CareQuality Commission

Outstanding ☆

Northumberland, Tyne and Wear NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

St Nicholas Hospital
Jubilee Road,
Gosforth,
Newcastle Upon Tyne,
NE3 3XT
Tel: 01912130151 / 01912466800
Website: www.ntw.nhs.uk

Date of inspection visit: 31 May to 10 June 2016
Date of publication: 01/09/2016

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	Behavioural Assessment and Intervention Team	NE2 1QE
RX4E4	St Nicholas Hospital	Sunderland Learning Disability Service	SR5 1NB
RX4E4	St Nicholas Hospital	Northumberland Learning Disability Positive Behaviour Support Team	NE61 2NU
RX4E4	St Nicholas Hospital	Community Team Learning Disabilities	NE2 1QE

Summary of findings

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?	Outstanding	☆
Are services well-led?	Outstanding	☆

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

Contents

Summary of findings

Overall summary

We rated community based services for people with learning disabilities or autism as outstanding because:

- A proactive approach to anticipating and managing risks to people who use services was embedded and was recognised as being the responsibility of all staff. This was reflected in the risk assessments and plans.

- Staffing levels were sufficient to meet the needs of the service. Staffing levels had been estimated by obtaining the advice of staff, carers and other agencies. This model had been implemented in the Sunderland team and was in the process of being rolled out to other teams.

- Staff knew how to report incidents. All staff were open and transparent, and fully committed to reporting incidents and near misses.

- There was a team approach to the prescribing of medication. The approach ensured that psychological and social factors were given full consideration before medication was prescribed. This meant that service users were less likely to be prescribed medication unnecessarily.

- There was a truly holistic team approach to assessing, planning and delivering care and treatment to people who use services. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence based techniques were used to support the delivery of high quality care.

- We found the continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. This was reflected in the specialist training provided and the effectiveness of multidisciplinary meetings.

- Staff had close links with external agencies, including them in multi-disciplinary team meetings where appropriate. The systems to manage and share the information that was needed to deliver effective care were fully integrated and provided information across teams and services. This was reflected in the training provided to external care providers and families.

- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People that staff went the extra mile and the care they received exceeded their expectations.

- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.

- There were high levels of staff satisfaction across all teams. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff across all teams. Staff at all levels were actively encouraged to raise concerns.

- The leadership drove continuous improvement and staff were accountable for delivering change.

- Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. This included working with other agencies to reduce the number of people with learning disability or autism living away from their local communities or in long stay hospitals.

Summary of findings

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

Are services safe?

Good ●

We rated safe as good because:

- Medication was effectively monitored and reduced wherever possible. Psychiatrists were supported by positive behaviour support nurses and pharmacists who routinely offered professional guidance on alternative strategies to medication and ways to reduce medication use. This meant that people with learning disabilities and autism were less likely to be prescribed unnecessary medication and experience negative side effects.
- There were robust processes in place to report incidents and safeguarding concerns. Staff understood safeguarding procedures and knew how to report and what to report.
- Staff completed comprehensive risk assessments in a timely way. They included current and past history as well as positive protective factors.
- Staffing levels were good in all teams. Staff did not feel overwhelmed by their caseloads and the skill mix was good.
- Service users had rapid access to a psychiatrist in all teams. Psychiatrists attended multi-disciplinary team meetings and offered same day appointments to urgent referrals.

However,

- Not all teams were following the trusts lone working policy. The Newcastle teams did not check on the safety of staff at the end of each day. The entrance to the Newcastle team's location was dated and unwelcoming. There were plans to assess the suitability of the building in the near future.

Are services effective?

Outstanding ☆

We rated effective as outstanding because:

- There was a strong multi-disciplinary approach to care and treatment which was holistic and comprehensive. Multi-diciplinary working was embedded within the service. Different professionals worked collaboratively throughout the service user pathway to review, plan and deliver care and treatment. This meant that a range of professionals were able to input into assessments and care plans and helped ensure the full needs of the service user were met.
- Staff had a strong ethos of teamwork and sharing best practice.

Summary of findings

- Staff had strong working relationships with outside organisations. This included providing specific training to third sector providers. This meant that other providers were able to deliver person centred, individualised care in accordance with the care plan.
- There was a strong emphasis on promoting equality in healthcare and proactively seeking to engage primary care organisations to make reasonable adjustments. This meant that people with a learning disability or autism were now less likely to have poor health outcomes.
- People with challenging behaviour had access to positive behaviour support plans and interventions to reduce incidents. This meant that people who present with behaviour that challenged were cared for in the most effective way.
- Staff had access to specialist training that was promoted by the team managers. This ensured that staff had the appropriate skills to deliver safe care.

Are services caring?
We rated caring as outstanding because:

Outstanding ☆

- The service actively sought to involve families and carers as much as possible. Views of families were considered important and acted upon.
- Service users and families were active partners in decisions about care and treatment. Families and carers were involved in the assessment, care planning and reviews of service users.
- Staff provided training to families and carers to help them understand the needs of the service user. This allowed families to cope better with challenging behaviour and other issues.
- Families and carers had a named person they could contact if needed. Families and carers were contacted the same day if needed. Families felt the support was personalised and responsive.
- Staff used enabling and positive language in all their interactions. This showed that staff were respectful, professional and caring.
- Staff had access to a range of communication tools. Staff were able to develop individualised communication resources to meet service user needs. This meant that staff had the skills and resources to meet the needs of service users who were difficult to engage. For example staff had developed an anger management tool designed like a comic book to support one individual.

- Staff treated service users and family members with respect, compassion and understanding. They viewed each service user as an individual and took a personalised approach to care. Staff members from external agencies we spoke to told us they felt involved in person centred care when working with the service.
- Feedback on the service from service users and families was very positive.Service users and carers felt supported and confident in the care they received. Service users and family members spoke highly of staff involved in their care. They considered them to be understanding, committed and approachable.

Are services responsive to people's needs?

We rated responsive as outstanding because:

Outstanding ☆

- The service had developed systems and processes that provided intensive and person centred support aimed at reducing the number of admissions to hospital in line with the recommendations from the Winterbourne View Interim Report 2012.
- The service had been developed to allow easy access from referral to treatment and from treatment to discharge. This meant that service users were seen quickly and they were discharged safely with the appropriate support.
- The service had developed links with other organisations to ensure the needs of people with learning disabilities were met. Teams had good links with GP surgeries and hospitals. Staff shared skills, experience and education regarding providing reasonable adjustments. This meant that people with learning disability or autism had better access to essential healthcare services.
- The Newcastle team had developed a breast screening project aimed at increasing the number of women with learning disability and autism attending the breast screening clinic. This was successful and had improved links and understanding in primary care settings.

