff who were carrying out ` their observations, to enable staff to fulfil other duties on the ward.

Due to staffing shortages, activities were not pre-planned in advance, which meant patients with autism had no clear plan or structure in relation to their routine.

Staff directed and supported patients to access other services if they needed help. We saw evidence in care records that staff had referred patients to social services, acute hospital services, opticians, podiatry, dieticians, dentists and LGBT+ support services.

Staff followed policy to keep patient information private and confidential.

Forensic inpatient or secure wards

Involvement in care

Staff involved patients in care planning and risk assessments and sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff did not always ensure patients understood their care and treatment or find ways to communicate with patients who had communication difficulties. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group. However, information could be provided in an easy-read format for patients with a learning disability, patients had access to signers and translators and information could be produced in different languages using online translation services.

Staff involved patients in decisions about the service, when appropriate. For example, a patient had recently been involved in a staff recruitment exercise. Patients from wards were also members of the service's united voices forum which allowed patients the opportunity to influence positive change within the service. Staff told us that patients attended quality assurance group meetings to provide service managers with feedback from the wards.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us there were community meetings that took place on the wards in which they were able to provide feedback and suggestions as to how to improve the service. We saw you said, we did posters and notes of community meetings on the wards. However, on Nightingale, the notes of the community meeting on the patient noticeboards were for March 2021. On Hawthorn/Runswick ward, the walls had recently been painted so there were no posters or information on display in relation to patient feedback. There were quarterly patient satisfaction surveys and the trust had a complaints procedure. There were posters on noticeboards on the wards informing patients how to make a complaint.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff did not always inform or involve families and carers appropriately.

Staff did not always support, inform or involve families or carers.

We spoke with seven carers during our inspection. One carer whose loved one was on Kestrel/Kite ward said they were regularly invited to meetings but rarely received any minutes or agreed actions to be taken forward.

A carer of a patient on Nightingale ward said there was a total lack of contact from staff on the ward; a lack of clarity on whether their loved one wanted the family involved in care programme approach meetings and they had not received any information about the service when their loved one was admitted to the ward.

A carer for a patient on Brambling ward said they did not receive regular updates or communication from staff on the ward.

Forensic inpatient or secure wards

A carer whose loved one was on Mandarin ward said two other family members had not been invited to the patient's last care programme approach meeting and they did not know why.

Staff helped families to give feedback on the service. There were carers surveys, carers could provide feedback at carers groups and the trust had a complaints process. Carers knew how to make a complaint. They were given packs which included information about how to make a complaint.

Staff gave carers information on how to apply for a carer's assessment.

Is the service responsive?

Requires Improvement 

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed.

Bed management

Managers did not always ensure that bed occupancy was not above 95%. The provider reported in June 2021 that Kingfisher ward, Harrier/Hawk ward, Lark ward, Linnet ward, Merlin ward and Thistle ward all had a bed occupancy of below 95%.

The service had low out-of-area placements. In the 12 months prior to our inspection, there had been 13 out of area placements. This was out of a cohort of 270 patients and amounted to only five per cent of overall admissions.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. The provider reported that in the 12 months prior to our inspection, there was only one delayed discharge which was due to no suitable accommodation being available for the patient concerned.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw evidence in care records that staff worked with social workers, psychologists and external services to facilitate discharge. We also saw notes of discussions around discharge in care programme approach meetings.

Staff supported patients when they were referred or transferred between services.

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Not all patients we spoke with thought the food was of good quality. Patients had access to hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. However, patients on Thistle ward only had access to their bedrooms for one hour a day and there was no clear rationale for this.

Patients had a secure place to store personal possessions.

The wards had a full range of rooms and equipment to support treatment and care. However, one of the two activity rooms on Lark ward was being used as a donning and doffing station in order to comply with COVID-19 infection control measures. Patients had access to the second activity room apart from a Tuesday afternoon when it was used for multidisciplinary team meetings. However, other rooms were available during this time.

The service had quiet areas and a room next to the security control centre where patients could meet with visitors in private.

Patients could make phone calls in private if they had been risk assessed to do so.

The service had an outside space that patients could access easily. Some wards had exercise equipment in the garden area that patients could use.

Patients could make their own hot drinks and snacks and were not dependent on staff if they had been risk assessed to do so.

The service offered a variety of different foods, but six patients and two carers of patients said the food was poor, bland and tasteless.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. For example, we saw evidence in care records that patients were undertaking citizenship, maths and English courses. Core sessions on wards also included education around body dysmorphia and LGBT+ issues.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people. For example, a patient had been given a powered wheelchair due to their mobility issues to enable them to access their leave more easily. Other patients had been given walking aids and shower chairs to allow them to be more independent. Doors on Hawthorn/Runswick ward had been fitted with slow closures to stop them banging because a patient on the ward was sensitive to sound.

Staff could not always meet the specific communication needs of patients within the service. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not having been trained in the appropriate communication skills required for the patient group.

Due to staffing shortages, activities were not pre-planned in advance, which meant patients with autism had no clear plan or structure in relation to their routine.

Wards were dementia friendly and supported disabled patients.

Overall, staff made sure patients could access information on treatment, local service, their rights and how to complain. However, we found that information in relation to activities on noticeboards on Nightingale ward was three months out of date.

The service was able to produce information leaflets in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. These included Halal, kosher, vegetarian, vegan and gluten-free options.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them. Lessons learned were not always shared with the whole team and wider service for learning purposes.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. In the 12 months prior to our inspection, there had been 11 complaints about the service; none of which were referred to the ombudsman. Themes included staff attitudes, lack of facilities, clinical care and discontent about an entry in a patient's medical record.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Forensic inpatient or secure wards

Managers did not always share feedback from complaints with staff. One of the mechanisms for sharing feedback was team meetings and six of the nine wards we inspected were not holding team meetings.

Is the service well-led?

Inadequate 

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

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed and were not visible in the service and approachable for patients and staff.

Leaders did not have a good understanding of the services they managed. They were unaware of the extent of staff shortages on the wards because ward managers and other staff were not recording instances in which there were staff shortages as incidents.

They were also unaware that staff deployed to work on the learning disability and autism wards had not been trained in the appropriate communication skills required for the patient group.

A daily nurse co-ordinator who spoke with us said that audits identified any areas for improvement in care records, but we identified seven out of 33 we looked at contained issues in relation to risk assessments and risk management plans. Leaders did not ensure that all safeguarding issues in relation to the protection of patients were being referred to the local authority adult safeguarding team.

Leaders had not introduced systems or processes to monitor the delivery of therapeutic activities or measure the benefit of activities on the patients' treatment and recovery journey. Leaders had not ensured that restrictive practices were recognised by staff on the wards or that restrictions placed on patients were being regularly reviewed.

Leaders were not visible in the service and approachable for staff. Staff who spoke with us said that they only saw managers up to modern matron level and more senior managers only visited the wards when patients had requested to see them or if there had been a serious incident on the ward.

Leaders had not responded effectively to issues of concern which impacted upon safe and effective care within the service.

Vision and strategy

Staff knew and understood the provider's vision and values, but the service did not always follow these.

Forensic inpatient or secure wards

The trust's mission was to improve people's lives by minimising the impact of mental ill health or a learning disability. However, staff who had not been trained in autism were moved to the learning disability and autism wards. This had led to issues with communication between autistic patients and untrained staff.

Its vision was to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. However, there were inadequate levels of staff within the service which was detrimentally affecting patient care and treatment and staff morale.

The trust's values were a commitment to quality, respect, involvement, wellbeing and teamwork. However, staff did not feel respected by managers above modern matron level. Patients had been abused by staff both verbally and physically. Staff did not feel involved in decisions about the service and their health and wellbeing were being detrimentally affected by the impact of staff shortages on the wards.

Culture

Staff did not feel respected, supported or valued. They were not always able to raise any concerns without fear. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

The trust conducted a staff survey of the service in September 2020. The results highlighted the following issues within the service:

- There were not enough staff, staff faced unrealistic time pressures, put themselves under pressure to attend work and staff were leaving or thinking about leaving the service
- Staff felt unsafe at work and had experienced violent behaviour from patients
- Communication from senior managers was poor and they did not involve staff in important decisions or act on feedback from staff
- Staff did not look forward to coming into work and lacked enthusiasm
- Staff were unable to meet to discuss team effectiveness
- Staff's health and wellbeing was not considered, and staff had felt unwell due to work related stress
- Harassment and bullying of staff was not reported and staff felt unable to speak out
- Staff involved in errors, near misses and incidents were not treated fairly
- Staff felt the organisation would not address concerns about unsafe clinical practice
- Staff would not recommend working for the trust.

The trust had commissioned an independent review of the culture within the service which was completed in November 2019. An action plan had been created to improve the culture and actions were taken by the trust. However, staff members raised many of these themes when we spoke with them during the inspection which indicated there was still a negative culture within the service. We also received whistleblowing information relating to the culture within the service such as allegations of bullying of staff by managers and staff feeling managers did not listen to their concerns or care about them.

