

# Tees, Esk and Wear Valleys NHS Foundation Trust

## Inspection report

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






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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related evidence appendix.

## Ratings

### Overall trust quality rating

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 

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

# Summary of findings

## Background to the trust

Tees, Esk and Wear Valleys NHS Foundation Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008, they achieved foundation trust status under the NHS Act 2006. In June 2011 Tees, Esk and Wear Valleys NHS Foundation Trust took over the contract to provide mental health and learning disability services to the people of Harrogate, Hambleton and Richmondshire. On 1 October 2015, they took over the contract to provide mental health and learning disability services in the Vale of York. Tees, Esk and Wear Valleys NHS Trust serves a population of 2 million people, employs over 6,500 staff and provides mental health, learning disability services across a large geographical area. Their main towns and cities are Durham, Darlington, Middlesbrough, Scarborough, Whitby, Harrogate, Ripon, Vale of York and there are numerous smaller seaside and market towns scattered throughout their patch. They are also in the catchment area for the largest concentration of armed forces personnel in the UK (Catterick Garrison) and have several university populations.

The last CQC comprehensive inspection of Tees Esk and Wear Valleys NHS Trust was in January 2015. We last inspected the trust between June 2018 and July 2018, during which time we inspected six core services, four mental health inpatient services and two mental health community services and well led.

## Overall summary

**Our rating of this trust went down since our last inspection. We rated it as Requires improvement**  

## What this trust does

Tees, Esk and Wear Valleys NHS Trust provides services primarily across nine Clinical Commissioning Groups, 8 local authorities, and there are 3 STP / ICS footprints that relate to the trust.

The trust headquarters are at West Park Hospital, Edward Pease Way, Darlington, DL2 2TS.

The trust services are provided in 22 locations across 73 wards. The trust had a total 818 inpatient beds across services, of which 10 were children's mental health beds.

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units.
- Forensic inpatient/secure wards.
- Long stay/rehabilitation mental health wards for working age adults.
- Wards for older people with mental health problems.
- Child and adolescent mental health inpatient wards.
- Wards for people with learning disabilities or autism.
- Community mental health services for people with learning disabilities or autism.
- Community based mental health services for older people.
- Community-based mental health services for adults of working age.
- Community services for children and young people.

# Summary of findings

- Mental health crisis services and health-based places of safety.

The trust also provides:

- Adult social care

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eight core services, five mental health inpatient services and three mental health community services. We also inspected specialist eating disorder services. These were selected due to their previous inspection ratings or because our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well led key question at trust level. Our findings are in the section headed 'Is the organisation well led'.

## What we found

### Overall trust

Our rating of the trust went down. We rated it as requires improvement because:

- We rated safe as inadequate for one of the core services and requires improvement in six of the 11 core services. We rated effective as requires improvement in two of the 11 core services. We rated responsive as inadequate in one core service and requires improvement in two of the 11 core services. We rated well led as inadequate in one core service and requires improvement in three of the 11 core services. In rating the trust, we considered the current ratings of the core services we did not inspect this time. We also inspected one non-core service, a specialist eating disorder service. The eating disorder service ratings were not aggregated into the overall trust ratings.
- We rated well-led for the trust overall as good.
- Risks were not always managed effectively. In specialist eating disorder services risks were identified in the environmental ligature risk assessment but these did not always say how these would be mitigated. In specialist community mental health services for children and young people, patients waited long periods without contact, waiting lists were not reviewed to assess risk changes and staff did not know which children were waiting for treatment or receiving treatment. In wards for older people with mental health problems there were gaps in patient observation records and identified risks were not always mitigated.

# Summary of findings

- Staffing did not always meet the needs of patients. Patients assessments were delayed in mental health crisis services and health-based places of safety due to lack of availability of staff. In specialist community mental health services for children and young people, there were not enough staff to meet the number of referrals, complete assessments or deliver interventions and staffing levels were disproportionate across teams. Case loads were excessively high in some teams and staff and managers had no control over caseload size. In forensic inpatient/secure wards section 17 leave was regularly cancelled on Mallard and Linnet wards due to staffing issues.
- Medicines were not always effectively managed. In mental health crisis services and rehabilitation wards staff were not ensuring the correct temperature for safely storing medication at two locations visited. In acute wards for adults of working age and psychiatric intensive care units there was no rationale for prescribing medication used 'as required' in some patient records. In wards for older people with mental health problems the service did not use systems and processes to safely prescribe, administer, record or store medicine and didn't always follow infection control policy when dispensing medication.
- In some services, the poor physical environments were adversely impacting on the safety, privacy and dignity afforded to patients. There were examples of this in the health-based places of safety and CAMHS offices. In the learning disability and older people inpatient services, the trust was not achieving an acceptable standard of gender separation.
- Equality and diversity for staff and patients was not fully integrated into all areas of the work of the organisation. This was particularly needed for people who are LGBT+.
- Disciplinary and grievance processes were not always completed in line with trust policy. Timescales weren't always met and there were missing documents in the grievance files. This was an issue at the last inspection and continues to be the case.

However:

- We rated, effective and caring, as good.
- The trust had a talented and experienced leadership team. The board was working together well to respond appropriately to the ongoing challenges following the closure of the wards for young people at West Lane Hospital. The importance of the leadership team being visible and approachable was recognised. There were well structured arrangements to visit services across the wide geographical area served by the trust.
- The trust continued to provide leadership development for staff, a strong focus was still placed on creating a coaching culture that supported recovery and wellbeing. The trust continued with its leadership programme for staff from a black, Asian and minority ethnic background.
- The board and senior leadership team had developed a clear strategy and staff were aware of what it was. It was evident that staff and patients had been engaged during the formation of the strategy. The trust continued to embed the strategy as it developed its ongoing operational priorities.
- The trust had a values-based culture which was positive and open. There was a high degree of openness and transparency in the senior leadership team. Staff spoke about the positive culture during the inspections of services.
- The trust was making increasing use of digital technology to support the delivery of services to patients. The trust was introducing a new clinical information management system (CITO) which aims to allow staff to complete key pieces of information and store them in one place and link directly to the patient record.
- The trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. However, it would be helpful to have a trust strategy for user involvement to ensure this was embedded throughout the organisation.