However :

- Not all leaflets were available in easy-read format for people with learning disabilities and autism. This meant that important information was not easily available to promote safe and responsive care.

Are services well-led?

We rated well-led as outstanding because:

Outstanding ☆

Summary of findings

- Management encouraged staff to participate in research and projects to enhance service development and improve outcomes for service users. Staff were involved in a range of projects. These included the development of new outcome measure and a my healthy year project with service users. The service had been part of the NHS Improving Quality Winterbourne Medicines Programe. This had contributed to evidence based practice and national guidance.

- Senior managers within the service supported staff to build close links with the local authority and other partner organisations. This included a project to reduce the number of people with learning disability or autism living away from their local communities or in long-term hospital settings.

- The trust's vision and values were reflected in the delivery of care. Values were regularly considered in team meetings and during discussions about how best to support service users.

- There were effective governance procedures in place to monitor compliance with training and supervision. There were systems in place to report and manage adverse incidents. Managers were able to submit items to a risk register.

- The transformation programme had been implemented well and the model was managed effectively by senior managers and team managers.

- Morale was high for staff. Staff felt satisfied and proud of their work. Staff received regular supervision and felt supported by management. Managers regularly accompanied staff on home visits to stay connected with the nature of the work. There were opportunities for career progression and leadership development.

- Team working was embedded in the culture of the service. Staff were supportive of each other and worked collaboratively. This meant that service users received holistic care and treatment.

- New systems and ideas were developed by staff and supported by the senior management team. This meant that staff were involved in service design and development of the service. Staff participated in clinical audit.

Summary of findings

Information about the service

Northumberland Tyne and Wear NHS Foundation Trust had six community learning disability teams based across the catchment area. Support was provided to people with learning disability or autism who required support regarding mental health, challenging behaviour and physical health needs. We visited four teams which were,

- Newcastle behavioural assessment and intervention team
- Newcastle learning disability team
- Sunderland learning disability team
- Northumberland learning disability team

The service had an overall vision that each location would have one large integrated team providing services in a multidisciplinary model. Each team would be divided into three streams focussing on physical health, positive behaviour support and mental health.

The Newcastle behavioural assessment and intervention team focussed on the psychological needs of people with learning disability or autism. The team provided services to the Newcastle area and were based at Benton House in Newcastle. There was an emphasis on reducing challenging behaviour by using positive behaviour support plans to encourage improvements in understanding of service user's needs. Positive behaviour support plans are specific individual plans that have considered triggers for particular behaviours and include personalised strategies for de-escalating challenging behaviour. The plans should be developed with the service user at the heart of the model. The Newcastle behavioural assessment and intervention team were changing to the positive behaviour support pathway within the integrated learning disability team in Newcastle.

The Newcastle learning disability team were also based at Benton House in Newcastle. The team were changing into two pathways; physical health and mental health. The physical health pathway had developed links with primary care services and focussed on improving the physical health of service users. The mental health pathway focussed on supporting people with learning disability and autism who also had mental health needs. The two pathways will join with the positive behaviour support pathway to form an integrated learning disability team.

The Sunderland learning disability team was one large integrated team with well established pathway streams. These were physical health, positive behaviour support and mental health streams. The team was based at Monkwearmouth Hospital and provided services covering the Sunderland area.

The Northumberland team provided mental health and positive behaviour support streams. The physical health stream was provided by Northumbria Healthcare NHS Foundation Trust. The team was based at St George's Park in Morpeth and provided services to a large rural area.

Teams were commissioned by the following commissioning bodies

- Newcastle and Gateshead clinical commissioning group
- Sunderland clinical commissioning group
- Northumberland clinical commissioning group

This was the CQC first inspection of this trust using the current methodology.

Our inspection team

Chair: Paul Lelliott, Deputy Chief Inspector (Mental Health), Care Quality Commission

Head of Inspection: Jenny Wilkes, Head of Hospital Inspections, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Jennifer Jones, Inspection Manager (Mental Health) Care Quality Commission

Summary of findings

Sandra Sutton, Inspection Manager (Acute) Care Quality Commission

The team inspecting community mental health services for people with learning disabilities or autism comprised one CQC inspector, one mental health nurse and one occupational therapist.

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 service users, 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 service users, carers and staff at focus groups.

During the inspection visit, the inspection team:

- visited four of the teams based at three sites and looked at the quality of the environment and observed how staff were caring for service users

- spoke with four service users and six carers

- spoke with the managers for each of the teams

- spoke with 24 other staff members; including doctors, nurses and psychologists

- spoke with three staff from external organisations

- attended and observed nine multi-disciplinary meetings and service user contacts

- collected feedback from one service user using comment cards

- looked at 17 care records of service users

- examined six service user prescription charts

- carried out a specific check of the clinic and treatment rooms at Sunderland and Newcastle.

- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

People who use this service said that staff were respectful, compassionate and cared for their wellbeing. Service user questionnaires completed in March 2016 provided positive feedback regarding the service. Service users, carers and outside organisations have continually given good feedback about staff and services during the inspection process.

Good practice

There was a process in place to ensure that National Institute for Health and Care Excellence guidance was being followed in respect of the prescribing of medication. In Sunderland the psychiatrist was supported by a nurse and a pharmacist when deciding whether to prescribe medication to a service user with learning disability or autism. The nurse led on what alternative interventions could be suggested and tried.

Summary of findings

The pharmacist supported the psychiatrist on how to minimise the dose of medication for a shorter period of time. There was a plan in place to review the effectiveness of the medication and reduce it in a timely manner if no positive change was noted. This model of prescribing was in the process of being introduced to other teams.

The Sunderland team met on a daily basis to discuss service users who were at risk of relapse. The aim of the meeting was to alert all relevant agencies of any mental health or challenging behaviour crisis, to respond quickly and for all agencies to be well coordinated. There was a multidisciplinary approach to service user care and treatment which was holistic and comprehensive. The meeting was attended by all staff within the team as well as local authority social work teams, inpatient and crisis staff. Clinical advice and guidance was offered from occupational therapists, nurses with various specialisms, psychologists, speech and language therapists and psychiatrists. If necessary extra support in the community could be offered to service users which was provided by the team. Other teams meet on a daily or weekly basis and mirrored this team approach.

The service had excellent working relationships with external organisations. The teams provided service user specific training to third sector organisations working in partnership to provide the best care for service users. This was regular and routine practice. Feedback from external organisations highlighted good liaison and involving them in the care planning process. External organisation staff said they felt valued and involved in person centred care.