Forensic inpatient or secure wards

Staff did not always feel able to raise concerns freely with all managers within the service or wider trust. Staff who spoke with us felt they could raise concerns with managers up to modern matron level but not with more senior staff because they did not know them and as such, did not know if they could trust them.

We reviewed closed circuit television footage of an incident on Kestrel/Kite ward after commissioners had raised concerns about an allegation that a staff member had abused a patient by tipping them out of a chair. The footage evidenced that the abuse did take place and that other staff were present; had witnessed the abuse but did not intervene to help the patient or report the abuse as an incident. This indicated there was an issue in relation to openness and transparency within the service.

Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian.

Teams worked well together but did not always feel managers addressed issues promptly or appropriately. For example, staff told us that staffing shortages and cultural issues in the service had been ongoing issues for a considerable length of time. These issues continued at the time of our inspection.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the trust promoted equality and diversity in its day to day work. Examples included that there was a diverse workforce including staff from the black and minority ethnic and LGBT+ communities, education for patients in relation to the LGBT+ community to promote tolerance and equality and the fact the trust had equality and diversity policies in place.

Staff had access to support for their own physical and emotional health needs through an occupational health service, access to psychology and an employee assistance programme.

Staff within the service celebrated success. Managers complimented staff and provided encouragement and feedback about work they had completed well. Two staff members on Hawthorn/Runswick ward had received praise from managers within the service; one for how they dealt with an abusive patient and the other from the service's patient property lead about their work. Staff on Thistle and Mandarin wards had received praise for their work and their close team working.

During our inspection, we were shown a memorandum that had been issued to all staff within the service. This instructed staff not to contact the duty nurse co-ordinator between 7 and 7:30am, 8:30 and 9am, 12:30pm and 1pm, 3:30pm and 3:45pm and 7pm and 7:30pm because the duty nurse co-ordinator was attending service planning meetings at these times. Staff were advised to contact their ward manager in relation to staffing issues or inability to find cover for breaktimes. However, during our inspection, we found ward managers were not always available due to sickness absence, annual leave, covering the duty nurse co-ordinator rota, attending training sessions or covering other wards. This added to the pressure staff were already under and led to staff feeling they were not being listened to.

Governance

Our findings from the other key questions demonstrated that governance processes operated ineffectively at team level and that performance and risk were not managed well.

There were ineffective governance process and systems within the service.

Forensic inpatient or secure wards

Staffing shortages had not been addressed by managers within the service or wider trust. This resulted in adversely affecting the delivery of therapeutic and psychological activities and in patients' escorted Section 17 leave being cancelled. The trust reported that between April 2020 and March 2021, over 30% of shifts had not been covered by bank or agency staff.

Managers within the service deployed staff from the mental health wards to work on the learning disability and autism wards due to staff shortages. However, there were no checks or systems in place to ensure these staff had the necessary communication skills and knowledge to meet the needs of the patient group.

There were no systems or management oversight in place to ensure that team meetings were regularly taking place on the wards. Six out of nine of the wards did not have team meetings and this meant that staff did not always receive feedback following the investigation of incidents or complaints in order to improve quality and safe practice within the service.

Governance processes failed to identify that staff did not always report incidents when needed. Documentation evidenced that staffing levels within the service often fell below the assessed safe levels. However, on only two occasions had incident reports been completed in relation to staff shortages. This meant senior managers within the service and wider trust had not been made aware of the extent of staff shortages. Incident reports in relation to a strangling incident, sexual safety and a patient experiencing trauma had also not been submitted by staff.

The trust did not have a safeguarding adults policy which meant there was no guidance for staff in relation to when safeguarding referrals should be made to the local authority. Safeguarding referrals had not been made in relation to a patient expressing suicidal thoughts; incidents of violence and aggression and a patient who received a threatening text message.

Audits within the service were not always effective in identifying issues on the wards. On Thistle ward a patient's observation levels were different on two pieces of documentation. Also, on this ward, we saw two observations sheets and two daily care round forms that were incomplete.

Audits had failed to identify that care records contained risk management plans that were not appropriate for the risk identified or lacked risk management plans at all. For example, risk management plans were not updated following an incident of trauma, sexual safety incidents or concerns and there were inconsistencies in relation to documentation around a patient's suicidal ideation.

Staff placed patients on restrictions passports with bronze, basic silver, silver, and gold categories, of which bronze contained the most restrictions and gold the least. However, there were no systems in place to ensure staff understood the use of the passports and regularly reviewed them.

Staff reported that the care records system could be very slow, sometimes froze and power cuts within the service sometimes resulted in any information not yet saved being lost and having to be inputted all over again. During our inspection, staff found it difficult to find specific documentation in the care records system such as positive behaviour plans.

However, staff within the service had a good understanding of the Mental Health Act and Mental Capacity Act and applied them correctly. The wards were clean, staff adhered to infection control procedures, bed management within the service was effective and discharge arrangements worked well.

Forensic inpatient or secure wards

Management of risk, issues and performance

Teams did not always have rapid access to the information they needed to provide safe and effective care.

The service had business continuity plans for emergencies such as adverse weather or a flu outbreak. Prior to our inspection, the service had been operating in business continuity due to staffing pressures which had been impacting on patients' care and treatment and patient and staff health, wellbeing and safety. Shortly before we started our inspection, the trust informed us that the service was now out of business continuity. However, during our inspection, we found staffing pressures were still a significant issue and continued to have a detrimental effect on patients and staff and the overall running of the service.

Commissioners of the service highlighted issues on Thistle and Kestrel/Kite wards. They had undertaken a review of Thistle ward in response to concerns about overly restrictive practice on Thistle ward which identified significant concerns around the culture on the ward, staff not following agreed protocols, patient safety, staff numbers, staff attitudes and behaviour, lack of management oversight and visibility and patient behaviours being exacerbated due to new, unfamiliar and frequently changing staff teams.

Despite managers devising action plans to address these significant concerns, there had been no assessment of the impact of actions and the issues remained in place. The actions were, therefore, ineffective in addressing the concerns commissioners had identified.

Templates within the care records system such as positive behaviour plans could only be saved as 'blank letter template' because the drop-down list for naming files was so limited. This made it time-consuming for staff to find information.

During our inspection, staff members found difficulty navigating the system to find information we requested to see due to the number of different places within the system information was saved.

Staff at ward level could escalate concerns to be included on the risk register. Risks on the risk register included the impact of staffing numbers such as patient safety and facilitating Section 17 leave, the potential for delayed discharges due to accommodation issues, the impact of COVID-19 on the delivery of psychology interventions and a lack of senior occupational therapy provision.

Information management

Staff collected and analysed data about outcomes and performance but did not always respond to any issues identified.

Staff did not always make notifications to external bodies when required. For example, safeguarding referrals had not been made for two instances of violence and aggression, a patient with suicidal ideation and a patient receiving threats of violence via a text message.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work, but the care records system was slow and some information saved to it was difficult to find due to there being a limited naming convention for files. The information technology infrastructure, including the telephone system, worked well in the main and helped to improve the quality of care. However, we found mobile phone network connection was problematic on the site.

Forensic inpatient or secure wards

Information governance systems included the need to ensure the confidentiality of patient records.

Team managers had access to information in an accessible format to support them with their management role. This included information on the performance of the service, staffing and patient care. However, staffing shortages were a significant issue and, patients had limited access to activities and Section 17 escorted leave which indicated managers were not proactive in addressing issues when they were made aware of them.

The service participated in the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. The network meetings discussed what was working well within the service and what the areas for improvement were.

Staff within the service were participating or had participated in research. This included

- problem solving in secure environments
- dental study in forensic services: exploring perceptions and experiences of forensic in-patients with learning disabilities towards their oral health
- genetic links to anxiety and depression study
- 'It's all about the trauma': an exploration of the facilitators and barriers to positive treatment outcomes for individuals 18 years and over, with a personal experience of complex needs and trauma, within medium and low secure hospital settings and
- high functioning autism spectrum disorders in medium secure units: a case-control study of male mentally disordered offenders with and without Asperger's Syndrome (or high functioning autism spectrum disorders) regarding their pathways in and out of medium secure units and co-morbid psychiatric conditions.

Users of the service had been involved in shaping future research by working with a small project team to identify their key priorities.

A forensic sleep research group had been in operation since 2019 and included clinicians, academics and patients to develop home grown research in this area. An event was hosted in January 2020 to develop further engagement from patients to allow them to contribute to the development of the future research proposal.

The service participated in national audits. These included the Prescribing Observatory for Mental Health use of depot/long acting Injectable antipsychotic medication for relapse prevention and antipsychotic prescribing in people with a learning disability under the care of mental health services.