# Summary of findings

- Staff were skilled and supported. Compliance with mandatory training was high. Staff engagement was positive. The making a difference programme included a number of workstreams to promote a positive working experience for staff. This included initiatives to improve staff health and well-being.
- The quality improvement programme was well embedded across the trust. There were a number of trust wide quality improvement priorities including work to increase the proportion of inpatients who feel safe on the wards.

## Are services safe?

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

- We rated one of the of the 11 core services as inadequate and six as requires improvement for the safe key question. This takes into account the ratings of the core services which were not inspected at this inspection.
- Risks were not always managed effectively. In specialist eating disorder services risks were identified in the environmental ligature risk assessment but these did not always say how these would be mitigated. In specialist community mental health services for children and young people, patients waited long periods without contact, waiting lists were not reviewed to assess risk changes and staff did not know which children were waiting for treatment or receiving treatment. In wards for older people with mental health problems there were gaps in patient observation records and identified risks were not always mitigated.
- Medicines were not always effectively managed. In mental health crisis services and rehabilitation wards staff were not ensuring the correct temperature for safely storing medication at two locations visited. In acute wards for adults of working age and psychiatric intensive care units there was no rationale for prescribing medication used 'as required' in some patient records. In wards for older people with mental health problems the service did not use systems and processes to safely prescribe, administer, record or store medicine and didn't always follow infection control policy when dispensing medication.
- Environments were not always suitable or managed appropriately. In mental health crisis services and health-based places of safety the environments compromised the privacy and dignity of patients. In specialist community mental health services for children and young people, premises where children and young people received care were not always safe or fit for purpose. In wards for older people with mental health problems and wards for people with learning disabilities or autism the service did not comply with guidance relating to mixed sex accommodation.
- Staff and patients did not always have access to alarms to summon assistance. In some community older people locations alarms were not available for staff. In forensic inpatient/secure wards and long stay/rehabilitation mental health wards for working age adults not all patients had access to personal alarms.
- Staffing did not always meet the needs of patients. Patients assessments were delayed in mental health crisis services and health-based places of safety due to availability of staff. In specialist community mental health services for children and young people, there were not enough staff to meet the number of referrals, complete assessments or deliver interventions and staffing levels were disproportionate across teams. Case loads were excessively high in some teams and staff and managers had no control over caseload size. In forensic inpatient/secure wards section 17 leave was regularly cancelled on Mallard and Linnet wards due to staffing issues.

However

- All wards were clean, well equipped, well furnished, well maintained.
- There was adequate medical cover across all wards including out of hours.
- The completion of mandatory training was high, although improvements were needed in the specialist eating disorder service.

# Summary of findings

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The trust had systems in place to identify learning from safeguarding alerts and make improvements. There was a clear ‘think families’ focus across the safeguarding team and the trust.
- Overall staff managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Are services effective?

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

- We rated 9 of the 11 core services as good and 2 as requires improvement for the effective key question. This takes into account the ratings of the core services which were not inspected at this inspection.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. In specialist eating disorder services staff used a holistic approach to care and treatment and used new evidence-based techniques to support high-quality care delivery.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other staff from services that would provide aftercare following the patient’s discharge and engaged with them early in the patient’s admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Staff supported patients to make decisions on their care for themselves. They understood the provider’s policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The trust had an effective approach to investigating and learning from complaints and incidents. They encouraged feedback for patients and carers and used this information to inform service development.

However:

- Staff did not always keep accurate records. In wards for older people with mental health problems people mental capacity and best interest decisions were not recorded clearly. In mental health crisis services and health-based places of safety individual care plans were not clearly developed or updated and interventions didn’t correspond with care plans. In specialist community mental health services for children and young people care plans were not always recorded to demonstrate holistic, person centred and recovery focused care and consent to share information was not well recorded. In acute wards for adults of working age and psychiatric intensive care units care plans did not reflect assessed needs and were not personalised.
- Some areas of training were not available to some staff and records were not always kept. In wards for older people with mental health problems training for dementia was not recorded.
- Recording of supervision rates was low on some wards although staff said they received regular supervision.

# Summary of findings

## Are services caring?

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

- We rated nine of the 11 core services as good and one as outstanding for the caring key question. This takes into account the ratings of the core services which were not inspected at this inspection.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Overall staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Overall staff informed and involved families and carers appropriately.
- We rated ten of the 12 core services as good, one as outstanding and one as requires improvement for the effective key question. This takes into account the ratings of the core services which were not inspected at this inspection.

However

- Staff did not always maintain confidentiality or secure information about patients in wards for people with learning disabilities or autism.

## Are services responsive?

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

- We rated one of the 11 core services as inadequate and two as requires improvement for the responsive key question. This takes into account the ratings of the core services which were not inspected at this inspection.
- Privacy and dignity of patients was compromised in some areas. Some observation disturbed patients. Some environmental issues such as windows not having the ability to be covered and CCTV compromised privacy. Some patients were still sharing dormitories although plans were underway for these to be replaced.
- Meaningful activity was not always available. On Willow ward we found little evidence of meaningful activity.
- Discharge planning was not always clear in one service. In long stay/rehabilitation mental health wards for working age adults care plans had no longer term formulation for discharge.
- Access to services differed across the localities. In some services there were delays and long waiting lists to access the service.

However

- Staff managed beds well. This meant that a bed was available when needed and patients were not moved between wards unless this was for their benefit. Patients placed out of area were returned as soon as a bed was available in their local area.
- The wards mostly met the needs of all patients who used the services - including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff mostly planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Although some patients had excessive lengths of stay the service was working continuously to find suitable placements.
- The design, layout and furnishings of the ward / service mostly supported patients' treatment, privacy and dignity. Most patients had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quite areas for privacy.