The Newcastle behavioural assessment and intervention team were involved in a joint housing venture with the local authority and other providers. The aim was to reduce the number of people with learning disability or autism living in hospitals and outside of the local area. This reflected the recommendations outlined in the Winterbourne View Interim Report 2012. The Newcastle behavioural assessment and intervention team provided individualised specific training to the staff teams who were delivering the care. The training was based on the positive behaviour support model. The Newcastle behavioural assessment and intervention team were responsible for identifying suitable service users who would benefit from the scheme.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The trust should ensure that lone worker procedures are followed in all teams.

- The trust should make all necessary leaflets available in easy-read format for people with learning disability or autism.

Care Quality Commission

Northumberland, Tyne and Wear NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Behavioural Assessment and Intervention Team	St Nicholas Hospital
Sunderland Learning Disability Service	St Nicholas Hospital
Northumberland Learning Disability Positive Behaviour Support Team	St Nicholas Hospital
Community Team Learning Disabilities	St Nicholas Hospital

Mental Health Act responsibilities

Mental Health Act training was mandatory for all relevant staff. At the time of inspection, 88% of staff were up to date with this training.

Knowledge and understanding of the Mental Health Act was good and staff knew the process for requesting Mental Health Act assessments.

Consent and capacity to consent had been considered by staff and documented in service user's notes.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for all relevant staff. At the time of inspection, 89% of staff had completed and were up to date with this training.

Knowledge and understanding of the Mental Capacity Act and the five statutory principles was good. Issues regarding capacity were recorded and documented in service users notes.

Families, carers and other professionals were involved in best interest's decisions. Staff utilised various communication methods to ensure service users views and wishes were acknowledged.

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

Personal alarms were available for staff using the interview rooms. This meant that if staff felt at risk they could sound the alarm and staff would attend to assist. There was a system in place to indicate to staff which room was requiring support. In Sunderland, there were daily designated responders identified to fulfil this role. In Newcastle, reception staff would respond initially and request further support from clinicians if needed.

Treatment and clinic rooms were clean and tidy. Medication cupboards were locked and the key held by a registered nurse. Equipment for physical health had been checked regularly. Treatment and clinic rooms were available at the Sunderland and Newcastle locations. Medicines were stored correctly and were in date. In Sunderland, depot injections were ordered by staff from the hospital pharmacy and delivered to the team by the hospital porters and stored in the fridge. There was a system for signing in and out of the building. However, the daily fridge temperature check in Sunderland had been missed on four days out of 30.

Service user areas in all locations were clean with furniture that was well maintained. Waiting rooms were bright and airy and service user art work was displayed at the Sunderland location.

Safe staffing

Teams consisted of a mix of professional's dependant on the nature and need of the team and local area.

The Northumberland team had 12 substantive staff which included

- four nurses
- one occupational therapist
- three psychologists

The Newcastle behavioural assessment and intervention team had seven substantive staff which included

- two nurses
- four psychologists

The Newcastle learning disability team had 38 substantive staff which included

- 13 nurses and nursing assistants
- four psychologists
- 14 speech and language therapists
- six occupational therapists

The Sunderland team had 67 substantive staff which included

- 35 nurses and nursing assistants
- five psychologists
- two occupational therapists
- four speech and language therapists
- four physiotherapists

Each team also had access to psychiatrists within the teams and a range of administrative support.

There were three nursing vacancies in the Sunderland team which had recently been recruited to. There was also a nursing vacancy in the Newcastle behaviour and intervention team. There were no issues with sickness or absence rates in any of the teams. Team managers stated there was no work related sickness in the teams.

Staffing levels had been estimated using knowledge gained from staff workshops during the initial transitional period. Staff considered skill mix, services needed and pathways. The service also liaised with external partners such as GP's, commissioners, voluntary sector staff and service users and carers. The Newcastle and Northumberland teams had based their staffing levels on the Sunderland model which was in the process of being implemented. Staff in the Newcastle and Sunderland teams stated that staffing levels were good. However, there was no lower grade support staff in the Northumberland team. This meant that qualified members of the multidisciplinary team did not have any junior staff to support the implementation of care plans or other less complex work. There were plans to employ support workers in the service. However, these

Are services safe?

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

Good 🟢

plans had not been implemented due to the complex commissioning of the Northumberland learning disability services. Despite this, the impact on service users was minimal.

The average caseload per staff member in each team was

- Newcastle behavioural assessment and intervention team - seven
- Newcastle team - 18
- Sunderland team - six
- Northumberland team - seven

All staff spoke about caseloads being manageable and that stress levels were low. Caseloads were managed and discussed within monthly individual supervision sessions. Staff had the opportunity to discuss cases within daily or weekly review meetings which involved the full multidisciplinary team.

The service did not have a waiting list for service users to access the service. There was a system in place to manage new referrals into the service in a timely manner. This involved the referral being screened by a member of staff who was the allocated single point of access worker. The referral would then be sent to the appropriate team who would triage the referral during a multi-disciplinary team meeting. The most appropriate discipline would be decided to complete the consultation and assessment work. The teams were completing this process within two weeks, which was below the trust target of six weeks.

Cover arrangements for staff sickness, leave and vacancies could be arranged by using bank or agency staff. Managers explained this was easy to authorise and arrange. We saw that agency staff were being used effectively in the Sunderland team and bank staff in the Northumberland team to fill temporary gaps in staffing provision.

Psychiatrists were available within the same day if necessary for urgent referrals. The psychiatrists attended the daily or weekly review meetings where service users at risk of relapse were discussed and had input from a full range of professionals. The psychiatrist also had a vacant appointment each day to allow urgent appointments to be seen quickly. Outside of working hours a learning disability psychiatrist was available on-call.

At the time of inspection, the mandatory training compliance for community mental health services for people with learning disabilities or autism was 89% against the trust target of 85%.

The mandatory training that was below 75% included:,

Mental health clustering training

- Newcastle team 47%
- Northumberland team 15%

Medication management

- Newcastle behavioural assessment and intervention team 68%
- Northumberland 68%

Prevention and management of violence and aggression

- Newcastle team 70%

Clinical supervision training

- Sunderland 71%
- Northumberland 74%

Team managers explained that training was not always readily available and was cancelled at short notice. Team managers were able to provide documentation to demonstrate that all outstanding training had now been booked onto.

