

Outstanding

Northumberland, Tyne and Wear NHS Foundation  
Trust

# Community-based mental health services for adults of working age

## Quality Report

St Nicholas Hospital  
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## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team)   | Postcode of service (ward/ unit/ team) |
|-------------|---------------------------------|--|--|
| RX4E4       | St Nicholas Hospital            | North Tyneside West Community Mental Health Team, Oxford Centre                    | NE12 8LT                               |
| RX4E4       | St Nicholas Hospital            | North Northumberland Community Mental Health Team, Alnwick, Hawkhill Business Park | NE66 3PG                               |

# Summary of findings

|       |                      |  |          |
|-------|----------------------|--|----------|
| RX4E4 | St Nicholas Hospital | Central and South Northumberland, Community Mental Health Team, Greenacre Centre       | NE63 8BL |
| RX4E4 | St Nicholas Hospital | Newcastle West Community Mental Health Team, Silverdale                                | NE4 8RR  |
| RX4E4 | St Nicholas Hospital | Hexham Community Mental Health Team, Fairington Centre                                 | NE46 1QJ |
| RX4E4 | St Nicholas Hospital | South Tyneside Community Treatment Team (Psychosis), Jarrow, Palmer Community Hospital | NE32 3UX |
| RX4E4 | St Nicholas Hospital | North Shields Community Mental Health Team, Hawkeys Lane                               | NE29 0PN |
| RX4E4 | St Nicholas Hospital | Gateshead Community Treatment Team (Non-psychosis), Dryden Road Clinic                 | NE9 5BY  |
| RX4E4 | St Nicholas Hospital | Gateshead Community Treatment Team (Psychosis), Tranwell Unit                          | NE10 9RW |
| RX4E4 | St Nicholas Hospital | Sunderland South Team, Teleport House  | SR3 3XD  |

This report describes our judgement of the quality of care provided within this core service by Northumberland, Tyne and Wear NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Northumberland, Tyne and Wear NHS Foundation Trust and these are brought together to inform our overall judgement of Northumberland, Tyne and Wear NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Outstanding



Are services safe?

Good



Are services effective?

Outstanding



Are services caring?

Outstanding



Are services responsive?

Good



Are services well-led?

Good



### Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

We rated community-based mental health services for adults of working age as outstanding because:

There was a truly holistic approach to assessment, care planning and delivery of care to patients:

- Assessment and treatment of patients was a multi-disciplinary approach and considered the holistic needs of the patient which was incorporated into their care and treatment.
- Where appropriate patient's religious and spiritual identity was incorporated in to their recovery journey, care and treatment through access to spiritual therapy which was delivered by the chaplaincy team.
- Creative care planning was used to meet patient's needs. A pictorial care plan was created for a person with a learning disability written in basic language with easy read pictures.
- There was good access to a range of psychological therapies in both group and individual sessions recognised by National Institute for Health and Care Excellence.
- Patient's physical health was seen as an integral part of their mental health care and treatment. Robust systems were in place to identify and monitor people's physical health. Physical health checks and monitoring of medication levels such as, high dose anti-psychotic medication therapies, clozapine and lithium were completed and recorded.
- Teams used recognised outcome measuring tools to measure patient rated outcome and experiences, clinical rated outcome measures were used, such as perspective on side effects of medication.
- Patients and staff participated in research. Hexham community mental health team participated in NHS research in a focussed study into the effectiveness of cognitive behavioural therapy in people with a diagnosis of schizophrenia.

There was a commitment to the continual development of staff and their professional development. Professional

development of staff was maximised through team training stars developed using evidence based information, considered patient need and team feedback about staff learning needs.

Teleport house was equipped with a private treatment recovery room which was furnished with comfortable furniture and entertainment facilities.

The feedback from patients and their carers was universally positive. Patients and their carers felt that they were an active partner in their care and told us that staff went the extra mile. Patient's felt that staff understood the totality of their needs from mental health, physical health to spiritual and religious identity.

- Teams made reasonable adjustments for patients with additional needs.
- Risks to people were assessed and monitored.
- Staff reviewed risk assessments regularly to reflect any changes in risk to people. Teams identified and responded to changes in people's health. Teams were flexible and saw people urgently when needed.
- Teams used lone worker procedures and equipment was in place to support and protect safety of staff.
- Feedback from investigations was shared with staff in team meetings and in email communications from the trust.
- Gateshead community treatment team (non-psychosis) held weekend assessment clinics when needed.
- The trust's vision and values were embedded into teams. Staff knew the trust's values and explained how these applied to their everyday work.
- There was an open and transparent culture to raising concerns or issues to management and there was good staff knowledge of the trust's whistleblowing policy.
- Services were well managed with good governance structures. Staff knew who senior managers were. Staff felt supported by their managers and managers had the authority to make decisions about their service.

# Summary of findings

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

### Are services safe?

We rated safe as good because:

- Comprehensive risk assessments were used to assess risk to patients who used the service and staff. Risk assessment processes began from initial triage of referrals. Risk assessments were completed with people and regularly reviewed and updated thereafter.
- Teams recognised and responded quickly to changes in patient's health. Staff saw people the same day in clinic or at their homes when appropriate.
- Staff had good knowledge about safeguarding adults and children and felt confident in raising safeguarding concerns.
- Lone working and personal safety procedures were in place with appropriate equipment to support staff.
- The trust provided support to teams following incidents. De-brief sessions were held after incidents. Investigations took place where needed and teams received feedback from incidents.
- Vacancy rates were low across teams. Where teams received increasing levels of referrals staffing levels were increased through the use of bank and agency workers.
- Clinic rooms were well-equipped with facilities to complete physical health checks and interventions at teams and local satellite sites.

Good



### Are services effective?

We rated effective as outstanding because:

- There was good access to an extensive range of psychological therapies in both group and individual sessions recognised by National Institute for Health and Care Excellence.
- Robust systems were in place to identify and monitor patient's physical health. Physical health checks and monitoring of medication levels such as, high dose anti-psychotic medication therapies, clozapine and lithium were completed and recorded.
- Teams used recognised outcome measuring tools to measure patient rated outcome and experiences, clinical rated outcome measures were used, such as, perspective on side effects of medication.
- Patients' religious and spiritual identity was incorporated in to their recovery journey, care and treatment through access to spiritual therapy which was delivered by the chaplaincy team working with community mental health services.

Outstanding



# Summary of findings

- Teams developed training stars using evidence base information, considered patient need and team feedback about learning needs.
- Care plans were goal focused and recovery orientated. Crisis and relapse prevention was integrated into care plans.
- Discharge planning continued throughout patient's care and treatment. Wellness recovery action plans were used by teams.
- Mental Capacity Act training was mandatory for all staff. All staff knew where to get advice from about using the Mental Capacity Act.
- Consent to treatment forms were present for patients subject to community treatment orders.
- Medication was prescribed mostly in accordance with National Institute for Health and Care Excellence guidance. People were involved in discussing the treatment options which were available and side effects on physical health were monitored.
- Clinical audits regularly took place. An audit completed in May 2016 identified that reading of rights was not embedded into practice and people were not being read their rights every three months in line with the trust's policy. Following this audit team meetings were used to communicate the audit findings and teams developed action plans to address this.

However:

- Intramuscular or 'depot' medication prescribed was not always reviewed every six months as recommended by National Institute for Health and Care Excellence guidance.
- Patients subject to community treatment orders were not always read their rights every three months as stated in the trust's policy.

## Are services caring?

We rated caring as outstanding because:

- Patients' and their carers told us that they were treated with kindness, dignity, respect and were supported by staff who worked with them. Feedback about staff was universally positive.
- Staff involved carers in care and treatment with the consent of the patient who used the service. Teams provided carers with copies of care plans.
- Training for carers and young carers was available. Carer drop-in sessions were held at the same time and location as clinics for carers to access.
- Teams involved carers in delivering training to staff.