# Summary of findings

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

## Are services well-led?

Our rating of well-led at core service level went down. We rated well led at core service level as requires improvement because:

- We rated one of the 11 core services as inadequate and three as requires improvement for the well led question. This takes into account of those core services not inspected at this inspection.
- In the crisis and health-based place of safety and wards for older people there were a number of governance processes that did not operate effectively, and risks were not managed well. These issues included the documentation of risk and risk management, safe management of medicines and privacy and dignity in the health-based places of safety
- There were delays in patient assessments and treatment in the health-based place of safety due to the availability of doctors. The multi-agency arrangements in place to support the operations of the health placed places of safety were not always effective to ensure that patients' needs were always being met. We found delays to treatment because approved mental health practitioners were not available in a timely manner.
- There were not enough staff in specialist community mental health services for children and young people to meet the needs of the children and young people and caseloads were excessively high in some teams. There were long waiting lists in this service and the children and young people on these lists were not reviewed in relation to risks and managers did not know which children were waiting for treatment or which were receiving treatment.
- Environments in the specialist community mental health services for children and young people were not always safe or fit for purpose in York, Selby and Redcar. However, the trust had active plans to rectify some of these issues.
- In the wards for older people staff did not consistently participate in local clinical audits. Local audit schedules varied across teams and where staff did engage in local audit it was unclear whether staff always acted on findings or fed these up to management. Local audits failed to pick up areas of concern found in relation to rapid tranquilisation.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff,
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Teams had access to the information they needed to provide safe and effective care and most used that information to good effect.

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## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.



# Summary of findings

## Outstanding practice

We found examples of outstanding practice. For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including breaches of legal requirements that the trust must put right. We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in seven core services.

## What happens next

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

## Outstanding practice

### **Wards for people with a learning disability or autism.**

- All wards had clear, well written patient profiles that explained patient needs, preferences and risks.
- Every patient record had a bespoke communication plan in place. Some Bankfields Court staff had completed the Makaton language programme training. This uses symbols, signs and speech to enable people to communicate.
- Staff used technology and equipment to support patients. Two Bankfields Court had recently purchased an eye tracking device that could be used by patients to communicate and interact. This allowed nonverbal patients to use their eyes to respond to questions. The package also included learning activities for patients to complete. On Oak Rise ward one patient had a self-controlled squeeze vest that applied adjustable pressure to provide comfort.
- Staff at Oak Rise ward completed a safety cross for patients to evidence patient progress. This was a visual representation that recorded patients' behaviours each month using coloured bars. The safety cross was shared and discussed with patients, families and staff and provided a pictorial snapshot to see the improvements patients made during their admission.
- Staff used the admission process to inform and orientate patients to the ward and to the service. At the respite services patients visited and then progressed to an overnight stay. Staff also encouraged patients, families and carers to pop in for a cup of tea to maintain the familiarity at Aysgarth ward. At Two Bankfields Court, staff had arranged a bedroom on a decommissioned unit next door to facilitate respite care for a patient. This bedroom replicated the patient's bedroom at home including the décor and sheet colour.
- Staff informed and involved families and carers appropriately and provided them with support when needed. Family and carer involvement were fully embedded into the care delivery on all the wards.

### **Community-based mental health services for older people.**

# Summary of findings

- There was a well embedded culture of wellbeing across the service. Staff gave many examples of how their managers and the trust provided genuine support. Managers and the teams demonstrated mutual respect and value for each other both through their interactions and through the feedback they provided to inspectors.

## **Specialist eating disorders service.**

- The service had ensured an adolescent admission transitioned appropriately into the service and had joint care arrangements in place to maintain familiarity for the patient and ensure appropriate expertise were available. This included nursing staff working each shift, but also regular attendance by a consultant with adolescent Mental Health expertise.
- The team consisted of all the required specialisms and there was good working with other departments, agencies and organisations. This included in the provision of physical health, where the service worked closely with the acute trust from who a doctor was rotated to the unit every four months and the services nurse was from the acute trust. This was also seen with links to diagnostic services and provision of monitoring health such as bone density and teeth health. The service also ensured if physical health admission was required, patients would be admitted to the link ward at the acute trust, where staff familiarity about eating disorders was present.

## **Wards for older people with mental health problems**

- Staff on Roseberry ward had engaged in research resulting in an article being published in Occupational Therapy news in September 2019 called 'introducing the power of hen keeping to an inpatient ward'. Staff had introduced hens to the ward after establishing the benefits caring for these animals can have on patients with dementia.

## **Long stay or rehabilitation mental health wards for working age adults.**

- Staff at Kirkdale and Lustrum Vale had been trained in the occupational therapy model of creative ability, a developmental approach to working with patients to ensure each individual was engaged at an appropriate level and helped to bring about change themselves. The model had contributed to a reduction in length of stay for inpatients.
- Kirkdale and Lustrum Vale had held a quality improvement event to review the service model. This led to a move to an enhanced community service to enable the closing of locked rehabilitation beds.
- Kirkdale and Lustrum Vale were working on the Royal College of Psychiatrists 'enabling environments' as part of the development path for the service.
- Staff had access to e-learning about issues facing transgender patients.
- There was positive work around research. The modern matron at Kirkdale and Lustrum Vale was a research champion, and on Talbot ward, patients had been involved in setting research priorities for the health and justice service.

## **Forensic inpatient or secure wards.**

- Patients on Newtondale ward were managing their own Section 17 leave paperwork. Patients completed the leave documentation with key information such as where they were going and what they were wearing. This was then signed off by staff before the patient left the ward.

## Areas for improvement

We found areas for improvement in this service.