Assessing and managing risk to patients and staff

We examined 17 care records across the service and found them to contain detailed information relating to risk assessments that were completed during the triage and assessment stage. We saw evidence of risk assessments being updated regularly or when needs changed. Staff used a narrative risk assessment tool for most service users. For more complex service users or those under the care programme approach model, (a national approach, which sets out how mental health services should help people with mental illness and complex needs), the functional analysis of care environments risk assessment tool was used. Both were comprehensive and included information on historical and current risks and protective factors.

Crisis plans had been completed within the risk assessment document and were relevant and up to date. Emergency contact information and an action plan was included.

Are services safe?

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

The teams had effective systems in place to enable them to respond quickly to service users when their physical or mental health had deteriorated quickly. This included rapid access to a psychiatrist, same day intervention from a member of staff, prompt discussion within a multi-disciplinary team and a flexible approach to working hours.

There was a process in place to ensure that National Institute for Health and Care Excellence guidance was being followed in respect of the prescribing of medication. In Sunderland the psychiatrist was supported by a positive behaviour support nurse and a pharmacist when deciding whether to prescribe medication to a service user with learning disability or autism. The positive behaviour support nurse advised what alternative interventions could be suggested and tried. The pharmacist supported the psychiatrist on how to minimise the dose of medication for a shorter period of time. There was a plan in place to review the effectiveness of the medication and reduce it in a timely manner if no positive change was noted. This model of prescribing was in the process of being introduced to other teams.

Safeguarding training was mandatory for all staff and compliance was 94% for this service. Staff were able to describe the safeguarding referral process and gave relevant examples of when safeguarding procedures had been implemented. Staff could also define the safeguarding principles and practices. Teams had close working relationships and a full multi-disciplinary approach with other service providers. This meant that relevant safeguarding information was shared appropriately with others. There were safeguarding leaflets available. However these were not easy read versions for people with learning disabilities or autism.

Lone working procedures were in place in each team. This included an in/out board for staff entering and leaving the building and a buddy system. Staff documented their whereabouts within their online calendars that other staff had access to. Staff also had mobile phones and some had lone worker devices, (an electronic call system). Lone worker devices were in the process of being given to all staff, although not all had yet received them. Not all teams were following the trusts lone working policy. The Newcastle teams did not check on the safety of staff at the end of each day. This was brought to the attention of managers during the inspection and rectified immediately.

There was a management of violence and aggression steering group that met monthly to discuss how to eradicate aggression and violence from the service. This group fed into the patient safety group, the quality and performance group and eventually the board of directors. There were systems in place to audit the effectiveness of the meetings and associated actions.

Track record on safety

There were 106 incidents reported by the service in the last 12 months. Seventy percent were safeguarding incidents and eight percent were deaths. There was one serious incident that required investigation in the 12 months prior to inspection which was categorised as an unexpected death or serious harm. The serious incidents related to commissioning problems and deaths of patients. We examined the information regarding the deaths and found that the following recommendations had been made to the service,

- discharge letters should be sent to the service user, GP and all other relevant agencies involved in providing care

- any service user documents provided by local authorities and others should be scanned into the RiO system and a reference made in the progress notes

- if risk assessments are completed by other agencies, a functional analysis of care environments should still be completed

During the inspection we found documents had been scanned into RiO and that the appropriate risk assessments were in place.

The service had begun to implement a lone worker device system to improve the safety of staff. The device allowed staff to alert a call centre if they felt unsafe.

Reporting incidents and learning from when things go wrong

Staff demonstrated a good knowledge and understanding of how to report incidents. Staff were able to describe examples of incidents and how these were logged on the electronic system. The system for logging incidents had been simplified and staff were confident that all incidents were reported as necessary.

Are services safe?

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

There was a process in place for feeding back information gathered from internal and external investigations. Staff received information during specific de-briefs, team meetings, and supervision.

Staff showed a good understanding of Duty of Candour. Duty of Candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong. These include informing people about the incident, providing reasonable support, providing truthful information and an apology. Staff demonstrated an open and transparent attitude to dealing with mistakes. Staff shared examples of when things had gone wrong and how this had been dealt with by the team.

Staff explained that they would apologise to the service user and family or carers and rectify the mistake as soon as possible. Mistakes were documented on the incident reporting system as required and the team or individual would have a de-brief with the team manager. Investigations and lessons learnt would be feedback to the team via supervision and team meetings.

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 examined 17 care records in total across the teams. They all contained comprehensive and timely assessments. There was a tracker system in place during the assessment phase to monitor the progress of each referral. Sixteen care plans were up to date, personalised, holistic and recovery focused where relevant. One care plan was out of date.

Care plans had been offered to service users and their carers. Care planning information was communicated verbally to service users as well as in easy read format if appropriate. The Newcastle and Sunderland learning disability teams created easy read care plans for approximately 70% of service users. In the Newcastle behavioural assessment and intervention team talking mats and other communication aids were used.

RiO was the electronic record system. This system was secure and staff could access this easily on their laptop in the office or when visiting service users in the community.

Best practice in treatment and care

The Newcastle team held a psychological skills group on a fortnightly basis to discuss particular cases or topics of interest for the team. National Institute for Health and Social Care Excellence guidance was used to aid the discussions and offer direction to decisions.

A range of psychological therapies were available in all teams. These were delivered using a multi-disciplinary approach and liaison with outside agencies, carers and families. They were delivered either one to one or in groups depending on service user needs and local demand. Therapies included,

- dialectic behavioural therapy
- skills teaching
- acceptance and commitment therapy
- cognitive behavioural therapy
- behavioural intervention
- systematic therapy
- psychodynamically informed therapy
- family therapy

Group workshops were also available and included

- wellbeing groups
- personality disorder groups
- cognitive behavioural therapy elements
- health promotion
- safe sex education

The service in partnership with skills for people had developed the mindfulness for life project. Mindfulness is a relaxation technique. This project provided mindfulness skills for people with learning disability or autism. The service had also created self-help guides for depression aimed at adults with autism. This was in partnership with another trust and two universities.

The service had also developed an intensive art psychotherapy and community arts project for service users who were at risk of relapsing. This explored crisis and recovery themes using art as a communication method.

Support for employment, education and housing was considered by the team. The team had good local knowledge of how to signpost service users to the correct service within the community. Staff would assist with forms and supporting letters if needed. Care plans addressed issues regarding meaningful activities and this was seen as an important element in service user's care and treatment.

Activities of daily living for people with learning disabilities were promoted by the service. Training was delivered to staff from third sector providers to ensure they understood the benefits of being active, independent and social.