Mental health crisis services and health-based places of safety

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

We found a breach of regulation in relation to the safe storage of medication at West Park Hospital. Due to the limited scope of the breach, we have not limited the rating as all other aspects of this key question were good.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. At West Park Hospital, issues regarding privacy and dignity identified in a previous inspection had been resolved.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff carried out regular risk assessments of the care environments including a ligature assessment. The services ensured patients did not have unsupervised access to any rooms with ligature points.

All interview rooms had alarms and staff available to respond. Rooms that were used by patients were fitted with alarm activation points and staff carried alarm handsets and there were clear processes in place to ensure that staff on site responded to alarms. Alarm systems were tested on a regular basis. Trust policy stated that two staff should remain with patients in the health based places of safety and staff confirmed they adhered to this.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All the health-based places of safety we visited contained either a pull-out sofa bed, a reclining chair or a bean bag. Some did not have a clock in the suite, or in the assessment room that was visible from the suite.

All health-based places of safety had bathroom facilities. The location of the bathrooms varied across the sites we visited. In some cases, they were directly attached to the suite. At Roseberry Park they only had one toilet for four rooms. However, there was access to another toilet in the main reception area.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed domestic staff cleaning patient areas in the three service areas we visited.

Staff followed infection control guidelines, including handwashing. Prior to entering the team locations or health-based place of safety, staff ensured visitors were wearing the appropriate level of personal protective equipment (PPE) and wearing a face mask unless patients were exempt. Signage was in place to remind patients to wear PPE and used hand sanitiser upon entering each area. In waiting room areas there were signs indicating the maximum numbers of patients who could use the area at any one time and fixed chairs identified as not to be used due to social distancing.

Mental health crisis services and health-based places of safety

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. In Tees and North Yorkshire, we found they had low vacancy rates and vacancies that did exist were recent and processes were in place to recruit new staff. However, in Durham and Darlington managers told us they had provision for 60 whole time equivalent clinicians but only had 24 in post. The drop in staff had been identified by the trust who had placed that team under a business contingency model prior to our inspection whereby managers reported daily to senior managers the staffing levels. We saw staff from other teams had been seconded and referrals were passed outside the crisis team to other community teams who were already aware of the referred patient or they did not meet the criteria for an urgent assessment. Staff at Durham and Darlington told us before this intervention, they had experienced high caseloads and that they were often the only clinician in that location on that day.

Durham and Darlington had also amalgamated both the crisis teams and home intensive treatment teams into one so staff could be allocated an urgent referral requiring a four-hour response as well as a home intensive treatment referral.

The service had low rates of bank and agency nurses. The service had over the previous six months averaged 15 shifts per month covered by bank and agency staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us they used the same staff when allocating shifts.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low and / or reducing turnover rates. Turnover figures for the teams were unreliable due to restructuring and renaming of teams, this showed that some services had over 100% turnover. However, senior managers were able to assure us this was not the case but an anomaly of the restructure. Staff we spoke with also told us they felt the teams were stable, apart from staff at Durham/Darlington. A number of staff had moved from Durham/Darlington to Tees.

Managers supported staff who needed time off for ill health. We spoke to staff who had experienced time away from the workplace and all stated they had been supported while away and with return to work plans that had been fully completed before resuming full time.

Levels of sickness were low in Tees and North Yorkshire. The service had over 12 months from June to June 2021 an average of 8.2% of sick leave. However, the Durham and Darlington team had an average of 17.2%. On our inspection we were told that there were 24 registered nurses in work and 9 on sick leave (a total of 33 staff).

Managers used a recognised tool to calculate safe staffing levels. The service had been redesigned in 2020 and at that time the staffing numbers were assessed against demand and team numbers allocated.

Mental health crisis services and health-based places of safety

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff. Every team had access to a consultant psychiatrist, junior doctor, psychologist and assistant psychologist support.

There had been no use of locums in the last 12 months.

The service could get support from a psychiatrist quickly when they needed to. There was an effective 24-hour rota for all the teams. If there was a delay in completing assessments in 136 suites these were because the out of hours staff were engaged elsewhere other than not being available.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The service had an overall compliance rate for mandatory training at 87%. Basic life support had the lowest percentage at 77%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The three teams operated slightly differently from each other, but all had a hub which took referrals from other agencies and phone calls from a dedicated number used by the public to contact the trust regarding mental health concerns.

The staff within each hub were either band 6 clinicians who worked in the hub on a rota or band 3 support staff. They assessed patients using a trust risk assessment pro-forma. This identified patients presenting with a low or high risk, highlighted concerns about capacity, behaviours and medicines. The risk assessment was supportive of staff who may not have had specific mental health training. There was also a case co-ordinator who audited the assessments to ensure it was used appropriately. The hub team provided referrers with information and advice between initial referral and assessment.

Mental health crisis services and health-based places of safety

In the hub staff completed initial triage assessments for each patient upon first contact and allocated more detailed assessments to staff within the team dependent upon risk. Other teams within the crisis care pathways could also be utilised dependent on the level of risk and need of each patient. There was a four hour target for urgent referrals and a 24 hour target for those assessed as suitable for the home intensive treatment team. The service operated 24 hours a day.

The health-based-place of safety staff liaised with the relevant police force to determine the level of risk a patient presented and assessed if the level of staff needed to be increased in advance of a patient's arrival. There was also a pro-forma assessment form for all patients arriving at the place of safety.

Staff used a recognised risk assessment tool. Staff used recognised tools to assess drug and alcohol dependency. They also used several different tools to assess the mental health needs of patients and the severity of any symptoms. These were recorded on an electronic case management system.

We examined 52 care plans. At the last inspection it had been identified that 13 out of 18 did not demonstrate good practice on assessing and managing risks to patients. On this inspection we found only one care record that did not have a risk assessment. All staff knew how to navigate the electronic care record system and access information.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We found good examples of what staff referred to as safety plans. These recognised the risk that patients presented. We examined seven records of patients who had entered the service via the health-based places of safety and who had been discharged into the crisis team for home treatment. In all cases we saw a safety plan outlining the risks of the patient, including protective factors such as family support and the voice of carers which allowed staff to assess risk while the patient waited for their first home visit in 24 hours from discharge. Hub staff knew where these were on a system and could easily access them if a patient or carer contacted the service due to a deterioration in circumstances.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. In the hub we observed good examples of staff following up on patients. One patient had been triaged by the out of hours service and staff contacted the patient for additional information on risk. The patient was given a urgent face to face appointment as their level of risk had increased.

We saw another patients risk changed by the hub and allocated as an urgent assessment to a clinician.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. There was a daily team meeting at which staff were allocated assessments and patients risk discussed. At one of these, we saw a patient's risk changed as a result of this and allocated as an urgent assessment to a clinician. There was also an afternoon meeting where managers spoke with staff to assess daily tasking.

Staff followed clear personal safety protocols, including for lone working. They used mobile phones to keep in touch with each other and there was someone delegated to monitoring departure and arrival times for home visits using a white board in each location. Staff told us they felt safe and where they identified higher risk patients or patients they did not know, they could either arrange to see patients elsewhere or ask a colleague to accompany them on a home visit.

However, the shift co-ordinators did rely on staff updating them and after the morning allocations, they were not always sure who was where and who was available for an urgent referral. Some staff did tell us that they often could not get through to the hub.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

They used recognised safeguarding tools to assess if a referral was appropriate.

Staff kept up to date with their safeguarding training. Safeguarding training is part of the mandatory training for all staff and up until June 2021, 89% of all staff in this core service had completed both safeguarding adults' level 2 and safeguarding children level 2 and 94% of staff had completed safeguarding children level 3.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. From September 2020 to May 2021, the crisis teams had made 439 safeguarding referrals, 104 regarding adults and 335 children. Staff were aware of the safeguarding lead within the trust and knew how to make an online safeguarding referral and to which local authority it needed to be made. Staff told us they had a very helpful internal safeguarding team that would support them with more complicated cases.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff working across the three services we visited kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. All patient records were kept on an electronic recording system which was accessible for all staff. Staff in the individual teams said the system was easy to navigate and patient information available to them.

Staff completed a, 'section 136 MHA 1983 record' for every patient admitted to the health-based place of safety. This contained information including the patient's age, gender, ethnicity, mode of transport to the place of safety, time taken to begin and complete assessment, time the police remained, and outcome of assessment, and total time the patient spent in the place of safety.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us there were no delays in accessing patients' records, as all teams had access to the same electronic record.

Records were stored securely. All electronic systems were password protected.

Medicines management

Mental health crisis services and health-based places of safety

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were only stored at West Park hospital as part of a patient group directive. However, as on the previous inspection there were days where the room temperature had been recorded above 25 degrees and no action had been taken. There were also gaps where the room temperature had not been recorded at all. Medications that were stored in the room stated on them that they should not be stored above a certain temperature, so staff could not be sure if medicines were effective or safe to use.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines, for example side effects. We saw records where patients had been referred to their local doctor for heart monitoring. Any changes to prescribed medicines were authorised by the patient's psychiatrist or duty doctor.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff we spoke with said they reported anything they considered a reportable incident in line with the trust policy and were encouraged and supported to do so by their managers. In total from May 2020 to May 2021, 476 incidents were recorded. Of these, 44 were deaths and eight were severe incidents.