# Summary of findings

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

## Action the trust must take to improve:

### Mental health crisis services and health-based places of safety.

- The trust must ensure that the physical environments and practices in the health-based places of safety are reviewed and that they ensure the privacy and dignity of patients using them. **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.**
- The trust must ensure that timely assessments are carried out by doctors for patients entering a health-based place of safety. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The trust must ensure that governance processes operate effectively. This includes the documentation of risk and risk management, safe management of medicines, operations of the health-based places of safety and privacy and dignity in the health-based places of safety. **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.**

### Specialist community mental health services for children and young people.

- The trust must ensure that there are enough staff in each team to meet the demands of the service. Staffing levels must be regularly reviewed to meet the changing needs of the population. **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing**
- The trust must promptly pursue plans to relocate offices based in Selby, Redcar and York. **Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and Equipment.**
- The trust must actively monitor children and young people on waiting lists for both assessments and treatments for changes in risks and needs. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**

### Wards for older people with mental health problems.

- The provider must ensure patient observations are conducted and recorded accurately to ensure risks to patients are managed appropriately. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure that staff assess patient risk prior to them utilising section 17 leave and that staff document this accordingly. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure that staff consider the need for a personal emergency evacuation plan with each patient and create these for patients where necessary. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure that actions identified in the environmental risk assessments are implemented to keep patients safe. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure that appropriate actions are taken to mitigate risks relating to out of range clinic room temperatures. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**

# Summary of findings

- The provider must ensure staff conduct regular checks of emergency equipment. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure they act in line with guidance relating to mixed sex accommodation. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**
- The provider must ensure that staff follow trust policy when using and recording the use of seclusion. **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.**
- The provider must ensure that all audits in place are effective in identifying areas of concern. **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.**

## **Wards for people with a learning disability or autism.**

- The provider must ensure that they comply with the Mental Health Act Code of Practice regarding mixed sex accommodation to maintain the privacy of people that use the service. **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and Respect.**

## **Specialist eating disorders service.**

- The trust must ensure ligature risk assessments used by the service include management plans for each risk or detail contingencies for these risks. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**

## **Long stay or rehabilitation mental health wards for working age adults.**

- The provider must ensure patients on Talbot ward have access to call alarms. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.**

## **Forensic inpatient or secure wards.**

- The trust must ensure that staffing levels on Mallard and Linnet wards do not impact on patient's ability to take their section 17 leave. **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.**

## **Action the trust should take to improve:**

### **Trust wide**

- The trust should ensure that recommendations from the review of governance are implemented to ensure processes and systems are effective across the trust.
- The trust should ensure it progresses its plans to eliminate dormitory style accommodation across the trust.
- The trust should ensure disciplinary and grievance processes meet trust policy requirements in respect of timescales and completeness.
- The trust should ensure that equality and diversity is fully integrated and includes all protected characteristics.

### **Mental health crisis services and health-based places of safety.**

- The trust should ensure that risk and the management of risk is effectively recorded.
- The trust should ensure that there is a consistent use of crisis plans across the different localities.
- The trust should ensure that consent to treatment is clearly recorded in all care records.

# Summary of findings

- The trust should ensure that patients care is effectively documented and reviewed
- The trust should ensure that patients are routinely offered a copy of their care plan and that care plans reflect the patient involvement that takes place.
- The trust should ensure that specific training is offered to staff operating in the health-based places of safety.
- The trust should ensure that all medicines are stored at the correct temperature and that there are effective systems in place to monitor this.
- The trust should ensure they work closely with local authority partners to address the issues relating to approved mental health practitioners attending health-based place of safety assessments in a timely way.

## **Specialist community mental health services for children and young people.**

- The trust should ensure care plans are personalised, holistic and recovery orientated and demonstrate collaborative working.
- The trust should ensure records containing information relating to consent to treatment and to share information are recorded consistently.
- The trust should continue to work with commissioners to ensure improvements to the service take place.

## **Wards for older people with mental health problems.**

- The provider should ensure that staff complete and record any actions from fire risk assessments in a timely manner.
- The provider should ensure that staff are conducting fire drills in line with trust policy.
- The provider should ensure that staff consistently follow infection control policy.
- The provider should ensure that all staff, including temporary staff, have access to up-to-date patient information.
- The provider should ensure that staff are recording instances of rapid tranquilisation as incidents.
- The provider should ensure that patient care plans are holistic.
- The provider should ensure that staff consistently and clearly assess, and record decisions related to capacity for patients who might have impaired mental capacity.
- The provider should ensure that all wards meet the needs of all patients with communication needs.
- The provider should ensure that a record is available of which staff have completed specialist training in dementia and where needed this training is completed.
- The provider should ensure that all blanket restrictions are noted and reviewed on the service's restrictive practices log.
- The trust should ensure that the design, layout, and furnishings of the wards support patients' treatment, privacy and dignity.

## **Wards for people with a learning disability or autism.**

- The provider should ensure that systems and processes are fully established to support all wards with the transfer of patients to psychiatric intensive care units if required.
- The provider should ensure that staff record all incidents on the trust incident reporting system and that incidents include the duration of restraints in line with best practice guidance.

# Summary of findings

- The provider should ensure that all patient identifiable information and records, including photographs, are kept secure and only accessed by authorised people.
- The provider should ensure that they identify, manage and mitigate all potential risks from the environment to maintain the health, safety and welfare of people using services.

## **Community-based mental health services for older people.**

- The provider should ensure disabled patients can summon assistance from the disabled toilet at Aysgarth.
- The provider should ensure staff can summon assistance in an emergency at Aysgarth and the Old Vicarage.
- The provider should ensure meeting rooms at the Old Vicarage provide patients privacy during consultations.

## **Specialist eating disorders service.**

- The trust should ensure senior leaders are visible and known by staff and patients.
- The trust should ensure its vision and strategy are shared with all staff and that they have opportunities to discuss how this applies to their work and role.

## **Long stay or rehabilitation mental health wards for working age adults.**

- The provider should ensure patients at the Orchards have access to take home medication when they go on leave
- The provider should ensure that on Oakwood, a system is implemented to enable staff to identify medicines where the shelf life has been reduced due to high fridge temperatures.
- The provider should consider sharing the 'mate crime' poster across the service.
- The provider should ensure all care plans on Oakwood and Talbot wards are correctly named.
- The provider should ensure that care planning on Willow ward includes what is needed for discharge and begins early in each patient's admission.
- The provider should ensure patients on Willow ward have opportunity to participate in activities that are personalised to accommodate their preferences, provide support and promote community and social inclusion, with the focus on recovery and safe rehabilitation into the community.

## **Forensic inpatient or secure wards.**

- The trust should ensure patients have a call alarm unless significant risk to health, safety and wellbeing is identified.
- The trust should ensure that patient checks do not impact on patients physical and mental health.
- The trust should ensure consistency in record keeping across all records.