All care records contained information showing that physical health needs had been considered and where necessary acted upon. This was at the assessment and care planning stages of treatment. There was a system in place to ensure staff sought information from the GP regarding physical health tests and other relevant information. A primary healthcare liaison nurse was responsible for ensuring that reasonable adjustments were made to meet the needs of service users with learning disability and autism. The role also involved educating GP's and other primary healthcare professionals on how to support people with learning disabilities. The service encouraged staff from third sector providers to ensure hospital passports were completed and kept at the service users home. This meant that hospital staff would have access to detailed information about how best to communicate with the

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.

service user including likes and dislikes. However, the service did not always record annual health check information. The primary care liaison nurse in the Sunderland team accessed this information from clinical commissioning groups and GP records. Other teams did not. The clinical commissioning group planned to collate this data and allow primary care liaison nurses within learning disability teams to focus on specific GPs who were not completing annual health checks. This would include education on reasonable adjustments.

Positive behaviour support plans were available for all service users who required them. We found that the positive behaviour support model was embedded in the culture of the service and formed a significant aspect to service user's care. Psychologists were integrated into the teams and nurses and other professionals had access to specialised psychological training.

Outcome measures were being developed that were specifically designed for the learning disability service. There were plans in place to present this to the trust board and implement in every learning disability and autism community team throughout the trust. At the time of inspection this measure was being piloted and any results were not yet known.

Staff were involved in clinical audits which over the last 12 months included,

- positive behaviour support plans audit, (to audit the quality of behaviour support plans)

- Northumberland care plan to discharge audit, (to determine the length of time clients spent between having a care plan implemented and being discharged and to ensure that the team was compliant with the Newcastle model.)

- new referrals audit, (to identify what proportion of referrals were seen within 18 weeks and six weeks and to determine what proportion of referees received a written reply within two weeks).

Skilled staff to deliver care
The staffing model in the Sunderland team was to be implemented throughout the service. The team was divided into three streams, physical health, mental health and positive behaviour support. Each stream had a specific staff skill mix designed to meet the needs of that service user group. There were plans in place for all other teams to

follow this model and this had been implemented to varying degrees in other teams. Staff we spoke to in the Sunderland and Newcastle teams described being well staffed with appropriate skill mix. However, staff in the Northumberland team felt they did not have enough staff and this had an impact on their ability to deliver bespoke care plans to service users and their care teams. The manager of the Northumberland team explained that the service required four support workers to enable them to have a full complement of staff. This meant that although the service was able to deliver good care and treatment to service users, the service was not as well-resourced as other teams within the service. The Northumberland team did not employ any speech and language therapists. However, staff could refer to the Northumbria NHS trust who were commissioned to provide this service. Staff said this was an easy process and access was reasonable. There had been plans for the services to become more integrated in the past. However, due to complex commissioning and service re-design in both trusts, these plans had not been implemented.

All staff received a corporate and local induction into the service. Agency staff received a local induction which was overseen by the team manager.

Staff received monthly clinical supervision from either their team manager or clinical lead. Staff described this occurring as planned and was rarely cancelled or postponed. Staff also had access to formal and informal peer supervision, and case discussions with weekly or daily team meetings. The supervision rate in the last 12 months was 90% for this core service. The appraisal rate in the last 12 months for non-medical staff across the service was 75% and 100% for medical staff. Re-validation rates for medical staff was 100%.

Staff were experienced and qualified for their posts. There was a good mix of highly experienced staff who supported newly qualified staff. Staff had opportunities to enhance their qualifications via further education. Specialist training was available for staff within all teams. Staff had access to additional training that was funded by the service to enhance the quality of skills and career progression. Training included accreditation by the "board of Certification in Behavioural Analysis". Three staff had completed this and one at doctorate level. Master's degrees in applied behaviour analysis via an online university course had been completed by seven staff and specialist

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.

positive behaviour support training was available for other staff. Psychologists had received extra training in psychodynamic work, systemic interventions, psychosocial interventions and acceptance and commitment training. All the speech and language therapists working with dysphagia had completed the Manchester post basic dysphagia course and occupational therapists had received sensory integration training.

The service had not suspended, dismissed or closely supervised any staff in the last 12 months. Managers explained that this had not been necessary and that any minor issues had been addressed informally.

Multi-disciplinary and inter-agency team work

The Sunderland team met on a daily basis to discuss service users who were at risk of relapse. The aim of the meeting was to alert all relevant agencies of any mental health or challenging behaviour crisis, to respond quickly and for all agencies to be well coordinated. There was a multi-disciplinary approach to service user care and treatment which was holistic and comprehensive. The meeting was attended by all staff within the team as well as local authority social work teams, inpatient and crisis staff. Clinical advice and guidance was offered from occupational therapists, nurses with various specialisms, psychologists, speech and language therapists and psychiatrists. If necessary extra support in the community could be offered to service users which was provided by the team. Other teams meet on a daily or weekly basis and mirrored this team approach.

All teams held other regular meetings which included a monthly business meeting, stream (pathway) meetings and urgent multi-disciplinary meetings if required.

The teams had good working relationships with other internal teams within the trust. Staff remained in close contact when service users were admitted to hospital or required input from the crisis team. Staff spoke passionately about their role continuing when service user care crossed pathways.

The service had excellent working relationships with external organisations. The teams provided service user specific training to third sector organisations working in partnership to provide the best care for service users. This was regular and routine practice. Feedback from external organisations highlighted good liaison and involving them in the care planning process. External organisation staff

said they felt valued and involved in person centred care. The service had developed a range of training programmes specifically designed to meet the needs of care providers working with people with learning disability or autism. The training was developed by clinicians within the service in partnership with universities and other organisations. The training included,

• dimensional model of challenging behaviour

• acceptance and commitment training

• adapting cognitive behavioural therapy for people with learning disabilities

• supporting people with learning disabilities to participate in activities of daily living

External organisations attended two workshop events held in October 2015 and April 2016 called 'working together to make services better'. The aim of the workshops was to involve agencies and community groups in service design and development. These were attended by local advocacy groups, city councils and care agencies.

The Newcastle behavioural assessment and intervention team had a close working relationship with the local authority and third sector providers. The team were involved in a joint housing venture and provided staff training and consultancy to the project.

The Northumberland team had strong links with the Northumbria Healthcare NHS Foundation Trust who were responsible for providing physical health care to people with learning disability or autism. Staff spoke about being able to make referrals quickly and easily. Staff from the Northumberland team regularly spent one day a week working from the Northumbria team base in order to forge stronger liaison between the teams. Staff described this working well and that they were able to work jointly when needed.