**Outstanding**



# Summary of findings

- Our observations of staff interactions with people showed that staff worked in a person centred way, respected patient's views and considered patient's emotional and social needs.
- Staff involved patients in writing their care plans, some patients told us what was written in their plans and other patients showed us their own copies of their care plans.
- Participation in social, recovery focussed and educational groups was encouraged through work with the recovery college.

However:

- Patients we spoke to told us they have not taken part in recruiting new staff for the teams involved in their care. Patients told us that they would like to participate in recruiting staff for the team that they receive services from.

## Are services responsive to people's needs?

We rated responsive as good because:

- Creative care planning was used to meet patients' needs. A pictorial care plan was created for a person with a learning disability with easy read pictures and basic language.
- Reasonable adjustments were made for patients with additional needs. Teams worked flexibly to see patients in the community or at their own homes.
- Teleport house was equipped with a private treatment recovery room which was furnished with comfortable furniture and entertainment facilities.
- Gateshead community treatment team (non-psychosis) held weekend assessment clinics when needed.
- Teams had statements of purpose and operational policies. There were clear referral criteria which outlined the degree of mental health needs that the team would work with.
- A duty system was in place with a dedicated worker each day to respond to referrals, increased risks and changes in mental health.
- Information was displayed about how to make complaints by teams. Teams discussed complaints in team meetings and key messages were shared from across the trust following complaints.

Good



## Are services well-led?

We rated well-led as good because:

Good





# Summary of findings

- The trust's vision and values were embedded into teams. Staff knew the trust's values and explained how these applied to their everyday work.
- There was an open and transparent culture for raising concerns or issues to management and there was good staff knowledge of the whistleblowing policy.
- Services were well managed with good governance structures. Staff knew who senior managers were. Staff felt supported by their managers and managers had the authority to make decisions about their service.
- Hexham community mental health team participated in NHS research in a focussed study into the effectiveness of cognitive behavioural therapy in people with a diagnosis of schizophrenia.
- Managers supported staff's continuous professional development through further education and additional training.

# Summary of findings

## Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust provide a range of community mental health services for adults of working age across Gateshead, Newcastle, North Tyneside, Northumberland, South Tyneside and Sunderland.

Community-based mental health teams consist of staff from a range of different professional backgrounds which include: community clinical managers, team managers, consultant psychiatrists, psychologists, occupational therapists, nurses, social workers, support workers, peer support workers and administration staff.

A range of different mental health services are provided by community-based mental health teams. The services provide assessment, diagnosis and treatment for people experiencing severe and enduring mental health illness that often results in complex health and social care needs. Teams work in a recovery focused way to

maximise potential for recovery and independence. Teams work with people at their bases, satellite sites and at patient's homes in the community. Treatments provided include talking therapies, psychological group based therapy and social interventions.

Community adult mental health services support people to build and maintain their independence by strengthening social relationships to reduce social isolation. Physical health is monitored by teams to manage medication and the potential effects on physical health. This includes annual health checks and blood monitoring clinics to monitor those prescribed anti-psychotic medication and prescribed intramuscular or 'depot' medication by injection.

We have not inspected Northumberland, Tyne and Wear NHS Foundation Trust's community mental health services for adults of working age before this inspection.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Paul Lelliott, Deputy Chief Inspector (Mental Health)

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

**Team Leaders:** Brian Cranna, Inspection Manager (Mental Health), Care Quality Commission. Jennifer Jones, Inspection Manager (Mental Health), Care Quality Commission. Sandra Sutton, Inspection Manager (Acute), Care Quality Commission

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

- is it well-led?

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

The inspection was completed across community-based mental health services for adults of working age. We

# Summary of findings

visited a sample of mental health services as part of our new inspection process. We visited ten community mental health teams for adults of working age. These were located at ten different sites. The teams that we visited were:

- North Tyneside West community mental health team based at the Oxford Centre
- North Northumberland community mental health team based at Hawkhill Business Park
- Central and South community mental health team based at the Greenacre Centre
- Newcastle West community mental health team based at Silverdale
- Hexham community mental health team based at Fairnington Centre
- South Tyneside community treatment team (psychosis) based at Jane Palmer Community Hospital
- North Shields community mental health team based at Hawkeys Lane
- Gateshead community treatment team (non-psychosis) based at Dryden Road Clinic
- Gateshead community treatment team (psychosis, Step Up and Early Intervention Psychosis) based at the Tranwell Unit
- Sunderland South community treatment team based at Teleport House

During the inspection visit, the inspection team:

- visited 10 of the teams and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 34 patients who were using the service
- spoke with 15 carers of patients who were using the service
- spoke with the managers of each of the teams
- spoke with 72 other staff members; including doctors, nurses, social workers, occupational therapists, psychologists, support workers, peer support workers, administrators, pathway co-ordinator, assistant practitioners and a chaplain
- attended and observed 10 home visits
- attended five outpatient clinic appointments
- attended seven multi-disciplinary meetings.

We also:

- looked at 42 patients' care records
- looked at a range of policies, procedures and other documents relating to the running of the service
- collected feedback from patients using comment cards

## What people who use the provider's services say

We spoke with 34 patients using the service and 15 carers.

- Patients told us that they feel welcome and accommodated when they visit teams because all staff are friendly towards them.
- All patients that we spoke to told us that staff were respectful, helpful and understanding.
- Patients reported that staff cared about their physical and mental health and believed that staff wanted them to get better.
- Carers told us that they feel staff supported and included them in the care and treatment they provided to patients.

- Patients told us that they felt listened to and that they can contact the team and speak to someone quickly when needed. Patients were aware of how to contact services out of hours and in a crisis.
- Patients reported to be involved in their care plans and people who wanted a copy of their care plan had one and could tell us what it said.

We collected feedback from 49 patients using comment cards about community adult mental health services. Of these, 32 were positive and nine were negative. There were eight comment cards with mixed feedback. Negative feedback related to staff consistency, communication and tasks not been carried out in a timely manner. Positive feedback related to caring staff and satisfaction of services provided by teams.

# Summary of findings

## Good practice

Patients' religious and spiritual needs were supported and included in their care and treatment by community adult mental health services. Sunderland South Community Treatment Team worked collaboratively with the trust chaplaincy service to link religion and spirituality into mental health recovery and treatment. Regular pathway meetings took place where chaplaincy service attended. Staff referred cases for chaplaincy involvement and visits were completed together from the team and chaplaincy.

A member of the chaplaincy team held a caseload and had dedicated time per week to work with patients who used community based services in Sunderland South area. The chaplaincy worker continued their involvement through the community to inpatient and rehabilitation with people. The chaplain worker specifically worked with patients to promote religious and spiritual belief in mental health recovery.

## Areas for improvement

### Action the provider **SHOULD** take to improve

The trust should ensure that patients subject to community treatment orders are read their rights at regular intervals as outlined in the Mental Health Act and the Mental Health Act Code of Practice.

The trust should ensure that prescriptions for intramuscular or 'depot' medication are reviewed at least every six months as recommended by National Institute for Health and Care Excellence guidance.