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

- The trust should ensure that clear rationale for the use of PRN medication is documented in all patient records.
- The trust should continue to ensure that all patient records are personalised holistic, and recovery focused.
- The trust should continue to find a solution to the ensuite bathroom doors that have been removed.
- The trust should ensure that staff supervision is recorded and monitored by managers.
- The trust should ensure that all staff are up to date with mandatory training.

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led stayed the same. We rated it as good because:

- The trust had a talented and experienced leadership team. The board was working together well to respond appropriately to the ongoing challenges following the closure of the wards for young people at West Lane.
- The importance of the leadership team being visible and approachable was recognised. There were well structured arrangements to visit services across the wide geographical area served by the trust.
- The trust continued to provide leadership development for staff, a strong focus was still placed on creating a coaching culture that supported recovery and wellbeing. The trust continued with its leadership programme for staff from a black, Asian and minority ethnic background.
- Succession planning continued to be in place throughout the trust. Trust strategies had a focus on creating a coaching culture that supported recovery and wellbeing. The head of organisational development and talent management lead monitored the recruitment of leaders and managers in the trust to highlight any succession planning issues. The trust had a talent management system which was an integral part of appraisal.
- The board and senior leadership team had developed a clear strategy and staff were aware of what it was. It was evident that staff and patients had been engaged during the formation of the strategy. The trust continued to embed the strategy as it developed its ongoing operational priorities.
- The trust worked effectively in partnership with other stakeholders across a large and complex health and social care economy. The trust actively contributed to plans to meet the needs of the local population. The trust was pro-active in seeking guidance and support where needed and was working collaboratively to consider future plans for young people's mental health inpatient services.
- The trust had a values-based culture which was positive and open. There was a high degree of openness and transparency in the senior leadership team. Staff spoke about the positive culture during the inspections of services.
- The trust recognised the importance of supporting staff to speak up. This was reflected in their plans for dignity at work champions.
- The trust had well established governance processes at provider level. They recognised that a review was needed of the governance structures and processes following the closure of the wards at West Lane. They had highlighted this as a strategic risk on their board assurance framework. The trust knew it was not appropriate to make quick changes to the governance processes and that they needed to learn from an external review that was going to take place. In the mean time they were applying more rigor to identified concerns and were making better use of soft information.
- Staff and service leaders understood their risks and were able to report them and escalate them when required. Each of the trust directorates had a risk register and the trust was bringing these together in a corporate risk register which was under development. The board assurance framework was used actively by the board. It identified areas of strategic risk and these were examined systematically. The trust was strengthening how it managed risk. The audit committee was now also looking at the systems and processes for the escalation and gaining assurance on risk.



# Summary of findings

- The organisation had data available and accessible to all levels of staff. This same information informed the board on the performance of the trust. The trust was making significant changes to support staff to access and use the patient record system with greater ease. Leaders told us that data was clear and usable and allowed them to manage their services effectively.
- The trust was making increasing use of digital technology to support the delivery of services to patients. The trust was introducing a new clinical information management system (CITO) which aims to allow staff to complete key pieces of information and store them in one place and link directly to the patient record.
- The trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. However, it would be helpful to have a trust strategy for user involvement to ensure this was embedded throughout the organisation.
- Staff engagement was positive. The making a difference programme included a number of workstreams to promote a positive working experience for staff. This included initiatives to improve staff health and well-being.
- The quality improvement programme was well embedded across the trust. There were a number of trust wide quality improvement priorities including work to increase the proportion of inpatients who feel safe on the wards.
- Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles.
- There was positive progress in research with research leads across the trust. The trust had a senior nurse research leadership programme.

However:

- There was more to do to promote equality and diversity for staff and patients and ensure this was fully integrated into all areas of the work of the organisation. This was particularly needed for people who are LGBT+.
- Disciplinary and grievance processes were not always completed in line with trust policy. Timescales weren't always met and there were missing documents in the grievance files. This was an issue at the last inspection and continues to be the case.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jan 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020

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

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Forensic inpatient or secure wards	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020
Child and adolescent mental health wards	Inadequate ↓↓ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Inadequate ↓↓ Aug 2019	Inadequate ↓↓ Aug 2019	Inadequate ↓↓ Aug 2019
Wards for older people with mental health problems	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Wards for people with a learning disability or autism	Requires improvement ↓↓ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Community-based mental health services for adults of working age	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018
Mental health crisis services and health-based places of safety	Requires improvement ↓ Feb 2020	Good ↓ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Specialist community mental health services for children and young people	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Community-based mental health services for older people	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Community mental health services for people with a learning disability or autism	Good ↔ Sept 2018	Requires improvement ↓ Sept 2018	Outstanding ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018
Specialist eating disorders service	Requires improvement Feb 2020	Outstanding Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
<b>Overall</b>	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020

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

# Forensic inpatient or secure wards

Good  

## Key facts and figures

Tees, Esk and Wear Valley NHS Foundation Trust provide forensic inpatient/secure ward services for adults of working age with mental health problems along with care for adults with learning disabilities and autism.

There are 17 wards based in Middlesbrough; 12 mental health wards and five learning disability wards. All wards provide care for patients aged over 18 who require hospital admission.

Patients are admitted to the service from prison or from other secure services. Patients who are admitted have a diagnosis of a severe and enduring mental illness who will usually have committed an offence or be a risk to others and be detained under the Mental Health Act 1983.

The forensic medium secure learning disability wards were, Hawthorne/Runswick and Thistle. With Harrier/Hawk, Kestrel /Kite and Clover/Ivy being learning disability low secure wards. The medium secure wards were Merlin, Nightingale, Linnet, Mandarin, Sandpiper and Swift with the low secure wards being Jay, Newtondale, Lark, Mallard and Brambling. All wards are either male or female, there are no mixed sex wards.

The Care Quality Commission last inspected forensic inpatient/secure wards in October 2018. At that inspection, we rated the services as requires improvement overall. We rated key questions; safe and response as requires improvement and effective, caring and well-led as good.