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 year, there have been no 'prevention of future death' reports sent to Tees, Esk and Wear Valleys NHS Foundation Trust relating to this service.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. All staff that we spoke to talked confidently about what types of things should be reported and how they would report them. They told us that information was shared with them via regular team meetings, which we saw evidence of and during regular staff huddles and handovers.

Mental health crisis services and health-based places of safety

Staff reported serious incidents clearly and in line with trust policy. We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 20 reported.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. These reviews included the patient's contact with the crisis team and review of their care to decide if there were lessons learnt and or changes need to be made. Staff told us reports were completed and they were involved in investigation and outcomes. This included changes to systems, processes and practice. Staff told us reporting incidents was positive, transparent and managers had a no blame approach, but focused on improvement.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. In 2020, managers identified that care record keeping was contributing to incidents occurring. Changes to the trust policy on completing care records were made and staff training in the form of quality improvement events were held to ensure records were more comprehensive, accurate and in date.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to give us examples of incidents being shared in reflective practice and staff meetings, as well as information brought back to them as a result of investigations.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. The teams within the crisis care pathway used an evidence-based assessment, which included trauma informed care, mental health, medication, psychosocial and psychological needs, strengths and areas for development and suicide risk.

We found staff knew where to find and update this information. All the files we examined contained comprehensive progress notes and all interactions were recorded with the outcomes and further actions required at the next visit. Care records generally reflected that a good quality service was being delivered, patients' needs were being met and progress was being made.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Physical health assessments were completed by the local GP and we saw evidence of referrals.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. For those patients brought into a health-based place of safety during regular office hours, we found that mental health assessments were being carried out within the trust target of three hours. However, where the three-hour target was not met this was due to intoxication of the patient or the out of hours availability of an Approved Mental Health Practitioner and doctors to attend to carry out assessments. Some assessments took up to 12 hours, but never more than 24 hours.

Staff regularly reviewed and updated care plans when patients' needs changed. Patients who were referred into the home intensive treatment team were seen several times with the 72-hour target, these care plans were updated and comprehensive.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. A programme of brief interventions was offered to people that were assessed as requiring it. Some patients were also directed to services for home treatment or for support with psychosis if it was assessed as necessary. It was also evident from the care records that staff were supporting patients to access social care, benefits advice and giving them access to information about medication.

Staff delivered care in line with best practice and national guidance. In some cases, they used rating scales to help support patients to recognise their own progress or deterioration. Staff working for the crisis teams and in the health-based places of safety participated in some clinical audit, benchmarking and quality improvement initiatives.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff told us that they had good relationships with GPs, adult social care, local drug and alcohol services, voluntary organisations and counselling services which enabled staff to support patients and families and carers to live healthier lives.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The York and Selby, Scarborough, Whitby and Ryedale, and Hambleton and Richmondshire teams had all achieved the Royal College of Psychiatrists home treatment accreditation certification. Durham and Darlington and Teesside teams had not had any accreditation for 12 months.

The crisis teams had taken part in two national clinical audits examining treatments for depression and the long-term use of antipsychotic medication. There had also been six local clinical audits which looked at safeguarding for adults and children and the use of high dose antipsychotics.

Managers used results from audits to make improvements and were able to provide examples.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients, including psychologists and assistant psychologists. During our visit we observed an assessment and telephone support in the hubs. From our observations it was clear that staff had the skills and experience to deliver good quality care. There were a range of appropriately qualified multidisciplinary staff available to support patient's needs, including qualified nurses, social workers, support workers and clinical administrative staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. There were qualified staff available 24 hours a day for assessments.

Managers gave each new member of staff a full induction to the service before they started work. We spoke with new members of staff who had recently completed their induction which they considered to be comprehensive. One new staff member told us they had worked in the hub taking telephone calls and they had been supported by senior staff to discuss how they felt about dealing with distressed callers.

Managers supported staff through regular, constructive appraisals of their work. At the time of the inspection, the trust wide appraisal rate was 99%.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw evidence that team meetings were held regularly, as well as a daily team briefing which staff could connect to using audio visual communication systems.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service also had specialist posts for trainee nurses who worked in the service while completing a nursing degree with a local university. This gave non-clinical staff the opportunity to become qualified nurses.

Managers made sure staff received any specialist training for their role. Nurses had the opportunity to become nurse prescribers and we spoke with staff who had been allocated this training and had dates to begin the training.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All locations had a daily multi-disciplinary meeting at which all staff attended. We attended several of these meetings either in person or with other teams using audio visual technology. Staff from all disciplines attended the meetings. We observed a multi-disciplinary approach to discussion including, consent and capacity of patient's and understanding of the specialist needs of patients.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. The daily multi-disciplinary meeting was also chaired by the case co-ordinator in the hubs who discussed referrals and prioritised them for risk and allocated the referrals based on practitioner experience and need of the patient. These referrals were discussed by staff from the teams attending through audio visual technology. We saw staff speak with knowledge of patients and discuss with colleagues the patients' needs and outstanding care issues.

All the crisis teams provided crisis assessments and intensive home treatment, seeing urgent referrals within the four-hour response time. In Teesside the teams were separated into dedicated crisis and home treatment teams.

Crisis teams had effective working relationships with other teams in the organisation. We saw evidence that cases were referred to other community teams within the trust if that was the appropriate clinical route for the patient.

Crisis teams had effective working relationships with external teams and organisations. The teams had established positive working relationships with a range of other service providers such as GP's, police and other voluntary groups and organisations.

The three Police services in the trust area told us they had a good working relationship with the crisis teams. They had partnership agreements which clearly established who was responsible for which aspect of the process. Street triage staff worked alongside policing teams where it was required, ensuring that patients were assessed and supported at the earliest opportunity. This varied from area to area with trust staff sat in Police control rooms in some areas, while in some other areas street triage staff would accompany police officers to see a patient.

Where Police arrived with patients at health-based places of safety there was a risk assessment in place and Police would remain if there was concerns about the patient's threat of violence towards staff.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At 22 June 2021, trust-wide data indicated that the overall compliance rate for Mental Health Act level one at 100% and level two at 96.4%.

Mental health crisis services and health-based places of safety

Staff that we spoke to during our visit understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. They talked confidently about the Act and how it might impact their work. Staff could give us examples of where it was relevant to the work they undertook with patients.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff completed a 'section 136 MHA 1983 record' for every patient admitted to a health-based place of safety. This contained information about the patient such as age, gender, ethnicity. It was also a log of events such as mode of transport to the place of safety, time taken to begin and complete assessment, time the police remained, outcome of assessment, and total time the patient spent in the place of safety.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. This included the rights of those patients brought into the health-based place of safety under section 136.

Patients were provided with information about their rights and legal status in all the health-based place of safety we visited. In some cases, this information was visible on the walls of the suite. In other cases leaflets were available.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At 22 June 2021, trust-wide data indicated that the overall compliance rate for Mental Capacity Act training was 98%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff told us that they assumed capacity for patients that were engaging in treatment and that they would take necessary steps if they felt that a patient lacked capacity to make that decision. Staff were able to show us where to record capacity and were able to discuss capacity issues and where they had considered a patient to lack capacity.

Mental health crisis services and health-based places of safety

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. Staff were discreet, respectful, and responsive when caring for patients, providing patients with help, emotional support and advice at the time they needed it. We observed both staff supporting patients on the phone as well as assessing them at home. We also observed several handovers where staff spoke about patients and they put the needs of patients first and used their skills knowledge and experience in achieving this.

However, concerns were raised by staff at Durham and Darlington about some staff members attitude towards patients. One staff member had been challenged when admitting a patient onto a ward and another told us some staff had spoken inappropriately towards patients. They told us changes to staffing, which had recently occurred, meant they now believed all staff were caring. Managers confirmed that staff attitude had been a theme identified when dealing with complaints. The Durham and Darlington register of official complaints recorded 10 incidents, on closer examination three of those explicitly mentioned staff attitude.

The trust had launched a mental health support lines which was answered by the teams working in the hubs. This had been extended into a 24-hour service. Staff answering the phone could be talking to a person anywhere in the trust area. We observed several calls, some of which involved people in distress and staff were patient and compassionate. They spoke to patients as long as required, assessing the needs of that individual.

Staff supported patients to understand and manage their own care treatment or condition. For example, patients told us they were aware of their diagnosis and what medicines were prescribed for.

Staff directed patients to other services and supported them to access those services if they needed help. We saw several examples where patients were referred directly to another service which better suited their needs, or they were helped to access another service which complemented the care provided by the crisis teams.

Patients said staff treated them well and behaved kindly. All patients we spoke with were complimentary about the service and recognised the support they were being given by the staff.