## Northumberland, Tyne and Wear NHS Foundation Trust

# Community-based mental health services for adults of working age

### Detailed findings

#### Locations inspected

| Name of service (e.g. ward/unit/team)  | Name of CQC registered location |
|--|---------------------------------|
| North Tyneside West Community Mental Health Team, Oxford Centre                        | St Nicholas Hospital            |
| North Northumberland Community Mental Health Team, Alnwick, Hawkhill Business Park     | St Nicholas Hospital            |
| Central and South Northumberland Community Mental Health Team, Greenacre Centre        | St Nicholas Hospital            |
| Newcastle West Community Mental Health Team, Silverdale                                | St Nicholas Hospital            |
| Hexham Community Mental Health Team, Fairnington Centre                                | St Nicholas Hospital            |
| South Tyneside Community Treatment Team (Psychosis), Jarrow, Palmer Community Hospital | St Nicholas Hospital            |
| North Shields Community Mental Health Team, Hawkeys Lane                               | St Nicholas Hospital            |
| Gateshead Community Treatment Team (Non-psychosis), Dryden Road Clinic                 | St Nicholas Hospital            |
| Gateshead Community Treatment Team (Psychosis), Tranwell Unit                          | St Nicholas Hospital            |

# Detailed findings

Sunderland South Team, Teleport House

St Nicholas Hospital

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

During our inspection we looked at adherence to the Mental Health Act and Mental Health Act Code of Practice.

Training in the Mental Health Act was a mandatory training requirement for all staff. The trust had a target rate of 85% for training compliance. Information provided by the trust stated that 86% of staff had received training in the Mental Health Act as of May 2016.

Staff understood the Mental Health Act and the Mental Health Act Code of Practice. We spoke to 72 staff members during our visit and they told us about their knowledge of the Act and the Code of Practice in detail. The trust had a Mental Health Act office which staff told us they contact for any advice that they need about the Act and Code of Practice.

Information about independent mental health advocacy services was displayed by teams and staff told us that they

accessed and supported engagement with independent mental health advocates. We reviewed records that showed involvement of independent mental health advocacy services.

Mental Health Act paperwork was in place. We saw that consent to treatment and capacity requirements were adhered to for patients that were subject to Community Treatment Orders. The trust's Medical Records department scanned CTO12 and CTO11 forms and assessment of capacity records onto the electronic patient record system. Paper copies were attached to medication charts where appropriate.

However, patients did not always have their rights read to them at regular intervals. The trust completed an audit in May 2016. It was identified that the reading of rights was not embedded into practice. Managers across the teams told us that they had identified through audit that rights were not always been read to patients every three months. Teams had put in place action plans to address this and expected all patients to have their rights read by July 2016. Teams discussed reading of rights and this was minuted in team meeting minutes and business meeting minutes.

## Mental Capacity Act and Deprivation of Liberty Safeguards

During our inspection we looked at the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was part of the trust's mandatory training requirement. Overall, 89% of staff had received this training.

There was variable staff knowledge and confidence in using the Mental Capacity Act. Some staff recalled to us the five statutory principles of the act and described to us how they applied the Act in practice. These staff members explained to us some examples of people where they had used the Mental Capacity Act to assess capacity to make decisions.

Other staff were able to tell us the basic purpose of the act and explained that they would refer to the trust policy and seek advice when needed. These staff told us that they do not often work with people that lack capacity.

However, all staff told us that if needed support with the Mental Capacity Act they sought advice from:

- The trust's intranet page where all policies were located
- The trust's mental health act office and safeguarding office at St Nicholas Hospital
- Their colleagues and consultant psychiatrists in the team
- Local authority social work teams

# Detailed findings

During our inspection we reviewed 42 care records. We saw that staff recorded consideration of patient's capacity in patient's progress notes from their visits.

We asked staff if the trust monitor adherence to the Mental Capacity Act. None of the staff that we spoke to knew if there were arrangements in place to monitor the adherence to the Mental Capacity Act.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

We visited ten teams that provide community mental health services to adults of working age. Staff saw people at most of the community mental health teams we visited. Interview rooms were used to see patients at nine of the teams that we visited. Staff used alarms when they saw patients in interview rooms. Seven of the ten teams we visited used mobile alarms when seeing patients at team bases. Newcastle West team did not see patients at their team based they used facilities nearby at the Hadrian Clinic. Mobile alarms were used by staff when they used the Hadrian Clinic facilities. Mobile alarms were held by administrative staff at reception areas. Staff booked out mobile alarms to use when seeing patients in interview rooms. Fixed alarm points were present in interview rooms used at the Tranwell Unit used by Gateshead community treatment team (psychosis) and Dryden Road clinic used by Gateshead community treatment team (non-psychosis). All staff received training on the use of alarms which covered what action to take when alarms were activated. Staff knew what actions to take in response to alarms sounding.

Staff told us that they also see patients at their homes or at other community settings. Where increased risks were indicated, staff visited in pairs.

Six of the teams we visited had clinic room facilities with equipment to complete physical health examinations. There were four community mental health teams that used clinic rooms at satellite sites to complete clinical and physical examinations. These teams were: North Northumberland community mental health team, Central and South Northumberland community mental health team, Newcastle West community mental health team and North Shields community mental health team. Staff told us that there were plans to refurbish community mental health team sites at Hawkhill Business Park, Greenacre Centre, Silverdale and Hawkeys Lane. We saw plans that included purpose built clinic rooms and interview rooms at all community mental health teams.

Clinic rooms were well-equipped. Examination couches were present and could be in adjusted in height and

position. There was adequate storage. Sharps boxes were in place and there were appropriate facilities to dispose clinical waste. Hand washing facilities were available in all clinic rooms. Clinic rooms had portable blood pressure equipment and weighing scales present. Electrocardiogram equipment was available. This equipment is used to complete a test that measures the electrical activity of the heart to identify whether or not it is working normally. Point of care haematological analysis equipment was available. This is blood testing equipment. Equipment to measure oxygen levels in the blood was also available. All clinical equipment was well-maintained and clean. There were stickers on equipment which were visible and in date. Staff monitored and recorded room and fridge temperatures.

All areas were clean and well maintained throughout the teams. Areas were decorated in light and neutral colours. Furniture and flooring was in a good state of repair. Artwork completed by young carers was displayed at Dryden Road Clinic and the Tranwell Unit. Greenacre Centre used by Central and South community mental health team décor was more worn than other locations. Scuff marks were visible on walls and around door frames, however, transformation work to fully refurbish the building was planned to take place.

Cleaning records showed that regular cleaning took place. The teams had cleaning schedules that stated specific cleaning tasks that should be completed and how frequent these should be repeated.

We saw good adherence to infection control principles throughout our visits. Hand washing facilities were present throughout the environments we visited. Information was displayed about hand washing techniques and there was alcohol gel or foam available.

At Teleport House in Sunderland, there was a treatment recovery room that was available for patients to use whilst they were waiting for results. This was equipped with comfortable furniture and facilities to watch television.

### Safe staffing



# Are services safe?

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

We looked at the staffing levels across the teams that we visited. Community services for adults underwent a process of transformation to identify staffing levels and skill mix within teams. At the time of our inspection, the trust was in the process of rolling this out to all community teams.

Community mental health services for adults were under pressure to manage increasing levels of referrals. Managers told us that the amount of referrals teams were receiving was increasing for some teams, when needed additional staff were secured through agency fixed term contracts. Any use of bank or agency staffing was agreed with senior management. Managers told us that they felt they could request extra staffing resources when needed and they felt that this was supported by senior managers.

Vacancy rates for qualified nursing staff were low. Information provided by the trust as of 30 April 2016 showed that overall the percentage of vacancies for qualified nursing staff was less than one percent and the percentage of vacancies for nursing assistants was 6%.

Overall, sickness rates were average at 5%. Information provided by the trust showed that team sickness rates up to April 2016 for Sunderland South team were 9%, South Tyneside team (psychosis) was 8%, Gateshead (non-psychosis) was 6%, Central and South Northumberland team was 4%, community mental health team was 3%, Newcastle West was 3%, and Gateshead (psychosis) was 3%.

A system was in place to manage patient safety. Teams had a duty system in use. All teams had an allocated duty worker each day. The duty system involved a dedicated worker to manage incoming contact regarding referrals and contact from people who used the service. Urgent referrals were triaged by the duty worker and immediate action was taken when needed. For example, the duty worker would arrange for a colleague from the team to visit the person or the person would be seen at the team base the same day where appropriate. Duty workers would also manage contact from patients that were not allocated to a care co-ordinator or where patients' care co-ordinators were unavailable.