During this visit we inspected the whole core service and all five key questions; safe, effective, caring, responsive, well-led. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the visit, the inspection team:

- visited all 17 wards, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 43 patients
- looked at 41 care and treatment records
- spoke with 43 members of staff including service leads, ward managers, consultants, nurses, healthcare assistants, pharmacists and psychologists
- looked at 38 prescription charts
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Each ward was individualised and decorated by the patients.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

# Forensic inpatient or secure wards

- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff supported patients with activities outside the service, such as work and education opportunities.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

However:

- Patient section 17 leave was regularly cancelled on Linnet and Mallard wards due to staffing issues.
- Not all patients had access to personal alarms in the case of an emergency, in line with national guidance. Patients had been offered personal alarms, if they refused staff would review alarms with patients regularly.
- Patients informed us that the hourly care rounds in the evening were impacting on their physical and mental health

## Is the service safe?

**Requires improvement** ● → ←

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

- Patient section 17 leave was regularly cancelled on Linnet and Mallard wards due to staffing issues.
- Not all patients had a personal alarm in the case of an emergency, in line with national guidance. Patients were offered personal alarms, if they refused staff would review alarms with patients regularly. However, it was unclear from patient notes if patients who refused an alarm were having their needs reviewed regularly

However:

- All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Each ward was individualised and decorated by the patients.
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff involved patients in reviewing restrictive practice. The ward staff participated in the provider's restrictive interventions reduction programme.

# Forensic inpatient or secure wards

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There were inconsistencies in the recording of patient information.

## Is the service caring?

Good   



# Forensic inpatient or secure wards

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

## Is the service responsive?

Good ● ↑

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff supported patients with activities outside the service, such as work and education opportunities.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.

However:

- Patients informed us that the hourly care rounds in the evening were impacting on their physical and mental health.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Staff had access to development opportunities within the Trust.

# Wards for older people with mental health problems

Requires improvement   

## Key facts and figures

Tees Esk and Wear Valleys NHS Foundation Trust provides wards for older people with mental health problems for men and women aged 65 years and over with organic and functional mental health conditions, who require admission to hospital either informally or detained under the Mental Health Act.

The trust has 11 wards for older people with mental health problems located in nine hospital locations.

### Roseberry Ward

15 bed mixed acute admission ward for adults over the age of 65 with a wide range of mental health problems.

### Hamsterley Ward

15 bed female assessment and treatment ward for older people experiencing complex organic mental health problems.

### Ceddesfeld Ward

15 bed male assessment and treatment ward for older people experiencing complex organic mental health problems.

### Oak

12 bed mixed inpatient facility which provides assessment and care for older people who suffer from a wide range of mental health problems.

### Cherry Tree House

18 bed mixed ward for assessment and treatment for older adults with functional illness.

### Meadowfields Unit

18 bed unit providing inpatient assessment and treatment for people aged over 65 with an organic illness.

### Westerdale North

20 bed mixed acute assessment and treatment ward for older adults with a wide variety of mental health problems.

### Westerdale South

14 bed ward, specifically designed for patients with dementia.

### Rowan Lea Ward

20 bed mixed assessment and treatment ward for older adults with a wide variety of mental health problems.

### Springwood Ward

14 bed mixed complex needs unit for people over the age of 65 who need specialist mental health nursing care.

### Rowan Ward

16 bed mixed assessment and treatment ward for older adults with a wide variety of mental health problems.

# Wards for older people with mental health problems

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not consistently act to manage or mitigate risks identified for patients and this had not been identified or addressed through governance processes.
- There were gaps in patient observation records, so it was not clear if observations had taken place. We found examples of where staff were not mitigating risks in line with the environmental risk assessments, such as locking rooms to prevent patient access to keep them safe.
- Improvements were needed to maintain fire safety. Some patients did not have personal emergency evacuation plans and some actions related to fire risk assessments were not completed in a timely manner.
- Some patients did not have a documented risk assessment completed prior to taking section 17 leave.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines. Some clinic room temperatures and fridge temperatures were too high and appropriate action had not been taken by staff to mitigate this. There were missing checks of emergency bags on two wards.
- The service did not comply with guidance relating to mixed sex accommodation in five of the eight mixed sex wards where there was an inadequate level of separation between the male and female sleeping areas. We observed male patients in female bedroom areas. Male patients were using designated female lounges.
- Staff did not follow trust policy or best practice guidelines to ensure they were using and clearly recording the use of seclusion appropriately on Rowan Lea ward.
- Not all staff had easy access to clinical information as agency staff could not access patient electronic records and on Rowan ward paper files did not contain the most up-to-date information.
- Local audit schedules varied across teams and where staff did engage in local audit it was unclear whether staff always acted on findings or fed these up to management.

However:

- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- All patients had their physical health assessed and regularly reviewed during their time on the ward. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service safe?

**Requires improvement**   

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

# Wards for older people with mental health problems

- Staff did not consistently act to manage risks identified to patients. There were gaps in patient observation records, so it was not clear if observations had taken place. We found examples of where staff were not mitigating risks in line with the environmental risk assessments, such as locking rooms to prevent patient access to keep them safe.
- Improvements were needed to maintain fire safety. Some patients did not have personal emergency evacuation plans and some actions related to fire risk assessments were not completed in a timely manner.
- Some patients did not have a documented risk assessment completed prior to taking section 17 leave.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines. Some clinic room temperatures were too high and appropriate action had not been taken by staff to mitigate this. There were missing checks of emergency bags on two wards.
- The service did not comply with guidance relating to mixed sex accommodation in five of the eight mixed sex wards where there was an inadequate level of separation between the male and female sleeping areas. We observed male patients in female bedroom areas. Male patients were using designated female lounges.
- Staff did not consistently follow infection control policy as on Oak ward staff were dispensing patient's medications from a room without hand washing facilities and on Westerdale South ward some patient dietary supplements were being stored under a sink.
- Staff did not follow trust policy or best practice guidelines to ensure they were using and clearly recording the use of seclusion appropriately on Rowan Lea ward.
- Not all staff had easy access to clinical information as agency staff could not access patient electronic records and on Rowan ward paper files did not contain the most up-to-date information.
- Staff generally recognised incidents and reported them appropriately, but on Westerdale North two instances of rapid tranquilisation had not been recorded as incidents.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good   

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

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

# Wards for older people with mental health problems

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- All patients had their physical health assessed and regularly reviewed during their time on the ward. All wards apart from Rowan Ward, who were advertising the position, had access to a physical health practitioner.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However:

- Staff assessed the physical and mental health of all patients on admission but 5 of the 33 care plans we reviewed were not holistic.
- Staff did not always record capacity clearly for patients who might have impaired mental capacity or conduct and record relevant best interests decisions.
- Whilst the trust provided specialised training in dementia, the completion of this training was not recorded and so it was not clear who had completed the training.