Staff understood and respected the individual needs of each patient. During the daily briefings and observing the team environment we heard staff discussing patients. They all had an in-depth knowledge of the patients and could recite what care was being provided without consulting the electronic care records.

Mental health crisis services and health-based places of safety

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. The trust had freedom to speak up champions and staff were aware of who to contact should they need to use this service. All staff felt they could raise issues and gave examples where they had done so.

Staff followed policy to keep patient information confidential. Patients told us staff kept their information confidential and asked for their permission to speak to their family or other services they were involved with.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. Out of the 52 records we examined not all of them included information that patients had been provided with a copy of their care plan. However, we saw from our observations that patients were aware of their care records and the type of treatment they were receiving.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff had access to interpreters if patients needed them. Staff visited patients at home, and this included the consultant psychiatrists and psychologists so those patients with mobility issues were not disaffected.

Staff involved patients in decisions about the service, when appropriate. Patients told us they were involved in decisions about their care and their permission sought if the service felt the patient would benefit from a referral into other services.

Patients could give feedback on the service and their treatment and staff supported them to do this. There was a friends and family survey which was collected by the trust.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. In the safety plans we examined we saw clear evidence that where possible the carers voice was recorded. In the seven safety plans of patient's police had detained and who had not been admitted but were referred to the home treatment teams, the voice of carers and the protective factors they provided pending a home visit from the crisis teams were fully recorded. Within the electronic case system there was a prompt for staff to record the thoughts of carers.

Mental health crisis services and health-based places of safety

Staff helped families to give feedback on the service. Carers we spoke with were supportive of the service and thankful for the support of the staff. Those who received home intensive treatment, a 72-hour treatment package, said they built a relationship with the staff.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. The crisis service was a 24-hour service and received calls made on the trust central crisis line. These calls could be taken from any hub and not prespecify to the location of the caller. Staff told us they were confident they could assess the needs of the caller and there was a trust designed assessment form which guided staff and ensured consistency.

Patients entered the service either in crisis to be seen within a maximum of 4 hours, or for Intensive Home Treatment to be seen within a maximum of 24 hours (or earlier if needed). All those under Intensive Home Treatment would be seen daily over a 72-hour period by a registered member of staff unless clinically indicated.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. From December 2020 to May 2021, there had been an increase in referrals from 2564 to 2954 a month. In the hubs we saw considerable effort was made to track the targets set in the trust operational crisis policy of seeing patients within four hours and every 24 hours over a 72-hour period.

In the hubs, there was a large visual control board on which was displayed patients details such as target time, when they had been seen, what was still required to accomplish an assessment, for example referral to another agency or physical health check at GP.

We saw managers referring to the control boards during briefings, reminding staff of target times. Staff told us about the target of seeing each patient every 24 hours and completing a formulation within 72 hours.

From the 12 months June 2020 – May 21 87.7% of patients requiring an urgent assessment were seen within the four-hour trust target.

Mental health crisis services and health-based places of safety

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. For those patients brought into a health-based place of safety during regular office hours we found that mental health assessments were being carried out within the trust target of three hours. However, where patients were brought in out of office hours assessments could take up to 12 hours this was due to either patient intoxification or the availability of an Approved Mental Health Practitioner or doctors. We found two cases where a patient was detained beyond 24 hours, and these had exceptional reasons.

For example one was a young person under 16 who has extremely complex needs and the while the assessments had been completed it was difficult to find a placement. They were nursed in the 136 suites as an extension of the attached ward. We found the patient had not been disadvantaged and the outcome would have been the same.

The crisis teams had skilled staff available to assess patients immediately 24 hours a day seven days a week. The crisis teams worked alongside colleagues from the home treatment team and together they had skilled staff available to see patients that required urgent assessment immediately, 24 hours a day, seven days a week. Staff also provided cover for the 136 suites should the police take a patient to a place of safety.

The team responded quickly when patients called. (crisis-urgent and routine care)

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

The team tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times available. Staff offered patients flexibility in the times and locations of appointments. Where patients needed an alternative, the teams were responsive and were able to offer this. We saw patients attend the hubs for assessment, but we also saw examples of the consultant psychiatrist attending patients home addresses.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. We attended a daily 3.30pm team meeting where staff came together to discuss where they were and what appointments, actions were outstanding. Managers adjusted individual caseloads to reflect demand.

Staff supported patients when they were referred, transferred between services, or needed physical health care. We saw numerous examples of patients being referred to GP services for physical health checks.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.In the health-based place of safety at Lanchester Road Hospital the trust had acted upon issues raised about privacy and dignity in the previous inspection.

Mental health crisis services and health-based places of safety

The health-based place of safety at Roseberry Park had facilities for up to three patients when the need arose. There had been no occasions where three patients were present at the same time and it was rare for two to be present. However, there was only one toilet which would need to be shared if this occurred. We asked how this would be managed and staff told us they would ask patients to swap rooms so that the other patient could use the toilet if necessary.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Mental health crisis services and health-based places of safety

Managers investigated complaints and identified themes. Staff told us complaints were discussed in team and reflective practice meetings. Staff gave us examples of complaints being investigated and the outcomes of complaints being shared. In the last 12 months, there had been a total of 21 complaints raised across crisis teams within the trust. Eleven of the 21 complaints were currently ongoing, four were partially upheld and six were not upheld. None had been forwarded to the Ombudsman.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that the service had received complaints from the public that they believed the service had not properly identified risk to patients. Managers had accepted this and had designed workshops and improvement days focussing on identification of risk.

The service used compliments to learn, celebrate success and improve the quality of care. The service had received three formal compliments since 01 May 2020.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Managers had an awareness of the issues that we raised and were open and transparent in their responses. For example, locality and team managers at Durham and Darlington raised issues about the staffing levels and staff dissatisfaction. Managers acknowledged there was a shortage of staff but talked about the trust business continuity plan and the extra staff they had put into the service and referrals to other community services to ensure patients were unaffected.

Senior managers had added three extra managers and extra staff had been seconded to cover the hub and case allocation functions within the Durham and Darlington intensive home treatment team.

Team managers acknowledged that the street triage, intensive home treatment team and crisis teams had been amalgamated into one team as part of the trust's business continuity plan

Elsewhere staff told us that local managers and leaders in the service were visible, approachable, listened and supported them in their day to day tasks. Managers were willing to get involved in day to day work where needed, to support staff and patients to deal with difficult situations. We saw managers supporting staff in the hubs and attending assessments with staff. Staff and managers met regularly via management supervision and at regular team meetings.

Mental health crisis services and health-based places of safety

Team members from all three teams we visited gave examples of how they had been supported by managers. These included formal support for example through a return to work plan and informal support where a manager had seen a member of staff become upset as the result of an incident and they had immediately supported them.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

There were posters and intranet posts that detailed the trusts values and staff were also able to explain what they were and relate them to the work they were doing. Staff told us that they received regular communications from the provider which included information about the vision and strategy.

Managers were able to explain their visions clearly; several of the teams had carried out or were about to carry out restructures. Teeside had split the service so crisis and the home intensive treatment were different teams. The Harrogate team had moved to new premises. Durham and Darlington were changing their service delivery structure as the result of a trust review. Staff told us that they were given opportunities to be involved in planning and that their feedback was taken into consideration when decisions were being made.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff knew how to escalate concerns and use the whistle-blowing process and they knew about the role of the Freedom to Speak Up Guardian.

Managers acknowledged that some staff had become dissatisfied following a merger of the Durham and Darlington teams two years previously. The trust had conducted a review following staff complaints to the freedom to speak out champion. Following that review managers were preparing to change practices. At the time of inspection, staff received notification of their places of work and could therefore start at three different locations in a week. We were told this would change with staff becoming more location based with advanced practitioners as supervisors at each location.

Some staff told us they felt that managers did not appreciate the workload often being allocated on some occasions which could be as many as nine appointments a day, staff told us they felt half that number was appropriate. Some managers did not have a background in the crisis service so staff felt they did not appreciate how long some assessments could take. They told us that they felt pressurised to take urgent referrals into an already busy schedule.

Clinicians (those qualified to assess patients) told us on some occasions they were the only qualified staff member in an area. We visited the morning briefing at West Park Hospital and present was one qualified clinician, two support workers and one student.

All staff told us that the team had been unable to retain staff members because of the workplace environment with staff taking posts in other community services or transferring to teams within the service resulting in the low staff numbers.

Some staff in the Darlington and Durham team told us they were pleased with some of the staff changes. They believed managers were dealing with an entrenched workplace culture and that this was now changing and they, while acknowledging they also felt overworked, looked forward to a better workplace environment.

Mental health crisis services and health-based places of safety

Governance

There were systems and processes in place to assess and monitor the quality of care. The trust had identified issues within the Durham/Darlington team and had completed a review of its performance and had placed it in a business continuality model.

Within the trust crisis operational policy there was a clearly defined target;

“During the initial 72 hours of IHT there will be at least a minimum daily face to face to contact to assess the mental health needs with the individual, carer/families with review after this period to formulate the care and treatment plan. After this, the service user will be visited regularly, and the number of visits and level of input will be discussed with them based on their needs”.