Cover arrangements were in place for staff members on long term absences from work through use of short term contract agency cover. Managers told us that they applied the trust's leave policy to ensure that there was adequate staffing to cover services when staff were on planned leave.

The average caseload was 27 cases per care co-ordinator. We visited ten teams during our inspection and across these teams there were 250 people awaiting allocation of a care co-ordinator.

Caseloads were managed and reassessed regularly. Supervision agendas included full caseload discussions. Staff told us that they received formal supervision monthly and during supervision they discussed their caseloads. Some teams used a red/amber/green rating tool which graded cases by level of complexity. Red represented people with a higher risk that required more team involvement, amber presented medium risk requiring moderate involvement and green represented people with lower risk, requiring minimal involvement and moving towards discharge to primary care services. This tool was used to be able to balance the amount of cases and capacity on staff caseloads.

Staff members employed by the trust received comprehensive induction training. All staff members including agency staff received an onsite local induction. This followed a checklist of tasks and orientation activities that should be completed with staff as part of their induction to the teams.

Information provided by the trust up to March 2016 showed mandatory training courses were up to date with an overall percentage of 88%. Three mandatory training courses were not up to date. These were clinical supervision which was 72%, prevention management of violence and aggression which was 71% compliance rate and medicines management that had a completion rate of 78%.

Across the teams that we visited there was adequate medical cover. Consultant psychiatrists were integrated into teams. Managers told us that if they could add issues with medical cover to their local risk registers and escalate this to their managers if needed. Where managers had identified that there was insufficient medical cover previously, they told us that this had been resolved through use of additional locum consultant psychiatrists. Patients told us that they accessed a consultant psychiatrist when needed sometimes the same day or the same week when needed depending on their need.

## Assessing and managing risk to patients and staff

Teams assessed the risk to patients and staff promptly. We reviewed 42 care records during our visit. There was evidence of the risk assessment process beginning when

# Are services safe?

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

referrals were received at initial triage. Staff told us that when they receive referrals they contacted referrers for further information. If necessary staff contacted the police for further information around risk. Where patients had received involvement or were known to services, staff told us that they look at previous information on the electronic patient record system. Staff told us that they checked for any alerts and previous information on the electronic patient records before they make initial contact with patients.

The teams used the Functional Analysis of Care Environments risk profile in the assessment of patient risk. We reviewed 42 care records during our visits. Risk assessments were comprehensive. Risk assessments considered personal history, social circumstance, forensic history, treatment related risks, clinical symptoms and behaviour as indicators of risk. There was recording of both current and historical risks in all risk assessment. All risk assessments were scored to generate an overall risk status. Risk assessments were updated regularly to reflect changes in patient risk. Staff reviewed some risk assessments at a maximum interval of every six months where there was minimal change to patient risk. Staff recorded risk reduction actions that were put in place. For example, visits to people's homes were to be completed with two members of staff where there was increased risk. Alerts were present on the electronic patient record system to reflect current patient risk.

Crisis plans were integrated into care plans for all people who used the service. We reviewed care records and comprehensive crisis plans were in place. Crisis plans contained information for patients about who to contact when they were in crisis. Patients told us the information that was in their crisis plans and confirmed that they knew who to contact in an emergency and had the contact details for the crisis team. We did not see any use of advance decisions.

Changes in patient's health were responded to promptly by staff. Patients told us that they could contact the teams and they could speak to someone in the team straight away. The duty worker was available to contact about any deterioration in people's mental health. Staff visited patients or saw them in clinic the same day if needed. Staff told us that there was flexible cover provided by medics to ensure that people can be seen promptly when their mental health has deteriorated.

A waiting list protocol was used by teams. The procedure for patients on waiting lists was to prioritise people on waiting lists based on patient need and risk. Staff used an unallocated case monitoring tool to assess patients on waiting lists. Cases on the waiting list were rated red, amber and green. Red indicated the cases which were a priority for allocation and where appropriate contact was made with the crisis teams to assist. Waiting lists were monitored by managers daily and there was a system in place where staff contacted patients on waiting lists at least once every four weeks and completed a welfare check conversation. Staff would reassess patient need and risk and would prioritise patients waiting based on this information prioritising those with higher levels of risk as priority.

Safeguarding training was mandatory for all staff. All staff received training in safeguarding adults, safeguarding children and safeguarding children level 2 as part of their mandatory training. Staff were aware of the trust's safeguarding policy and told us that they could find this on the trust's intranet. All staff knew how to recognise potential safeguarding concerns and what action they should take. Staff provided examples of action they could take which included; ensuring the immediate safety of the individual and reporting the concern to their manager and local authority. Staff were able to describe different types of abuse and neglect and tell us possible warning signs that may indicate a safeguarding concern. Safeguarding was a regular item on the multi-disciplinary meeting agenda and business meeting agenda.

Pharmacists regularly visited teams to completed checks on medication, records and storage. We saw appropriate storage, transport and dispensing of medication. Medication was stored securely and stored in fridges where appropriate. Staff recorded temperatures of clinic rooms and fridges to ensure medicines were stored at the correct temperature to prevent deterioration.

Good personal safety protocols were in place. The trust provided lone working equipment to all staff. There was a lone worker policy in place that all staff followed. Staff told us that they checked for alerts on the electronic patient record system prior to any visits. If needed staff visited in pairs where there was an increased risk identified. Prior to leaving the team base staff ensured that their colleagues knew where they were going by using a whiteboard and electronic diaries. All staff were provided with a Reliance

# Are services safe?

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

identification card holder that was attached to a lanyard with break points. The Reliance equipment was worn by staff at all times. Prior to visiting in the community staff completed a signal check to check that the device is within signal range and they state the address they were visiting. At any time the reliance lanyard can be triggered to indicate that staff were in difficulty and needed assistance. This immediately links to a call centre and a call handler could hear what was happening at the location of the staff member through the equipment. The call centre contacted emergency services if needed directing them to the address that the staff member stated that they were at prior to the visit.

Team administrative staff knew procedures to contact staff when they did not arrived back to the team base at the expected time. This was escalated to management when there was no response from the worker. All staff were able to tell us about the procedures that were in place for lone working. Managers received lone worker equipment usage reports. Staff use of lone worker equipment was discussed in supervision.

## Track record on safety

In the period between, 1 January 2015 and 31 December 2015, the trust reported 49 serious incidents in relation to community mental health services for adults. This was 33% of the serious incidents that the trust reported during this time period. Forty eight of these incidents were categorised as unexpected / avoidable death or severe harm to patients, staff or public. The other incident was not categorised.

Trusts are required to report serious incidents via the strategic executive information system. Between 1 January 2015 and 31 December 2015 adult community adult mental health services reported 23 serious incidents. Seventeen of the incidents concerned met the serious incident criteria. This was 74% of incidents reported overall. These all concerned patient deaths in the community.

## Reporting incidents and learning from when things go wrong

A web based incident reporting system was used to report all incidents. All staff accessed incident reports via the trust's intranet. Staff told us that they report incidents using the web based form which adapts depending on the type of incident being report and the options selected in the form. All staff could explain what types of occurrences should be reported as incidents. Information provided by the trust stated that the community mental health teams for working age adults reported 373 incidents between 1 April 2015 and 30 April 2016. Fifty seven percent of incidents reported were safeguarding incidents. This was followed by incidents involving death at 12% and incidents involving violence and aggression at 10%.

Staff told us that one of the trust's values was about honesty and transparency and could explain the responsibilities of the duty of candour. Staff explained that when something went wrong investigations were completed. Following investigation feedback was received about the findings. This information included the changes that were going to be made as a result and an apology provided when appropriate.