## Is the service caring?

Good ● → ←

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff were discreet, respectful, and responsive when caring for patients and gave patients help, emotional support and advice when they needed it.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Staff gave carers information on how to find the carer's assessment and referred them for assessments where appropriate. Carers told us they felt staff really cared about their wellbeing as well as the patient's.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The food was of a good quality and patients could make hot drinks and snacks at any time.

# Wards for older people with mental health problems

- Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient and managers monitored the number of delayed discharges and staff liaised closely with the local authority and proposed placements to try and reduce delays.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- The design, layout, and furnishings of the wards did not support patients' treatment, privacy and dignity as on Rowan ward some patients were sharing dormitories with beds separated only by curtains. However, the trust recognised this work had not taken place and the ward was closing in April 2020.
- The service did not consistently meet the needs of all patients who used the service such as patients with communication needs, as there was limited signage on Westerdale North and Oak wards.
- On Westerdale South patients could not make their own hot drinks and this restriction was not documented on the service's restrictive practice log.

## Is the service well-led?

**Requires improvement** ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not always managed well.
- Whilst staff did participate in a trust clinical audit schedule, we found that staff did not consistently participate in local clinical audits specific to individual teams. Local audit schedules varied across teams and where staff did engage in local audit it was unclear whether staff always acted on findings or fed these up to management. Local audits failed to pick up areas of concern found in relation to rapid tranquilisation.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team and had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities.

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

Good  

## Key facts and figures

Tees Esk and Wear Valleys NHS Foundation Trust provides acute and psychiatric intensive care inpatient services for men and women aged 18 years and over with mental health conditions, who require admission to hospital either informally or detained under the Mental Health Act.

The trust has 14 acute inpatient wards and two psychiatric intensive care units located in seven hospital locations.

Five wards are based at Roseberry Park Hospital in Middlesbrough. These are

- Bedale ward: 10 bed mixed gender psychiatric intensive care unit
- Bilsdale ward: 14 bed male acute inpatient ward
- Bransdale ward: 14 bed female acute inpatient ward
- Overdale ward: 18 bed female acute inpatient ward
- Stockdale ward: 18 bed male acute inpatient ward

Three wards are based at West Park Hospital in Darlington. These are:

- Cedar ward: 10 bed mixed gender psychiatric intensive care unit
- Elm ward: 20 bed female acute inpatient ward
- Maple ward: 20 bed male acute inpatient ward

Two wards are based at Lanchester Road Hospital in Durham. These are:

- Farnham ward: 20 bed male acute inpatient ward
- Tunstall ward: 20 bed female acute inpatient ward

Two wards are based at Cross Lane Hospital in Scarborough. These are:

- Danby ward: 12 bed male acute inpatient ward
- Esk ward: 12 bed female acute inpatient ward

Two wards are based at Peppermill Court in York. These are:

- Ebor ward is a 12-bed female acute inpatient ward
- Minster ward is a 12-bed male acute inpatient ward

One ward is based at the Briary unit in Harrogate District Hospital. This is:

- Cedar ward is a 14-bed mixed gender acute inpatient ward

Tees Esk and Wear Valleys NHS Foundation Trust have been inspected on a number of occasions by the CQC since registration. We completed a comprehensive inspection of the acute inpatient wards and psychiatric intensive care units in June 2018. We rated the service as requires improvement overall. We rated the core service as requires improvement for safe, effective and well led and good in caring and responsive.



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

We issued the trust with two requirement notices for breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place between 23 September and 3 October 2019. The inspection of inpatient wards was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected the service using all the key lines of enquiry in the five key questions.

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust. During the inspection visit, the inspection team:

- spoke with two senior managers and three modern matrons
- visited all sixteen wards, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 40 patients who were using the service, and reviewed patient comments on 41 feedback cards
- spoke with two carers of patients who were using the service
- spoke with 16 ward managers who were available
- spoke with 85 other staff members including doctors, registered nurses, healthcare assistants, occupational therapists, occupational therapy assistants, a volunteer, psychologists, student nurses, pharmacists, pharmacy technicians, activity coordinators and health professionals who worked closely with the service
- looked at the care and treatment records of 45 patients, 20 records of the administration of rapid tranquilisation, and three seclusion records
- reviewed medication management including 60 patients' medication administration records
- attended and observed 13 report out meetings, six formulation meetings, and four discharge meetings
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

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

- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- There were variations in the monitoring and recording of supervision. Although staff said that they were having regular supervision five wards reported under 70% compliance.
- Ensuite bathroom doors had been removed as an interim measure to keep patients safe. The trust was correctly trying to find a more permanent solution to this issue.

## Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- There was adequate medical cover across all wards including out of hours.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. Briary in Harrogate had not used restraint since July 2019. Daily report out meetings took place.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

However:

- There were mostly sufficient nursing staff with the appropriate skills and experience. Where agency staff were used they were mostly booked for a longer period to promote consistency of care. However, there were a few instances where staffing was stretched. For example, there were wards in Scarborough with occasionally only one nurse on shift with support where needed from other wards. Harrogate were struggling to recruit due to the upcoming closure of the hospital.