We saw that team managers and staff within the locality teams were aware of this target and worked hard to meet it. From our examination of the visual control boards, it supported managers assertions that these targets were being met. However, when we asked for the data to assure ourselves these targets were met, we were told it was not recorded. We were also told this was a quality standard as opposed to a formal target.

The trust could not provide evidence that this target was monitored by senior managers and therefore they did not have oversight of how well teams were performing in assessing those in need of intensive support at a crisis point in their mental health. This lack of oversight at a senior management level was identified in our well led inspection of the trust.

There was one location where the safe storage of medication was not being safely reviewed.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement. There was a clear decision-based management structure and schedule of meetings at which performance was discussed.

The service operated a risk register that local managers could escalate issues to. There were mechanisms in place for risks to be discussed at different levels of the trust and we saw evidence of a useful flow of information between these different levels. For example, managers had escalated concerns in relation to staffing, which was recorded on the risk register with clear actions in place to manage the risk. The most significant risks identified by managers and staff on the service were:

- Review of Durham/Darlington team
- Tees intensive home treatment team had a large caseload
- North Yorkshire identified staffing issues with vacancies and absenteeism for certain teams

Staff told us that they could escalate risks and that they were kept informed of the outcome of issues that they raised. We saw evidence of performance and risk being discussed in team meetings notes.

Mental health crisis services and health-based places of safety

Senior leaders and the trust board were aware of the risks within the service and these were reviewed within quality review boards.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Patient information was stored on a secure electronic record system and all staff including agency staff could access the system. This system was used throughout the trust which helped teams to effectively communicate and manage a patient's treatment journey.

Staff had access to the equipment and information technology needed to do their work. Staff working in the community had access to a laptop or a mobile device where it was needed.

Staff were required to undertake information governance training as part of their mandatory training, 95% of staff had undertaken this training.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

We saw evidence that all areas were engaged with other health professionals, we saw organisations such as clinical commissioning groups, learning disability services, homelessness and alcohol and drug services attended meetings to discuss the need of the local population.

Specialist community mental health services for children and young people

Requires Improvement  

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

Safe and clean environments

Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. At some locations the environment was cluttered and required re-decoration.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. This included regular ligature audits and environmental risk audits. All premises had fire risk assessments that were in date. There were action plans in place at Viscount House, Rosewood and Lake House. Actions included removing materials from plant rooms, providing emergency lighting checks and to inspect a fire escape.

All interview rooms had alarms and staff available to respond. Children and young people were mainly seen at home or in community settings.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

Not all areas were well maintained, well-furnished and fit for purpose. Some premises were in need of redecoration and were untidy. Locations in York, Middlesbrough and Northallerton were tired and cluttered. However, there were plans in place for York to relocate in September 2021. The Northallerton location was due to move in August 2021. The Selby move had been delayed and rescheduled for April 2022. In the interim, office space for staff use had been identified at another location to alleviate pressure on the clinical space in the cabin in Selby. The Redcar location had already moved to more suitable premises earlier this year.

Staff made sure cleaning records were up-to-date and the premises were clean. The premises were visibly clean. Cleaning audits were paused during the second wave of the coronavirus pandemic. Six premises last had cleaning audits completed between August and November 2020. There was evidence of cleaning audits being reinstated. Two recently being completed in April and June 2021.

Staff always followed infection control guidelines, including handwashing. There were appropriate hand hygiene facilities available in each location visited. Staff were observed to be wearing masks where necessary. Buildings were well ventilated with open windows where possible.

Staff made sure equipment was well maintained, clean and in working order.

Specialist community mental health services for children and young people

Safe staffing

The service still did not have enough staff. Staffing levels were not sufficient to meet the high demand. Staffing levels were deemed not adequate during inspections in 2015 and 2019. Staff were unable to know all the children and families well in some teams due to high caseloads. Most staff had not received enough basic training to keep children safe from avoidable harm. There were a number of required training modules that were below the trust target. The number of children on the caseload of the teams, and of individual members of staff, was too high. This prevented staff from giving each child and family the time they needed.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. The staffing levels did not meet the high demand for the service. This meant that there was a significant waiting time for treatment and high caseloads. Children were waiting too long for treatment to begin and staff were unable to always review children on the waiting list. The average wait for treatment was 371 days. The longest average wait for treatment was 724 days. This meant that low staffing levels were having an impact on the safety of the service.

Children, young people and carers reported that waiting times and lack of contact was of concern.

The vacancy and sickness rates for each team varied. The overall vacancy rate for the service was 11%. The highest rate of vacancy were in the York, Scarborough and Northallerton teams, with vacancy rates of between 21 and 22 percent. There were no vacancies in the North Durham learning disability team.

The trust had taken action in the Durham and Darlington community eating disorder team with funding for 12 additional posts which were awaiting recruitment for the eating disorder pathway.

Most of these vacancies had been vacant over a 12 month period, the trust told us that this was because nursing staff were difficult to recruit.

The vacancy rates had an impact on staff's ability to work with people using the service due to high caseloads. Team managers reported that caseloads were approximately:

- North Durham 55-90
- South Durham 80-120
- Middlesbrough 50
- Redcar 46-105
- Stockton 40-95
- Scarborough 50

The service rarely used bank or agency staff. Managers described not wanting to employ temporary staff as this would be disruptive to the children, young people and their families.

The trust had introduced some initiatives to reduce the staffing deficits this included a staffing review prior to the covid-19 pandemic. From this staffing review there were plans to introduce new models of working and additional staff

into eating disorder services. Team managers told us that once the iThrive operational framework was further embedded many of the high waits would decrease. The iThrive model is a nationally recognised operational framework which promotes good mental health and wellbeing for children across whole populations. The model has five key elements:

- thriving
- getting advice and signposting
- getting help
- getting more help
- getting risk support

The trust also had plans to launch a new neurodevelopment pathway. The trust told us that many of the waiting lists for autism and attention deficit hyperactivity disorder would reduce and lessen the requirement for this work to be carried out by other clinicians. The increased demand since the coronavirus pandemic had been unprecedented. The service had a staffing review pre-covid. Since then extra money has been allocated to the neurodevelopment pathway and eating disorder service and to the wider systems as part of implementing the iThrive model in response to increase in demand. This extra funding was targeted at early intervention services as per the iThrive framework.

Overall the trust had employed 75 staff to work specifically with children with low level needs to prevent their needs requiring a secondary care service. This reflected the ithrive framework. However, during the onsite inspection we were not able to see the impact of this work as referrals into the service remained high.

Despite these plans there remained a significant staffing deficit that the service was struggling to address.

The service had a high turnover rate in some teams. The north Durham team had experienced a high turnover of staff.

Managers supported staff who needed time off for ill health. Managers spoke of being supportive towards staff who were absent due to sickness. Staff reported managers were supportive in relation to absence due to poor health.

Levels of sickness were low. Sickness rates overall for the core service were 4% for the last 12 months.

Medical staff

The service had enough medical staff in most teams. The medical staffing establishment overall met the needs of the service. There were two consultant psychiatrist vacancies overall which were covered by agency staff or trust locums. There had been an absence of a consultant psychiatrist in the Durham and Darlington learning disability team for some time. This post had been recruited to and the new doctor was waiting to start work.

Managers could use locums when they needed additional support or to cover staff sickness or absence. There was evidence of locum usage to cover for absent posts.

Managers made sure all locum staff had a full induction and understood the service.

The service could always get support from a psychiatrist quickly when they needed to. Children who required urgent psychiatry appointments could be seen within a day or two if needed.

Specialist community mental health services for children and young people

Mandatory training

Staff mandatory training had fallen below the trust target in a number of areas. This meant that not all staff were fully competent with essentials skills needed to fulfil their roles and duties. Many of the modules listed below were fundamental to safe service delivery. Most staff confirmed mandatory training had been completed with the exception of some face to face training. Two staff members stated training was difficult to complete due to time pressures of high caseloads. The trust target was 92%. Modules that fell below the trust target per team were:

Cardiopulmonary resuscitation

Intermediate life support

Raising concerns and whistleblowing

Medication assessment

PAT level one update

PAT level two update

Controlled drugs

Safe Prescribing

Safeguarding level one

Safeguarding level two

Safeguarding level three

Safeguarding (corporate)

Annual medication optimisation

Basic life support

Prevent

Harm minimisation

Observations and engagement

Fire

care programme approach and care coordination

Mental Health Act level two

Staff and managers confirmed that face to face training such as cardiopulmonary resuscitation had fallen below the trust target as these modules were prioritised for ward based staff due to covid 19 pandemic measures. Community teams were now being invited to book onto the training and training was available. Staff confirmed they had booked onto these mandatory training courses.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they were alerted when a mandatory training module was due.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for most children and young people at the first appointment, using a recognised tool, and reviewed this regularly, including after any incident. However risk management plans to mitigate identified risks were not always completed.