Incidents and the outcome of investigations were discussed in team meetings and key cards were sent out to staff by the trust to share learning from incidents external to the community mental health services for adults. There were individual de-brief sessions with staff following serious incidents. Staff felt that they were supported by their managers following incidents. Staff told us that changes had been made to practice following incidents and there was learning from when things go wrong. For example, staff told us that a letter was sent to the wrong person with the same initial and surname as another person who used the service. As a result changes had been made to administrative processes to minimise the risk of this occurring again.

# Are services effective?

Outstanding



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

## Our findings

### Assessment of needs and planning of care

We reviewed 42 care records. There was a holistic approach to the assessment process. We saw that teams completed comprehensive assessments. Staff told us that a multi-disciplinary team completed assessments. Social workers, occupational therapists, nurses, support workers and consultant psychiatrist took part in completing assessments with people. The personal background of people was an integral part of the assessment process. Patients were asked to provide background information by completing a form prior to their assessment to gather information. The care planning process was started at initial assessment stage. Crisis plans were integrated into care plans. Patients left their initial assessment with a crisis plan in place. Assessments included baseline physical health checks.

Care plans were written in a holistic way including patient's mental health needs, physical health information, relevant information about their personal history, recognising signs of becoming unwell and crisis information. Staff reviewed care plans regularly and all care plans contained crisis and relapse prevention information that was specific to the individual. Records were recovery orientated and there was good monitoring of physical health recorded. The teams offered annual health checks to people. The teams monitored physical health of people regularly through physical health clinics for high dose anti-psychotic therapy, clozapine and lithium. Staff recorded all contact with people in progress notes. We saw that staff considered mental state, capacity and risk at every interaction and recorded this in care records.

There was real-time information available across teams and services. The teams stored care records electronically on the patient record system. Access to the patient record systems was secure. Staff required a user account with password access. All staff had access to electronic records. One system for patient records was used across the trust. All information was accessible to staff in different teams and services. When cases were transferred across teams and services all staff had access and information was available immediately electronically. Some paper records were kept such as medication charts, Mental Health Act paperwork relating to Community Treatment Orders. Paper records were stored securely. Managers told us paper

records were sent to medical records department when they were not needed and these were scanned onto the electronic patient record system. We saw scanned complete medication charts and Mental Health Act paperwork on patient's electronic records.

### Best practice in treatment and care

Medication was mostly prescribed in accordance with guidance from the National Institute for Health and Care Excellence. Patient's told us that staff discussed with them different treatment options available and explained to them the possible side effects that they could experience. The trust provided information leaflets to inform patients of treatments available and side effects. Teams monitored side effects through monitoring of physical health and through patient's feedback from using self-assessed rating scales.

However, prescriptions for intramuscular injections of anti-psychotic medication were not always reviewed every six months. National Institute for Health and Care Excellence guidance recommends medical practitioners should review these prescriptions every six months. We reviewed 63 kardex medication charts. We found six medication cards in use which had exceeded six months since the last prescription review date. We found four medication cards in use which did not state an injection site for the medication to be administered. The trust policy states that prescribers must specify a review date with a maximum interval of six months and prescriptions must be reviewed at least every six months by the responsible medical practitioner. We informed managers of this on the day of our inspection and they told us that they would address this immediately.

There was an extensive range of psychological therapies recommended by National Institute for Health and Care Excellence available. Staff were trained in different types of psychological therapy skills. Teams provided psychological therapies for groups and individuals. Psychological therapies available included cognitive behavioural therapy, family therapy, dialectical behavioural therapy, graded exposure, behavioural activation, psychodynamic art therapy, spiritual therapy and eye movement desensitisation and reprocessing therapy.

We observed different therapies taking place such as one to one graded exposure therapy in the community. We spoke with patients who accessed dialectical behavioural therapy

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groups at North Tyneside community mental health team at Hawkeys Lane. Patients told us that initially they were sceptical and thought that the groups would not work for them, however, they have found that by attending and engaging in the group they had developed friendships and found peer support. Patients told us that they related to the modules the groups covered, that they developed concentration skills and could manage emotions better. The team ran two dialectical behavioural therapy skills groups each week which lasted for two hours. The programme was 12 months long and team had run the group for three years. The programme of the groups was on an eight week cycle which consisted of two weeks of mindfulness sessions and six weeks of teaching. Some of the skills covered by the group were around distress tolerance, emotional regulation and interpersonal skills.

Patient's religious and spiritual needs were supported and included in their care and treatment by community adult mental health services. Sunderland South Community Treatment Team worked collaboratively with the trust chaplaincy service to link religion and spirituality into mental health recovery and treatment. Staff put forward patients who they worked with for involvement from the chaplain. The chaplain completed joint visits to people with staff to work with them around spirituality and religion in recovery. The chaplain held a small caseload and had dedicated time per week to work with people who used community based services in Sunderland Area. The chaplaincy worker continued their involvement through the community to inpatient and onto rehabilitation with people when needed. Regular pathway meetings took place where chaplaincy service attended.

Sunderland South team had developed a waiting list group for psychological therapy. Where people were waiting for individual psychological therapy with psychologists in the team patients were offered the opportunity to attend group sessions. This group was starting when we completed our inspection.

The teams that we visited provided support with housing and benefits. Where more specific knowledge was required teams worked with and signposted to other organisations. The trust contributed funding to local authority for mental health trained workers to provide support to those at risk of homelessness including support with rent arrears, accommodation and neighbour relationships.

There was a robust system in place to identify and monitor people's physical health. Teams followed a flow chart which detailed the process to identify physical health checks that were appropriate. Initial assessments included baseline physical health checks which measured weight, height, body mass index, pulse and blood pressure. Blood tests for glucose and lipids were taken and the personal and family history was recorded. Following assessment staff used the Lester tool to identify appropriate physical health monitoring and interventions. The Lester tool is a guide in poster format to assist health workers in delivering safe and effective care by improving the physical health of people that have mental health needs. NHS England in partnership with NHS Improving Quality, Public Health England and the National Audit for Schizophrenia devised the Lester Tool.

Community mental health teams used a flow chart which identified which physical health checks and interventions should be completed. These included medication reviews, basic physical activity advice, nutrition counselling and intensive structured lifestyle education. The process specified checks required for patients taking clozapine, lithium, anti-psychotic, high dose anti-psychotic therapies. These checks took place on a time specific basis depending on the individual and their treatment. Clinicians used a physical health and treatment request tool to request packages of physical health and intervention monitoring. This tool grouped together different physical health checks into packages which were numbered. It identified which staff level was responsible for completing. For example, physical health monitoring was completed by trained support workers and nurses led physical treatment monitoring.

Staff checked patients' levels of clozapine, lithium and anti-psychotic levels in the blood regularly. These physical health checks were completed at different intervals. Possible intervals were: weekly, fortnightly, monthly, three monthly, annual and post titration monitoring depending on the individual and stage in their treatment. The system included flow chart processes for all clinics which detailed each stage of the clinic from clinic preparation to post clinic recording on patient records. Tasks were colour coded which represented different disciplines in the team such as, administrator, support workers and clinicians.

The physical health of patients was important to staff. We observed clinics during our visits and saw that staff



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recognised that patients' physical health was important. Clinical staff had read only electronic access to check physical health records from GPs to check test results. Patients and their carers told us that staff cared about their physical health as well as their mental health.