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

Mental Health Act training was mandatory for all relevant staff. At the time of inspection, 88% of staff were up to date with this training.

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.

Staff demonstrated a good working knowledge of the basic principles of the Mental Health Act and how community treatment orders can support service user's care. Staff explained how they could request a Mental Health Act assessment in the community and what this involved.

We looked at six prescription charts and found that consent to treatment and capacity had been considered and documented where appropriate.

Service user rights were explained to them regularly if they were subject to a community treatment order. This information was inputted onto the electronic recording system RiO. In Sunderland, the administrative team collated a record of when these were due and would alert staff. The Mental Health Act administrator would also remind staff if these were overdue. There were plans in place for an electronic dashboard to be created so there could be further oversight of this duty. In other teams there was no reminder system in place as the number of service users on community treatment orders was low. Staff and managers felt this to be appropriate and proportionate.

All teams had access to a Mental Health Act administrator who was based in a central team. Advice could be sought and staff were aware of how to contact the relevant person.

A trust wide audit was completed in May 2016 to ascertain whether service users subject to the Mental Health Act or community treatment orders were being informed of their rights as required by the Mental Health Act Code of Practice. The system and processes in place were found to be not robust enough and as a result an action plan was put in place which included the addition of a dashboard within the RiO system.

Independent mental health advocacy was provided by Newcastle Advocacy centre for the Newcastle area, Adapt North East for the Northumberland area and Total Voice in Sunderland.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for all relevant staff. At the time of inspection, 89% of staff had completed and were up to date with this training.

Staff we spoke to demonstrated a good understanding of the Mental Capacity Act and the five statutory principles. This was also evident in the electronic care records we examined. We found that service users, their families and carers were involved in best interest decision meetings.

The service had access to a Mental Capacity Act policy which was available on the intranet which staff could refer to as and when required. Any new information regarding the Mental Capacity Act was circulated in trust bulletins via email and discussed in weekly team meetings. Teams had Mental Capacity Act champions who could offer advice to other staff.

Capacity to consent was assessed and recorded appropriately in the care records. We saw that this was decision specific and that communication needs were considered and methods adapted to meet the service user's needs. Staff demonstrated a full understanding of best interest processes and this encompassed the services user's wishes and personal history.

Independent mental capacity advocacy was provided by Your Voice Counts in Newcastle, Adapt North East in Northumberland and Total Voice in Sunderland.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Staff were observed to be compassionate and warm towards service users. Staff took time to build rapport, were clear and confident in their interactions and allowed service users time to express their views and concerns. We observed staff remaining calm when service users presented with challenging behaviour. Staff took a person centred approach to all meetings and discussions. We saw positive and enabling language being used and service users responding well to staff interactions.

Service users described staff as respectful, compassionate and showing care for their wellbeing.

Carers described staff as brilliant, flexible and always available. Carers also said staff were very knowledgeable and respectful towards them and their families. They went the extra mile to meet the needs of the service user. We saw staff showing empathy towards the needs of carers and offering support and guidance.

Professional carers from outside organisations reported that staff were responsive and would visit the same day and into the evening if requested. They also commented that staff were very patient, focussed and supportive of service users, carers and care teams.

Carers described how staff clearly understood the needs of their family member and were insightful and proactive in dealing with any issues that arose. We observed staff using sorting symbol cards (based on the model of human occupation assessment tool) to engage with a service user. This allowed service users to express themselves and communicate using symbols. We saw examples of staff developing tools that were service user specific to meet individual needs. This involved staff developing an anger management tool that was a comic book design to support a service user who struggled to engage. The tool was a success and the therapy was delivered to the service user.

Information regarding service users and carers was stored on the secure electronic system. This meant that confidentiality was maintained of service user records and personal information.

The involvement of people in the care that they receive

Service users were encouraged to participate in care planning where possible. If service users were not able to engage at this level, staff endeavoured to include service user's views and wishes. Copies of care plans were routinely offered to the service user, their families and their care teams. The service had a strong emphasis on recovery and promoting independence which was evident in care plans and staff meetings.

Families and carers were involved in the assessment, care planning and reviews of service users. This was an intrinsic element to the ethos of the service and staff acknowledged that the involvement of families and carers underpinned the majority of their work. Families said they felt supported by the service and they were responded to quickly. Families told us their views were considered and acted upon.

Staff provided a range of support to families and carers. Families and carers were invited to attend two day training events focussing on the needs of people with learning disability and autism. Staff endeavoured to enhance the understanding of carers and families to ensure they were equipped and skilled to support the complex needs of service users. Carers also had access to the trust wide service user and carer network which was located in Northumberland, Sunderland and Newcastle. At team level, carers linked with the Newcastle behaviour and intervention team had access to the triangle of care network (carers group) and a local carer's forum. The Newcastle team had a carers champion and also access to the triangle of care network and Newcastle carers centre. In Sunderland, carers had access to the triangle of care network but there were no specific carers groups in the Northumberland team. Advocacy was provided to service users and families by Skills for People in the Newcastle and Northumberland areas. In Sunderland, Total Voice provided this service.

Service users and carers were involved in the pathway redesign two years ago which staff felt was a positive experience. Teams did not involve service users or carers in the process of recruiting staff.

Service users had access to a 'points of you' questionnaire. There were plans in place for this to be completed on the

Are services caring?

Outstanding ☆

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

telephone or face to face to increase responses and provide appropriate support. During March 2016, ten questionnaires were completed and provided the following results,

- likely to recommend the service to others 80%
- know who to contact in the service 90%
- staff listen 90%
- feel involved in own care 90%
- had a change of worker in last 12 months 60%
- know who is in charge of care 80%
- know who to contact out of hours in a crisis 80%
- find it easy to contact out of hours services 70%
- family are involved as much as you like 80%
- treated with care and compassion 90%

The Newcastle behavioural assessment and intervention team had developed a quality health checker questionnaire which was designed specifically for people with learning disability or autism. This aimed to capture the views of people using the service. This was being piloted in the Newcastle and Sunderland areas in partnership with advocacy organisations skills for people and people first. The questionnaire was being used with service users on discharge from the service with a plan to roll this out service wide.

Service user questionnaires in easy read format had recently been developed by the Northumberland team. Data for this was being collated by the team in order to improve services.

The Sunderland team had a service user satisfaction tool in the reception area. This was a token collector design and asked people if they were satisfied with the service. Service users collected a token and placed it in a clear tube marked either satisfied, unsure or unsatisfied. At the time of the inspection approximately 90% of service users had identified that they were satisfied with the service.

Are services responsive to people's needs?