We examined 69 care records. We found that 64 children had fully completed risk assessments and four children had initial risk assessments completed only. Risk management plans had been completed for 34 children. Twenty five children did not have risk management plans, 21 care records stated this was not clinically indicated for that child. However, we noted that there were a few examples where a risk management plan should be completed, such as for a child with inappropriate sexualised behaviour and another child who self-harmed.

Risk assessments and other corresponding records had been updated following incidents and at regular intervals.

Staff used a recognised risk assessment tool that had recently been developed by the trust.

Staff could not always recognise when to develop and use crisis plans and advanced decisions according to patient need. Most children had safety plans. We noted four children did not have safety plans when this was clinically indicated.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff were able to refer to a child and adolescent mental health crisis team to support children whose mental health had deteriorated, and their risks had increased.

Staff did not always monitor patients on waiting lists for changes in their level of risk well. Children in the Durham and Darlington and Teesside areas were triaged/assessed by the single point of access and then allocated to the caseload of clinicians. Children were risk rated (red, amber, green) dependant on their needs by the assessing team and clinicians attempted to contact them to review their care at set intervals (red - weekly, amber - monthly, green - three monthly). However, clinicians described feeling overwhelmed in some teams and were unable to keep up this level of contact and children were not always being contacted in line with the guidelines. Managers could not monitor which children were

receiving regular contacts and which were being missed. An audit had been undertaken, (keep in touch audit). However this only looked at a small number of children (143) waiting across the whole of the CAMHS caseload. The June audit showed 19% of children waiting were not receiving "keep in touch calls" as per protocol. This was due to be repeated in July 2021.

Data requested from the trust showed that of the teams visited:

- 63 children were rag rated red and 60 had been contacted weekly
- 409 children were rag rated amber and 387 had been contacted monthly
- 2180 children were rated green and 2010 had been contacted within three months.

This meant that out of 2652 children waiting for treatment 195 children (7%) had not been contacted as per policy.

This meant there was a risk at times that a child's mental health could deteriorate without the service being aware or able to respond to changing risks.

In the York and North Yorkshire teams, children waiting for a service were placed on a centrally held waiting list. Managers had oversight of the waiting list and were able to check whether children had been reviewed and action this as appropriate.

A dashboard was in development which would show waits for assessments, specialist autism assessments and treatment. This was due to be launched in September 2021, although the Durham and Darlington location was behind due to capacity issues.

There was a plan for the teams based in the Durham and Darlington and Teesside areas to review their practice of holding waiting lists within clinicians' caseloads and have a more centralised approach. The detail of this was undecided at the time of our inspection visit.

A patient tracking list was due to be developed to check the adherence to Keep in Touch calls. This would provide oversight to managers, but this was not in place at the time of our inspection.

Staff who were aware of children's increase in risk responded appropriately.

Staff followed clear personal safety protocols, including for lone working. There was a lone worker policy in place. Staff reported having good safety procedures and that they felt safe.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Training levels for some teams fell below the trust target. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff mostly kept up-to-date with their safeguarding training however in some teams this was below the trust target.

Specialist community mental health services for children and young people

Appropriate safeguarding training was in place for staff to access. However, not all staff were up to date with mandatory training requirements. Teams and modules that fell below the trust target of 92% were:

- Redcar team safeguarding level three 81%
- North Durham learning disability team safeguarding level three 87%
- South Durham child learning disability team safeguarding level three 83%
- Northallerton team safeguarding (corporate) 67%
- York team safeguarding level two 50%

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe examples of safeguarding incidents and both internal and external processes they would follow.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff working for the mental health teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Care records were easily accessible to all staff. Staff reported being able to locate the relevant care record when required. The electronic system was slow at times. A new electronic system was due to introduced in September 2022.

(Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.)

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing and recording medicines. The service did not store or administer medication. Medication that was prescribed was clearly documented.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed the care records of 13 children who were prescribed medication. In each case there was evidence of medication being reviewed at regular intervals and that physical healthcare was monitored as required.

Specialist community mental health services for children and young people

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw evidence of medication being considered as a last resort and that other therapeutic options were the preferred choice.

Track record on safety

The service had a good track record on safety. There had been no serious incidents reported in the teams visited in the last 12 months. Managers were able to give examples of serious incidents that occurred approximately 18 months ago. These included two deaths by suicide. More recent incidents had included self-harm, information governance breaches and a child on an adult mental health ward.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported that patient related incidents were rare but that other incidents were reported such as a clinical records error. Staff were aware of the incident reporting system and knew how to use it.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were reported appropriately. Information from serious incidents were shared at quality assurance group meetings. Managers shared serious incident information and learning in team meetings and other clinical discussion forums.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff were able to describe duty of candour incidents and how formal apologies were given to families concerned.

Managers debriefed and supported staff after any serious incident. There were notes for team de-briefs for the North Yorkshire teams and Teesside teams. There were no notes for team de-briefs following incidents for teams in the Durham and Darlington area.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Team meeting minutes noted feedback from serious incidents. Team de-briefs notes referenced incidents in other areas of the trust.

Staff met to discuss the feedback and look at improvements to patient care.

Specialist community mental health services for children and young people

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient. Children were assessed or screened by staff within single point of access teams. Assessments were thorough and included all relevant information.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Care records we examined showed evidence of physical health care being considered and addressed during the assessment process.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated and demonstrate collaborative working. The quality of care plans had improved since the last inspection.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated. We examined 69 care records. We found 66 care plans to be comprehensive and the patient voice was evident as much as possible. Care plans were detailed and person centred. However, one care plan contained very little detail and two had yet to be developed as the children were new to the service.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. There was a wide variety of treatment options available to children, young people and their families. This included family therapy, positive behaviour support and cognitive behavioural therapy.

Specialist community mental health services for children and young people

Staff delivered care in line with best practice and national guidance (from relevant bodies, e.g. NICE).The quality assurance and improvement group had formal oversight of all NICE related activity and other guidance. The locality quality governance groups oversaw assessment and implementation at a local level. Staff confirmed they received updates on changes to NICE guidance via an email bulletin and during team meetings. The service had transitioned to a nationally recommended operational framework of care called iThrive.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff encouraged patients to attend GP surgeries for any physical health need. There were physical health checks available within the service for children on the neurodevelopment pathway, with an eating disorder, or other clinical need.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Rating scales were used at regular intervals and available on the electronic care record system.

Staff used technology to support patients. There were electronic tablets in waiting rooms for children and families to give feedback on the service. However, due to infection prevention measures because of the covid 19 pandemic, these were not in use at the time of our visit. Children, young people and their families reported using online surveys to give feedback.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff participation in audits was limited due to a high demand for the service and the covid 19 pandemic. Managers spoke about audits they had planned for the near future, such as clinical records audits. Other audits that had begun included the keeping in touch audit that aimed to check whether children had been contacted or reviewed who were waiting for treatment as per the risk rating system.

Managers planned to use results from audits to make improvements.

Skilled staff to deliver care

The specialist community mental health services for children and young people included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients however access was delayed at times. There was a high demand for the service in some areas and for some specialisms. The neurodevelopment pathway was in high demand as was the eating disorder service. The neurodevelopment pathway was in its infancy. It was designed to make full use of community and third sector resources meaning the demand on child and adolescent mental health teams would lesson over time. Extra funding had been allocated to meet this demand. The eating disorder service had seen an increase in referrals during the covid 19 pandemic and extra funding had also been secured. Staff were considering how best to utilise the increase in resources to best meet the needs of children and families.

Specialist community mental health services for children and young people

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Teams employed specialist practitioners that were suitable for the needs of the patient group. Recruitment and retention of some specialist staff was difficult. Managers considered the skill mix of the teams where there were long term vacancies.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Appraisal rates for each team visited were 100%. Staff reported feeling supported by their line managers.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. Team meetings were well attended. Minutes were circulated via email to ensure all staff had access to the information.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers were aware of gaps in specialist training amongst the teams. Plans were in place to offer training to staff to ensure any gaps in specialist skills were filled.

Managers made sure staff received any specialist training for their role. Staff had received specialist training, which included cognitive behaviour therapy, dialectic behaviour therapy, psychodynamic therapy, family therapy, trauma informed care, positive behaviour support, motivational interviewing and leadership training. The specialist training programme had paused due to the covid 19 pandemic but was due to restart soon.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers described following human resources policies and procedures in order to address any staff performance issues.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Teams had regular huddle meetings and other multidisciplinary meetings to discuss any complex or high risk cases. Information was shared and a multidisciplinary approach used to plan care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation. Staff described having good relationships with colleagues within other internal teams.