The trust had a Commissioning for Quality and Innovation framework target for 2016/2017 to improve and embed the use of clinician and patient outcome tools into clinical practice. Teams used a mental health clustering tool to record summary of assessment, risk and needs of people. Clinical rated outcome measures were completed by staff using Health of Nation Outcome Scales. Outcome measures were also measured based on patient rated outcome and experiences through use of the Short Warwick-Edinburgh Mental Well-being Scale and the Friends and Family test questionnaires that people are asked to complete. Teams used the Liverpool University Neuroleptic Side Effect Rating Scale. This is a tool to assess and monitor the side effects of anti-psychotic medication. Patients were asked to rate on a scale how frequent they experience specific side effects. Other outcome measures including Goal Attainment Scaling and Recovery Star were used with people routinely.

Clinical audits regularly took place. The trust uses a quality monitoring tool which creates the themes for clinical audits. Other audits are completed at a local level by staff. An audit was completed across community adult mental health services in May 2016 into the reading of rights for patients subject to community treatment orders. The findings of this audit identified that across teams that patients were not being read their rights every three months. The trust policy states that patients should be read their rights every three months. Teams developed action plans to rectify this and the findings of the audit were discussed in team meetings with all staff. The action plans aimed for all patients subject to community treatment orders to have had their rights read by July 2016. Clinical staff took part in clinical audits regularly. Clinical staff told us that they had completed local audits into medication and personality disorder and referral to diagnosis analysis of people with bi-polar disorder at the Oxford Centre community mental health team.

## Skilled staff to deliver care

The staff working in the teams came from a variety of different professional backgrounds. Teams were comprised of consultant psychiatrists, social workers, psychologists,

occupational therapists, nurses, assistant practitioners, support workers, peer support workers, chaplain and administrators. The teams worked together to share knowledge and experience. When another team needed support; staff shared their time and experience across teams to assist. For example, some teams had nurses with specialist knowledge around eating disorders. Where needed this nurse worked across teams to provide this specialist input or advise colleagues from other teams.

There was a commitment to developing staff skills, competency and knowledge across the teams. Managers told us that increasing staff skills could enable teams to provide high quality and evidence based care. Managers used team specific training stars to identify staff training and development needs. In staff supervision and appraisal, staff discussed their training needs and rated their skills based on the five stages of the clinical skills training star. The clinic skills training star was a scale of 1 to 5 where staff rated their competence and knowledge in areas of practice. Information was collated to develop team training stars and forecast training needs of the teams based on team feedback, patient need and evidence base. Completed training stars identified what training staff required based and the level needed was role specific. Teams used a training star matrix to score training on a scale of 1 to 3. One indicated training not completed, a score of 2 indicated training in progress and 3 indicated training had been completed. Some of the training courses available for all staff were: coping with voices, trauma awareness, compassion focussed awareness and dual diagnosis awareness. Courses that were available for some qualified staff were dual diagnosis diplomas and family interventions at various levels.

The trust had an induction process which included training courses and a local on site induction to the teams. Induction training met with the Care Certificate standards for care. Staff told us that they felt confident in their roles and had access to additional training to increase their skills and knowledge. Staff had access to their own training record on the dashboard system where they could access when their training was due to expire.

Regular team meetings took place. All staff attended team meetings. Team meetings were completed weekly and all members of the multi-disciplinary teams attended these.

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Staff performance was measured through the appraisal process. The appraisal process was completed annually. Clinical staff received supervision monthly and non-clinical staff bi-monthly.

We reviewed supervision records and these confirmed that staff received supervision in with the trust target. Information provided by the trust of percentages of appraised staff at end of April 2016 was 86% of non-medical staff and 100% of medical staff. Revalidation had been completed by all relevant staff at the end of April 2016. Revalidation is the process of re-registration and clinical staff evidencing that they are fit to practice. Managers told us that they manage performance issues promptly through increased supervision, reduction in caseload and monitoring performance.

## Multi-disciplinary and inter-agency team work

Regular and effective multi-disciplinary meetings took place. These involved all members of the multi-disciplinary teams. Teams met at least once a week and all staff ensured that they attended team meetings.

We observed different types of multi-disciplinary and inter-agency team work. We attended a referral huddle which took place three times per week at the Hadrian Clinic and was attended by a consultant psychiatrist, psychologist, clinical lead, social worker and a secretary. We observed a complex case discussion that took place with a nurse, consultant psychiatrist and a manager at North Northumberland community mental health team.

Effective handovers and transfers of care between teams took place in the organisation. We observed a 72 hour meeting on an inpatient ward that was attended by staff from the team we visited. Staff told us that when there was a transfer of care from another service to the team they met with the existing staff involved to handover the case and introduce themselves to the person.

Teams worked with other agencies such as local authorities and primary care services to provide effective services. Teams attended regular interface meetings with local authorities, primary care services and third sector organisations.

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

Mental Health Act training was a mandatory training course for all staff. Information provided by the trust stated that

86% of staff had received training in the Mental Health Act as of May 2016. We spoke to 72 staff members during our visit and found that they had a good understanding of the Mental Health Act and the Mental Health Act Code of Practice. The trust had a central office for advice around the Mental Health Act. All staff told us they could contact the Mental Health Act office if they needed advice about the act.

We saw that consent to treatment and capacity requirements were adhered to for people that were subject to Community Treatment Orders. Mental Health Act paperwork was in place. CTO12 and CTO11 forms were completed where appropriate. A CTO12 form is required for people subject to community treatment orders that consent to receiving treatment and is completed by the approved clinician. A CTO11 form is required for people subject to community treatment orders that do not consent or are unable to consent to treatment. A CTO11 form must be completed by second opinion approved doctor appointed by the Care Quality Commission to approve treatment. Medical records scanned CTO12 and CTO11 forms and assessment of capacity onto the electronic patient record system and copies were attached to medication charts where appropriate.

Patients did not always have their rights read to them at regular intervals. The Mental Health Act and Mental Health Act Code of Practice states that people that are subject to the act should have their rights read at regular intervals. The trust policy stated that patients should be read their rights under the act every three months. The trust completed an audit in May 2016. It was identified that the reading of rights was not embedded into practice. Information provided by the trust showed that there were 147 people subject to community treatment orders receiving services from community mental health teams for adults of working age. Sixty seven percent of patients had had their rights read in the last three months. Managers across the teams told us that they had identified through audit that rights were not always been read to patients every three months. Communication had come from the medical director to responsible clinicians and teams had put in place action plans to address this and expected all patients to have their rights read by July 2016. Teams discussed reading of rights and this was minuted in team meeting minutes and business meeting minutes.

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Patients had access to Independent Mental Health Advocacy services. Staff told us that they accessed and supported engagement with Independent Mental Health Advocates when working with people. Three advocacy organisations were used across the services that we visited. These were:

- Your Voice Counts which covered Gateshead, Newcastle and South Tyneside
- Adapt North East which covered Northumberland
- Total Voice Counts which covered Sunderland.

We reviewed records that showed appropriate involvement of Independent Mental Health advocates.

## Good practice in applying the Mental Capacity Act

The Mental Capacity Act is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. Training in the Mental Capacity Act was a mandatory course provided by the trust. Overall, the teams had 89% training compliance in the Mental Capacity Act. The trust had policies and procedures on the Mental Capacity Act.

Staff knowledge and confidence working with the Mental Capacity Act was variable. All staff told us that they had received training on the Mental Capacity Act. Some staff recalled to us the five statutory principles of the act and described to us how they applied the act in practice. These staff members explained to us some examples of people

where they had used the Mental Capacity Act to assess people's capacity to make decisions. Other staff were able to tell us the basic purpose of the act and explained that they would refer to the trust policy and seek advice when needed. These staff told us that they did not often work with people who lack capacity. However, all staff told us that if they needed support with the Mental Capacity Act they could :

- Refer back to trust's policies on the intranet
- Contact the mental health act office and safeguarding office at St Nicholas Hospital
- Speak to their colleagues and consultant psychiatrists for advice
- Speak to the local authority social work teams.