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

Our findings

Access and discharge

The trust set a target of six weeks from referral to initial assessment. All teams met this target. The average wait for assessment for the last six months prior to inspection was,

- Newcastle behavioural assessment and intervention team 16 days

- Newcastle team 20 days

- Sunderland team 21 days

- Northumberland 24 days

The service design model allowed service users to access learning disability services when needed. Community support from other agencies was robust enough that service users could be discharged following the intervention.

Service users would be allocated to a worker immediately after the assessment or consultation process. However, for specific individualised interventions provided by psychologists, occupational therapist and speech and language therapist there were the following average waiting times based on the six months prior to inspection,

- psychology assessment 36 days

- speech and language assessment 35 days

- occupational therapy assessment 75 days

Staff explained that within the above waiting times, urgent needs would be prioritised and that the waiting lists were reviewed weekly by team managers and clinicians. Also, waiting times would increase if a male worker was required to provide the treatment as there were too few. The psychological assessment target was 18 weeks which was being met by the service.

There was a process in place to allow urgent referrals to be seen quickly. The referral was screened by a single point of access worker who would pass the referral to the correct team or pathway. The referral would then be triaged by the team during the daily or weekly multi-disciplinary team meeting. An assessment or consultation would then be offered depending on the nature of the referral. Urgent needs could be prioritised and service users or their families and carers could be supported on the same day. We examined data collated from the Sunderland step up

meetings for May 2016 and minutes from October 2015 to December 2015. These highlighted service users who were at risk of relapse but who were given early intervention to prevent this occurring. These interventions included,

- safeguarding referrals

- local authority liaison

- emergency respite

- daily contact from the team

- family involvement

- referrals to external organisations

- care and treatment reviews arranged

- support to attend GP and other health appointments

- advice offered to third parties

Detailed information was recorded regarding why a service user was accessing the step-up service and where the referral had originated from. This allowed the service to analyse the data and identify trends. On average, 14 service users each month were supported using this "step up" model of care over the last 12 months. This compares to on average one service user admission to hospital over the same time period.

All teams were able to offer this type of service. The Sunderland team were able to offer a 24 hour, seven day a week service. Other teams worked office hours but staff were flexible to meet the needs of the service. Staff described often working after 5pm in order to ensure the correct care was delivered. Staff said they were not pressured by the service to do this but the teams work ethic was a factor. There were plans in place for all teams to be able to model the Sunderland service based on local need in the near future.

Service users and carers told us that staff responded promptly and adequately when they had needed to contact the service. Carers explained that when they telephoned, if necessary staff could visit them within the same day, even at 6pm.

The service provided clinics for service users with dementia, epilepsy and forensic backgrounds. There were weekly allocated appointments for specialist assessment and treatment in the Sunderland team.

Are services responsive to people's needs?

| | Outstanding ☆ |

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

The Newcastle team had developed a pilot study on how to improve breast screening attendance for people with learning disabilities. The aim of the study was to improve the health inequalities of women with learning disabilities and autism. This was led by the learning disability primary care nurse within the Newcastle team. The study found that with support 77% of women successfully attended for screening. The joint working that took place also enhanced shared learning between learning disability staff and GP surgeries and other primary care departments.

Staff were aware that some referrals did not meet the criteria for a service within the teams. Staff had close links with the local authority and third sector organisations where referrals could be signposted. The teams also offered one-off short interventions if it was felt that this might benefit the service user.

The teams took an active approach to the needs of service users who found it difficult to engage. Staff would offer more appointments and use assertive engagement techniques. This included visits to bowling alleys or other places of interest for the service user.

Appointments were booked at times to suit service users as much as possible. Staff were aware of transport difficulties and tried to work around this. Staff were also aware of the appropriateness of some buildings and would make arrangements to meet in the community if necessary.

Appointments were rarely cancelled and generally ran on time.

The service aimed to be needs led and there was an effective discharge process. Staff said they focussed on the needs identified in the assessment and care planning process and service users were discharged when the outcomes were achieved. The discharge figures for each team for six months prior to inspection were,

- Newcastle behavioural assessment and intervention team 32

- Newcastle team 135

- Sunderland team 166

- Northumberland team 66

This demonstrates that the service was able to discharge service users without delay and therefore allow quick access from referral.

The Newcastle behavioural assessment and intervention team were involved in a housing project that aimed to accommodate local service users who had previously been placed in out of area placements. This involved working closely with commissioners, local authorities and third sector providers. The service provided consultancy and training to third sector providers to ensure that a fully person centred approach was delivered.

Staff at the Sunderland team had developed an anger management tool specifically for one service user who found it difficult to engage. The tool was a comic book design and broke down the barriers between the staff member and the service user. The tool was used successfully to deliver anger management and the idea was shared with all staff.

Assessments documented service user's life histories and demonstrated a good understanding of service user's needs. This was reflected in risk formulations and care plans and highlighted valuable insight into individual needs.

The facilities promote recovery, comfort, dignity and confidentiality

The Sunderland team base had been reconfigured specifically to meet the needs of the team a year ago. All areas were bright, clean and airy. There were eight consultation rooms of various sizes and one clinic room and one treatment room. There were no issues regarding noise or poor soundproofing. The Newcastle team base served the Newcastle learning disability team, behavioural assessment and intervention team. The building was shared with a child and adolescent team. There was shared access to six interview rooms of various sizes, a treatment room and one large meeting room. The child and adolescent team also had access to this bookable space. Staff explained there were sometimes not enough rooms for staff to see service users and their carers and external venues sometimes had to be used for training. Staff explained that the rooms were in high demand. This meant that staff often used rooms in the community which impacted on their time. Service users or carers were not seen at the Northumberland team base.

Leaflets were available in all team bases regarding diagnosis and treatment options. There were many leaflets on display in easy read format that included

• going to hospital

Are services responsive to people's needs?

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

- health promotion

- team description

- health action plans

If necessary, these could be ordered in braille or other languages. An information pack about the service was given to service users or their carers during the first appointment. This included information about the Mental Capacity Act and Deprivation of Liberty Safeguards, assessment process, service leaflet, (easy read) and a complaints leaflet. There was also information on display regarding appropriate local organisations and events.

However copies of some leaflets in waiting areas were not available in easy read format. These included the complains leaflet, the patient advice and laison service leaflet and some of the information on mental health diagnosis and treatments.