Specialist community mental health services for children and young people

Staff had effective working relationships with external teams and organisations. Staff worked closely with schools, local authorities and third sector organisations to meet the needs of children in a holistic way. The service worked collaboratively with a parent support group. Staff regularly offered drop in sessions at the local parent support group in Durham and Darlington and Teesside.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Most staff were up to date with Mental Health Act training. All teams were reaching the trust target for Mental Health Act training with the following exceptions:

- South Durham Team Mental Health Act level two training 83%
- York Team Mental Health Act level two training 72%

Staff described using the Mental Health Act as relatively rare but were able to state the guiding principles of the Act, how to access a Mental Health Act assessment and the importance of patients' rights if they were on a Community Treatment Order.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff were aware of online policies and guidance.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust website had policies and procedures relating to the implementation of the Mental Health Act that staff and patients could access.

Patients had easy access to information about independent mental health advocacy. Children's independent mental health advocacy services were available, and staff knew how to refer.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. The trust website had policies and procedures relating to the implementation of the Mental Capacity Act that staff and patients could access.

Staff knew where to get accurate advice on Mental Capacity Act. Staff reported they could seek advice regarding complex capacity issues during regular multidisciplinary meetings.

Specialist community mental health services for children and young people

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence of staff clearly documenting capacity issues.

Staff assessed and recorded capacity to consent more clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of the child. Care records demonstrated good examples of capacity assessments and best interests' decisions and processes.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary.

Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They supported patients to understand and manage their care, treatment or condition.

Staff were discreet and respectful when caring for children and young people.

Staff gave children, young people and their families help, emotional support and advice when they needed it. However, two carers described difficulty in accessing support from staff and telephone calls not being returned promptly.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Specialist community mental health services for children and young people

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. All children, young people and their families said they felt involved in their care and that they were given copies of their care plan.

Staff made sure patients understood their care and treatment. However, one carer said information had not been in an accessible format for their child.

Staff previously had a participation group to involve patients in decisions about the service; however, these groups were currently paused due to the covid 19 pandemic.

Patients could give feedback on the service and their treatment and staff supported them to do this. There were regular children and young people and carer experience surveys. The latest survey was conducted in May 2021 and gave mostly positive feedback from both children and their carers. However, from 130 people surveyed, 34 commented that waiting times and lack of contact from the service was a concern.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers; however, staff were not always responsive to telephone calls requesting advice and information. One carer felt unsupported due to the lack of medical reviews and physical health monitoring. Three other carers reported waiting too long for treatment.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

The service was not easy to access. There remained significant delays for treatment in some teams. Children and young people who required urgent care were seen more promptly and had access to the crisis resolution and home treatment team. Children and young people who did not require urgent care often waited too long to start treatment. Referral criteria was clear and did not exclude children and young people who would have benefitted from care.

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The service ensured that patients who would benefit from care from another agency made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists.

The service did not always meet trust target times for seeing patients from assessment to treatment. The trust target for referral to assessment was 28 days. This was mostly being met.

The trust target for assessment to treatment was 42 days, this target was not being met. The longest average wait was in the North Durham team which was 724 days. The shortest average wait was in the Middlesbrough learning disability team which was 231 days. This means the average wait from assessment to treatment was 371 days.

Staff saw all urgent referrals quickly but non-urgent referrals often waited much longer than trust target time to access treatment following their assessment. There was a system to rate newly assessed referrals and these children were given priority. Children who were particularly urgent could also be seen by the crisis team.

Staff tried to engage with children who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact children who did not attend appointments and offer support.

Children, young people and their families had some flexibility and choice in the appointment times available. Staff mostly saw patients in community settings where a mutual time could be agreed.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible. Staff stated they rarely cancelled appointments, and this would be a last resort. Staff claimed they would always seek to re-arrange appointments rather than cancel.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients. The trust had initiated a waiting time improvement journey starting in October 2019. Following a number of improvement events, a system that produced reports for:

- Number of children waiting for assessment (active since July 2020)
- Number of children waiting for treatment (active since December 2020)
- Number of children waiting for specialist autistic spectrum disorder assessment (active since February 2021)

Locality managers were sent weekly summary reports of the number of children waiting for treatment. This included information about how long children had been waiting.

However, during the onsite inspection, managers did not refer to the above dashboard or summary reports.

A patient tracking list was due to be developed to check the adherence to Keep in Touch (KIT) calls. This would provide oversight to managers. This would support managers to know if children had been contacted and reviewed in line with the RAG rating system.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff supported children who were transitioning into adult mental health services and developed plans and handover meetings to aid the transition.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Facilities at each location had enough rooms and equipment to meet the needs of children and young people.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The Stockton and Redcar locations were not on a bus route and so difficult for some to get to. However, staff mostly saw children and families in community settings.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information leaflets were now stored away due to infection prevention measures required to reduce the spread of Covid-19. However, these were readily available for staff and patients when required.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients had access to interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Children, young people and their families said they would contact the service directly if they had a complaint to make. Parents said they felt confident to complain and that their complaint would be listened to.

Staff understood the policy on complaints and knew how to handle them.

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Managers investigated complaints and identified themes. Managers were able to identify that themes from complaints was usually around the length of time waiting.

Staff protected patients who raised concerns or complaints from discrimination and harassment. There were policies and procedures in place that protected patients who complained.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers and staff knew the complaints process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was a standing agenda item for team meetings.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders were aware of risks within their services such as managing the increase in referrals alongside staffing concerns. Actions had been taken such as the implementation of a waiting list dashboard and extra funding for teams such as the eating disorder team to meet demand. However, leaders were slow to address long term vacancies, poor mandatory training compliance, high caseloads and risk management of the waiting list.

Managers spoke highly of the leadership training that had been widely available. During the inspection, all staff spoke very highly of their line managers and senior managers. Staff reported managers were very approachable and supportive.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff confirmed they felt highly respected and valued within their teams. Staff described team managers as approachable and supportive. The trust provided a range of internal specialist training that staff could access. Staff had opportunities to complete training for professional roles paid for by the trust. All staff said they could raise concerns with confidence and that they would be dealt with professionally and fairly.

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Governance

Our findings from the other key questions demonstrated that governance processes were not effective at team level and that performance and risk were not always managed well.

There were governance structures in place to support the governance of the service in order for leaders to monitor performance and risk.

There was a ward to board structure in place which allowed issues of concern to be escalated from team and service level into the quality assurance group and executive management meetings.

However, there were some areas of concern which the trust's governance processes had not addressed. This included low rates of compliance with mandatory training, staffing levels not matching service demand, long waiting lists, high caseloads and poor risk management of the waiting list.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but had not always used that information to good effect.

In order to monitor risk and performance, the trust had electronic systems that collated data on the number of staff appraisals and mandatory training. Other data was collected regarding the number of referrals, incidents, and assessments. Team managers had access to this data and discussed issues within team meetings. There were regular team meetings which were well attended by staff. Staff were aware of outcomes and recommendations from reviews of deaths, incidents and complaints

The service had a risk register which contained issues of concern from all three localities. Not all items on the risk register matched issues identified in the teams we visited. The Durham and Darlington risk register did not highlight any issues with capacity, demand or vacancies other than for the eating disorder service and the autistic spectrum disorder service. The risk registers for Teesside and York and North Yorkshire were more detailed and corresponded with issues identified during the inspection process.

However, the trust had not always acted on risks in a timely manner when they had become aware of them. This included staffing levels not reflecting the high demand for the service. There was a high level of vacancies in most teams. The trust had attempted to recruit staff and to offer training to staff already employed. However, there was no rolling recruitment programme and the trust had considered and dismissed using agency staff due to this being too disruptive to children and young people. There was minimal agency and bank staff usage in the Scarborough and York teams only. Waiting lists were excessively long with very little managerial oversight. Managers stated that referral numbers increased significantly during the coronavirus 19 pandemic. However, managers were unaware of current dashboards and weekly summary reports of waiting lists. Caseloads were too high for clinicians to safely manage. Extra funding had been allocated to the eating disorder pathway and the neurodevelopment pathway. Managers were hopeful that once the iThrive operational framework was further embedded, referrals would reduce and caseloads would also decrease. However, there was no plan to reduce caseloads in the short term.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. There were key performance indicators that were appropriate for the service to measure outcomes for the teams. The service had identified some areas for improvement that involved staff participation. These included:

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- assessment and treatment virtual improvement event June/July 2020
- attention deficit and hyperactivity disorder and autistic spectrum mapping work in York & Selby to identify improvement opportunities and engage the teams in improvement thinking
- children and young people eating disorders improvement work. To share and adopt best practice across the three localities
- demand and capacity session for York and Selby teams to help understand service pressures
- Stockton team engagement as a collaborative approach between quality improvement and coaching to identify areas of improvement and develop a team plan
- Fifty staff have completed quality improvement intermediate training

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. The service was striving to develop strong links with communities, third sector organisations and other bodies to strengthen support for children. In particular, the neurodevelopment pathway was looking at opportunities for children to receive support from within the community without/or as well as requiring specialist input from the teams. Most teams had yet to move to a full neurodevelopment pathway and this plan was in its infancy.