During our inspection we reviewed 42 care records. We saw that staff recorded consideration of patients' capacity in progress notes from their visits. For example, where a patient had expressed a view that could be seen as unwise, staff had ascertained if the person could understand, retain, weigh up and communicate their decision and documented in the progress notes that the patient had capacity to make that decision. We did not see assessments where patients had been assessed as lacking capacity and the best interest process being followed.

We asked staff if the trust monitored adherence to the Mental Capacity Act. None of the staff that we spoke to knew if there were arrangements in place to monitor the adherence to the Mental Capacity Act.



# Are services caring?

Outstanding



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

## Our findings

### Kindness, dignity, respect and support

During our inspection, we spoke with 34 patients. The feedback that we received from patients was universally positive about staff interactions. Patients told us that staff were respectful, polite, helpful and understanding. Patients told us that staff were always positive, understanding and honest. When asked about how they felt about staff, patients told us that staff were always welcoming and showed compassion towards them. Patients told us that when they visit the team they are always greeted by all staff and are accommodated. When asked about their experience of using the services patients told us that “staff want you to get better” “they care about my well-being” and “staff are interested in my care including my physical health as well”. Patients told us that they felt listened to and that staff have “normal conversations” with them. One patient told us that when they contact the team that the phone is answered straight away and that they get to speak to the right person.

Patients were involved in their care and treatment and staff worked in a person centred way. We observed staff completing home visits to patients, observed clinic appointments and attended multi-disciplinary meetings involving patients. We saw that staff always introduced themselves and explained their role to patients. We found that staff were polite and empathetic. We observed that staff used language that was easy to understand and gave patients time to express their views and needs. Staff asked patients how they were feeling and provided reassurance to patients when needed. Patients appeared relaxed and comfortable when staff were interacting with them.

Staff considered patients’ emotional and social needs. Staff discussed individual recovery goals with patients and encouraged social interactions. We observed that staff had a good understanding of the patients that they were working with and had awareness of their individual needs in order to provide the appropriate support. For example, one person had difficulties with memory. We saw that staff introduced themselves and their role, staff then provided a summary of their previous visit. Staff suggested that using a dictaphone to record information which the person could

play back to themselves when they needed to as a memory prompt may be useful. We observed staff asking for consent to speak to another staff member about organising support to purchase and use this.

### The involvement of people in the care that they receive

Patients told us that staff involved them in writing their care plans. We met with patients who used the service. Most patients said that they had a copy of their care plan and described to us what was in their care plan. Some of the patients that we met showed us their copy of their care plans. Some patients told us that they were offered but did not want a copy of their care plan.

Patients were involved in the creation of their care plans. Staff recorded the involvement of patients in care plans. Information about whether patients had or had not received a copy of their care plan was recorded. The reason why patients had not received a copy was recorded. For example, if the reason was that the patient did not want a copy of their care plan then staff recorded this in their records.

We observed care programme approach reviews which included patients. Staff ensured that patients knew when their care programme approach reviews were and patients had the opportunity to invite their families and carers to attend.

Wellness recovery action plans were used by some teams. Wellness recovery action plans are documents which are goal orientated and promote getting well and staying well. We observed patients being involved in the creation of their own wellness recovery action plans. Patients told us when they were expecting to be discharged by teams back to primary care service. Some patients told us that they were apprehensive but positive about being discharged from the teams. Patients told us that there had been clear communication from staff at the beginning of their involvement that they would receive episodic and not long term care unless there was a clear rationale.

Participation in social, recovery focused and educational groups was encouraged by staff. The Recovery College offers free access to courses and programmes. Some patients accessed courses through the Recovery College independently.



# Are services caring?

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

We spoke with 15 carers of patients who use services. Carers told us that they feel that staff supported and included carers well. Carers said that they felt that staff have the patient's well-being and interests at the centre of their work and that they would consider staff "more of a friend than a member of staff". When asked about interactions with staff carers told us that staff are supportive and respectful and that with the person's consent they are always kept up to date with the treatment of family member and receive copies of care plans. Carers felt that staff listened to them and responded promptly to concerns. Carer drop in sessions were scheduled to run alongside clinics. This meant that when carers accompanied patients to clinic they could access support for themselves at the same time. Staff told us that previously carer support workers were a part of their teams but now carer support was seen as part of everyone's responsibility in the teams. Carers told us that dedicated carer support work is now not available however, all carers said that they felt supported by staff and included in the care and treatment that their family member receives.

Teams involved carers and young carers in training. Some of the teams that we visited had delivered training to carers and young carers around about understanding mental health. Staff training incorporated the perspective of carers. Carers participated in delivering this training to staff.

Information was available to facilitate patients' involvement in the care that they receive. Information regarding local advocacy services was displayed at the team bases that we visited in the reception areas. There were leaflets available that patients could take away with them. There was a range of information sheets about different mental health needs and different treatment options available. Patients told us that they can find

information sheets about mental health needs and treatments available in the reception areas. Patients also said that the staff who work with them bring or post information sheets to them at their home if they are not expected to visit before patients need the information.

Patients told us that they had not been involved in the recruitment of staff. Staff told us that the trust completes recruitment centrally for all services. Patients said that they would like to be involved in the recruitment of staff for the teams involved in their care.

Patients who use the service were regularly asked to provide feedback on the service through various methods. One of these was through the Friends and Family test. Between February 2016 and April 2016, 216 patients completed the survey and based on the question "would you recommend this service to family and friends?" Only 2% of patients who responded said that they would be unlikely to recommend the service. Information provided by the trust stated that 45% would be very likely, 38% would be likely, 10% were undecided and 5% did not know if they would recommend the service.

At Sunderland South Community Treatment team there was an interactive feedback method where patients were encouraged to place a plastic token into one of two tubes which were either labelled yes or no. The question was based on today's visit would you recommend this service. The team held records on the numbers of patients who had voted yes and no.

The teams encouraged patients to give feedback in the trust's points of view stakeholder survey. Some of the patients told us that they had received surveys to give feedback about groups they attend to give local feedback about their experiences.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

Teams had either an individual statement of purpose document or an operational policy per team. These outlined the aims, functions and remit of the teams. Teams had referral criteria. Referral criteria stated what age and degree of mental health needs the team would work with. The Trust Waiting Times Quality Priority from referral to being seen by the multi-disciplinary team was 18 weeks. As of 31 March 2016, 99.5% of referrals had met this target.

Each team had a duty worker on site every day. Duty workers triaged referrals that teams received against referral criteria. Where referrals were not appropriate to the teams they were signposted or sent to appropriate services. Teams had allocated urgent assessment clinic time each week. Urgent referrals were seen promptly for assessment in these dedicated clinic times. When needed teams prioritised visits to patients in the community. Staff completed same day urgent visits for patients on the team caseload and to urgent referrals when this was needed.

Staff told us that there was good communication between teams and the crisis services. Crisis services provided out of hours cover and urgent support to patients experiencing mental health crises. The teams worked with crisis services to provide a transfer of care to patients who no longer require crisis services.

We spoke with patients who use the service and their carers. They told us that when they contacted the teams they could speak to someone anytime the team is open to discuss any issues that they had.

The trust had an engagement policy to support teams with engaging with patients who are reluctant to engage with services and treatment. Staff told us that they follow the engagement policy and they consider the capacity of patients who do not engage with involvement from services well. Protocols were in place for when patients do not attend appointments or home visits. Staff told us that they use different methods to remind patients of their appointments such as, letters and telephone call reminders. When patients did not attend appointment they were rescheduled and patients were informed of their new appointment time and date.

Intensive support was provided by the Step Up team. Step Up services are aimed at providing higher levels of involvement to provide care and treatment to patients who are not in crisis or require inpatient care but need more involvement than community treatment and community mental health teams can provide. Step Up work with patients who are reluctant to engage with services. Step Up worked across Sunderland and South Tyneside.