Meeting the needs of all people who use the service

The entrance area to the Newcastle location had been adapted to meet the needs of people using a wheelchair. However, the entrance area was dated and unwelcoming. The waiting room had wheelchair accessible toilets and a shower room available. Car parking was also very limited. Carers also mentioned the poor parking facilities. This would make visiting this location difficult, especially for those less mobile. There was a plan in place to review the suitability of the premises and staff were hoping these issues would be resolved.

In the Sunderland location, the premises were appropriate for wheelchair users with two disabled access toilets. The environment was pleasant and there was a noticeboard containing photographs and names of staff. There was a Makaton (communication method), sign of the month on display as well as service user artwork. We noted that parking facilities were limited at busy times.

If necessary, teams had access to interpreters and signers via a request to a central team.

Listening to and learning from concerns and complaints

The service had received one complaint in the last 12 months that was upheld. This related to the Newcastle team. There were no complaints referred to the ombudsman.

The service had received two compliments in the last twelve months relating to the Northumberland team.

Information about how to complain was given to service users at the initial appointment in the form of a leaflet. Further leaflets were available in the waiting areas of each team. These were not easy read format.

Complaints were handled appropriately by staff who demonstrated a good understanding of the complaints process. Staff knew how to escalate complaints and how to support service users and carers.

Outcomes of complaints were feedback to staff during team meeting and clinical supervision.

Are services well-led?

Outstanding ☆

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 values of the trust were caring and compassionate, respectful, honest and transparent. These values were reflected in the attitudes of staff we spoke to. New staff being recruited into the service underwent a values based assessment to ensure staff shared these values. Values were revisited regularly in team meetings and during discussions about how best to support service users and each other.

All staff confirmed that the senior management team were a visible presence in the teams. Managers regularly accompanied staff on home visits in order to stay connected with the nature of the work. The chief executive attended the team away days and other events.

Good governance

There were effective systems in place that ensured staff received mandatory training, supervision and appraisals. These figures were collated centrally and the senior management team had oversight of any fluctuations or anomalies to the figures. Where teams were below the expected trust target, managers were aware and were addressing the issues via supervision and team meetings.

Staff had an effective electronic records system that allowed them to maximise their time spent with service users completing direct work. However, at the Newcastle and behavioural assessment and intervention teams, staff were sometimes unable to utilise the facilities and had to drive to other locations in order to see service users. This was due to a lack of rooms and also poor car parking facilities.

There were clear systems and processes for reporting incidents. Staff explained how this had been streamlined and was now quicker and easier to complete. Staff knew how and what to report and had access to the electronic reporting system. Incident data was analysed by a central team and reported back to team managers. Any immediate issues were flagged up quickly to team managers to address urgently.

Clinical audits were completed by staff. These included referral rate audits, post involvement questionnaire audits, national institute of health and social care excellence guidelines audits and medication management audits.

Data from incidents, complaints and service user feedback was collected by a centrally based health and safety department. Any themes were shared with managers and staff teams. Information from lessons learnt was shared during team meetings. This included local and trust wide lessons learnt.

The services performance was measured by the use of key performance indicators as outlined by the clinical commissioning group, a range of commissioning for quality and innovation targets and trust wide quality priorities. This data was used by senior and team managers to identify any weak areas within the service.

Team managers told us they were well supported by an effective administration team and that they felt they had enough authority to complete their roles. They were not able to adjust staffing levels due to the commissioning status.

All team managers described being able to submit items to the risk register. This was done during managers meetings and fed up to senior managers.

Leadership, morale and staff engagement

Sickness and absence rates were low across the service. There were no staff absent from work due to work related stress. Team managers explained that bank staff could be used to cover absences were necessary.

There were no issues of bullying or harassment reported by staff or managers.

Whistleblowing processes were known to staff who demonstrated knowledge and confidence in doing this if needed. Staff told us that management were open and approachable and that they could raise concerns without fear of victimisation. Staff were encouraged to raise any issues in "speak easy forums" (meetings to discuss any concerns). Teams had access to "freedom to speak up champions" that were designated staff to support staff to raise a concern or complaint. Staff were also invited to discuss results from the community services group staff survey strategy 2015.

The main issue raised was the impact of local authority cuts in social care and the criteria for accepting referrals. An action plan was due to be drawn up.

Morale and job satisfaction was high in every team. Staff spoke about feeling empowered in their roles and that staff of all grades and disciplines were supportive of each other.

Are services well-led?

Outstanding ☆

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.

There were many opportunities for career progression and leadership development. All staff were encouraged to consider further specialist training and additional courses. These included courses at masters and doctorate levels and were role specific.

We observed excellent team working and mutual support. All teams held daily or weekly full multidisciplinary team meetings which included every member of the clinical team. The purpose was to discuss new referrals, service users at risk of relapse and complex cases. All staff contributed to this and shared experience and good practice. Team managers routinely asked if any staff required a de-brief regarding any incidents or stressful work. The Sunderland team had developed a wellness recovery and action plan for each stream. The aim of this was to identify triggers and early warning signs of the team not functioning well. This included initial actions to take and a crisis and contingency plan.

Commitment to quality improvement and innovation

The Newcastle team had developed an outcome measure that was specifically designed to capture learning disability measures and meet the needs of the commissioning structures and Winterbourne View Interim Report 2012 recommendations. There were plans in place to present this to the trust board and implement it in every learning disability and autism community team throughout the trust.

The service was involved in the Winterbourne Medicines Programme, NHS Improving Quality Report, April 2015. The aim of the programme was to develop better understanding and prescribing practices for everyone working with people with learning disabilities or autism.

This formed a significant element of the positive behaviour support pathway for local teams. The work also contributed to national evidence and guidance found within the report.

The Newcastle behavioural assessment and intervention team were involved in a joint housing venture with the local authority and other providers. The aim was to reduce the number of people with learning disability or autism living in hospitals and outside of the local area. This reflected the recommendations outlined in the Winterbourne View Interim Report 2012. The local authority had commissioned the building of clusters of bungalows to individually house people with complex mental health and learning disability needs. Other organisations provided staff to support the service users. The Newcastle behavioural assessment and intervention team provided individualised specific training to the staff teams who were delivering the care. The training was based on the positive behaviour support model. The behavioural assessment and intervention team were also responsible for identifying suitable service users who would benefit from the scheme.

The Newcastle team were also involved in the my healthy year project alongside a local advocacy service. The aim was to improve and promote healthier lifestyles for people with learning disabilities and autism. The project provided a year long programme of workshops regarding physical health, wellbeing and mental health. The workshops were delivered in the form of peer support groups, healthy lunches and positive social time. The project was led by staff from the Newcastle team during the first 12 months. The advocacy service was continuing with the work with oversight from the Newcastle team.