Access to services was flexible. Clinics ran at various times throughout Monday to Fridays. Gateshead Community Treatment Team (non-psychosis) held weekend assessment clinics when needed. Administrative staff informed patients if appointments ran behind schedule. Staff provided cover for short notice staff absences to ensure that appointments were completed or rescheduled as a last resort. Staff informed patients of changes to their appointments and provided an explanation and apology for any inconvenience.

### The facilities promote recovery, comfort, dignity and confidentiality

In all of the teams we visited where patients were seen at trust-owned sites, the facilities were clean, well-maintained and furnished. Interview rooms and clinic rooms were available at most team bases and where they were not satellite bases were used such. For example, at Newcastle West community mental health team patients were seen nearby at the Hadrian Clinic outpatients' department facilities. Plans were in place for refurbishment of teams as part of the trust's transforming care agenda to include increased facilities within team bases.

Interview rooms used to see patients were sound proof to protect privacy. Sunderland South Community Treatment Team at Teleport house had a treatment recovery room. This was fitted with comfortable furniture and entertainment where patients could wait in private after their appointment whilst they were waiting for results.

Patient information was available about different mental health conditions and treatment options. Patient information was accessible in reception and waiting areas of all team bases. Leaflets were available in a range of different languages and easy read format. Team bases displayed information in reception and waiting areas for patients to access leaflets to take away. Posters were displayed about local services such as advocacy and the recovery college community groups. Information was

# Are services responsive to people's needs?

Good 

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

displayed about making comments and complaints about the service. Patients told us that staff brought information to them on home visits or arrange for information to be posted to patients that do not access the team bases.

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

Reasonable adjustments were made for patients that had additional needs. Teams based on the first level had lift access from the main entrances. The lift at Sunderland South community treatment team was not in use due to maintenance issues. Staff told us that the lift had not been in use for a few months and that there was on going communication with the trust and landlord to rectify this. Staff visited patients in the community either at their own home or an alternative community location if they were not able to access the team base due to issues with access whilst the lift was not in use.

Information leaflets were accessible in all teams. Information was displayed in reception and waiting areas for patients to access. Leaflets were available in a wide range of languages. The teams had easy access to interpreter services. Staff told us that when information was not available in the spoken language of a person using the service that interpreters were used to translate information. The information was translated back to ensure that the information has not lost or changed meaning through translation.

Care plans were written in accessible language. We saw a pictorial care plan that was created for a person with a learning disability. This plan was in an easy read format with pictures to enable the person to understand the contents of their care plan. The care plan showed planned activities with pictures that corresponded to the activity and a picture of a telephone was added near the contact telephone numbers on the page as a prompt

Teams responded to the needs of the local community. Teams had workers with specialist knowledge to work with patients. An example of this was that managers told us that

teams were receiving an increase in the referrals of patients with an eating disorder. Some teams had staff with specialist knowledge in eating disorders that were allocated to work with patients who had an eating disorder. Newcastle West team had started an eating disorder clinic which was run by staff that had specialist knowledge and received training.

## Listening to and learning from concerns and complaints

The trust provided information regarding complaints received about community adult mental health services. Thirty five complaints had been received between 1 May 2015 and 30 April 2016. Twenty six of these complaints were upheld. Newcastle West team received the highest number of complaints with seven.

We spoke with 34 patients who used the service. Most patients said that if they needed to complain they would speak to their worker or contact the team and ask how they could do this. Patients we spoke with told us that information about making a complaint was available at the sites. We saw that information was displayed in teams about complaints and Patient Advice and Liaison Services.

We spoke to teams and they described complaints were a way of improving the service by reflecting on how things were done to learn lessons for the future. Staff told us that complaints are always investigated and there were lessons learned from the outcome of investigations. When asked about handling complaints, staff told us that firstly they tried to address concerns informally but if they could not be resolved then they followed the formal complaints process. All staff were aware of the complaints policy and Patient Advice and Liaison Service.

Patient complaints were discussed in team meetings. Any changes in practice as a result of complaints were discussed in team meetings with the team. The trust sent out key cards which were messages from the outcome of complaints and investigations as a memo to teams to share learning across the services.

# Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

The trust had vision, mission and values statements. The vision statement was to improve the wellbeing of everyone we service through delivering services that match the best in the world. The mission statement was: we strive to provide the best care, delivered by the best people to achieve the best outcomes.

The values were:

- Caring and compassionate
- Respectful
- Honest and transparent

The organisation's values were embedded into teams. Information about the organisational values was displayed in the teams that we visited. Staff recalled to us the organisational values and explained how they show the values in their work every day. Staff were motivated and engaged in the work they did and wanted to deliver the best care and treatment that they could.

Staff teams knew who senior managers were. Staff told us that senior managers visit their teams and that they think that senior managers understand their services.

### Good governance

Each team had systems in place to ensure that staff received mandatory training. Teams were provided with governance assurance through access to electronic dashboards. Dashboards showed staff their own training compliance. Managers had access to team dashboard which showed mandatory training rates in real time. The trust target for mandatory training was 85% for all courses with exception of information governance which was 95% target completion rate. Overall mandatory training compliance rate was 88% across the teams. There were three mandatory training courses under the trust target. These were prevention management of violence and aggression 71%, clinical supervision 72% and medicines management 78%. Teams used training stars for additional training to improve the skills of staff teams.

The trust had completed work to improve effective discharge planning from inpatient to community services and facilitate the transition to community services. In August 2015, Northumberland Tyne and Wear NHS Trust

commissioned a consultancy to carry out a productivity analysis of inpatient wards. As a result of this the trust commenced a transformation programme to increase the communication and collaborative working of inpatient and community teams. Contact between community teams and contact with patients on inpatient ward was monitored and discussed through regular meetings between community and inpatient service managers to monitor community attendance at meetings on inpatient wards.

Managers had completed work with teams to try and use resources more effectively. Managers identified that qualified staff were spending time doing administrative tasks. The work was reorganised to free up clinical staff to complete direct care and patient contact with more effective use of administrative staff.

We found services were well managed and had governance structures in place. Staff were clear about the teams' management structures. Staff told us that they felt supported by their managers and colleagues. Managers told us that they felt they had authority to make decisions about their service. Managers could add things to the local risk registers and could escalate these up to the trust risk register where appropriate.

Systems were in place to ensure that staff were appraised and supervised regularly. The trust had a policy on supervision and appraisal all staff told us that they received regular supervision however; information provided by the trust stated that the compliance with clinical supervision for community adults' mental health services was 68%. This was below the trust target of 85%.

Regular meetings took place with external organisations such as local authorities, clinical commissioning groups, and third sector organisations. These meetings were attended by managers and the information from these meetings was communicated back to the teams.

Clinical staff regularly took part in completing clinical audits.

### Leadership, morale and staff engagement

There was an open and transparent culture. Staff told us that they were able to raise concerns or issues with senior management. Staff were aware of the whistleblowing policy. They felt that teams were supportive and staff felt free from reproach of raising concerns.

# Are services well-led?

Good 

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Staff sickness was average at 5%. There was 7% vacancy rate and the staff turnover rate was 5%. There were no reported cases of bullying and harassment across the service.

Staff told us that they were encouraged in their continuous professional development through further education and received support with accessing funding for education. Some staff accessed further education outside of their job role to develop their skills and knowledge.

## **Commitment to quality improvement and innovation**

The trust was completing work with two adult community clinical teams to evaluate current approaches and attitudes, increase awareness, improve feedback of outcomes information and explore presentation methods.

At the time of our inspection, the Fairnington Centre community mental health team were participating in NHS research into the effectiveness of cognitive behavioural therapy in patients with a diagnosis of schizophrenia that were resistive to treatment. Staff received training in cognitive behavioural therapy as part of the team's participation in research.