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

- Whilst patient records were mostly of a satisfactory standard we did find occasions where the quality of recording needed to improve. Risk safety summaries in Scarborough did not reflect the incidents in three of the patient records. Care plans on Danby ward did not clearly state how rapid tranquilisation would be used and we found two incidents on this ward where intra-muscular medication was recorded but staff said that oral medication had been given. The trust was working to improve the patient record system to make them easier for staff to use.
- Four mandatory training courses were below 75%. These were safeguarding level three, rapid tranquilisation, safe prescribing and PAT level one update. The trust was monitoring this closely and arranging training where needed.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission and 72-hour formulation meetings were taking place across all wards.
- All patients had intervention plans. We reviewed 45 plans and found the quality of these had improved since the last inspection.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Some care plans did not reflect assessed needs and were not personalised. Managers continued to audit the quality of care plans and work with staff to ensure improvements continued.
- Recording of staff rates of supervision remained low on some wards despite staff reporting that they were having supervision. Managers said this was a reporting issue and were working to collect accurate data.

## Is the service caring?

Good   

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

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- Patients in Harrogate said that they did not know what was in their care plan.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Patients placed out of area were returned as soon as a bed was available in their local area.
- Most wards were proactively discharging patients. This was discussed at formulation and good links were in place with third sector providers and community teams.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom. The trust had removed some ensuite bathroom doors but remained patient's privacy and dignity with signs on doors. and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was generally of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- There was variation in the length of stays across the service. In Harrogate two patients at been on the ward for one year. In Scarborough four patients had been on the ward over 90 days.
- There were mixed responses from patients about the quality of the food. Patients on Esk ward and Cedar the Briary complained that the food was not good.
- Cedar at the Briary was still dormitory bedrooms and the trust had put partitions between beds since the last inspection. The ward was due to close in Spring 2020.

## Is the service well-led?

Good  

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

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Opportunities for development and support for staff wellbeing.
- Our findings from the other key questions demonstrated that governance processes operated effectively on most wards and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Governance systems through the use of medication audits had not identified the incorrect recording of rapid tranquilisation on Danby ward in Scarborough.

# Specialist community mental health services for children and young people

Requires improvement  

## Key facts and figures

Tees Esk and Wear Valleys NHS Foundation Trust provides specialist community mental health services to children and young people throughout North Yorkshire and York, Teesside and County Durham. The child and adolescent mental health teams were based in:

- Hartlepool
- Middlesbrough
- Scarborough
- Durham
- Northallerton
- Stockton
- York
- Harrogate
- Selby
- Redcar
- Darlington
- Easington

Child and adolescent mental health teams provides care and treatment to children and young people from 0 to 18 years of age. They are a key point of contact to any individual who is concerned about a child or young person's emotional wellbeing. They provide care and treatment to children and young people with a range of mental health needs. This includes autism, attention deficit hyperactivity disorder, anxiety, depression and psychosis. There were specific teams that dealt with referrals and triage, other teams that support children experiencing a crisis of their mental health and teams specifically aimed at children with learning disabilities and eating disorders.

On this inspection we looked at all five key questions. Our inspection was a short notice announced inspection (staff did not know we were coming until the day before the inspection) to enable us to observe routine activity.

We inspected four child and adolescent mental health teams, three eating disorder teams, two crisis teams and two learning disability teams.

Before this inspection, we reviewed information that we held about the service. During the inspection we:

- spoke with 34 staff including nurses, doctors, psychologists, social worker and support workers
- spoke with seven managers
- spoke with six children and young people
- spoke with nine carers
- reviewed 53 care records

# Specialist community mental health services for children and young people

- carried out a tour of eight community teams including the offices and interview/meeting rooms
- observed 13 clinic appointments or multidisciplinary team meetings
- gathered feedback from 15 children, young people and their families and carers via comment cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

A comprehensive inspection of specialist community mental health services for children and young people was last carried out by the Care Quality Commission in February 2015. Specialist community mental health services for children and young people were rated as good overall. However, there were two areas the trust were told they should improve:

- The trust should continue to monitor and review the number of staff to ensure a safe and prompt service.
- The trust should make sure all the team managers monitor the uptake of supervision in the CAMHS services, to ensure it meets the new supervision guidance.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not provide safe care. Clinical premises where patients were seen were not all safe or fit for purpose. The number of patients on the caseload of the teams, and of individual members of staff, were too high and staff could not give each patient the time they needed. There were not enough staff to manage the volume of patients. Staff did not manage waiting lists to ensure that patients who required urgent care were seen promptly.
- The service was not easy to access. Staff were not always able to assess and treat patients promptly. Patients waited too long to start treatment.
- Care plans were not always personalised, holistic or recovery-orientated.
- Staff did not record decisions relating to consent well. There was no consistent approach to recording consent. Consent information was located within the electronic recording system and paper notes.

However:

- Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

# Specialist community mental health services for children and young people

## Is the service safe?

**Requires improvement**  

Our rating of safe went down. We rated it as requires improvement because:

- Children and young people on the waiting list were not reviewed to assess changes to risk. Children and young people waited long periods without any contact from the service. There was an emphasis on children and families to inform the service of increases of risks or needs. Managers did not know which children were waiting for treatment or which were receiving treatment.
- Staffing levels were not sufficient to match the number of children and young people referred into the service or meet their needs. Staffing levels were disproportionate in some teams. There was not enough staff to complete assessments or deliver interventions. This was causing long delays.
- Caseloads were too high for individual practitioners to manage. Caseloads were excessively high in some teams. Staff and managers had no control over the size of individual caseloads.
- Clinical premises where children and young people received care were not always safe or fit for purpose. There were environmental issues with the buildings in York, Selby and Redcar.

However:

- Staff had received basic training to keep patients safe from avoidable harm.
- Risk assessments and risk management plans were completed and up to date for children and young people who were in active treatment. Risk assessments contained detailed information relating to how to keep children and young people safe.
- Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The teams had a safeguarding lead.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff followed good personal safety protocols.

## Is the service effective?

**Good**   

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

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



# Specialist community mental health services for children and young people

- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16.

However:

- Care plans did not always reflect the comprehensive needs and interventions of children and young people. Care plans were not always holistic, person centred, or recovery focussed. There was evidence in care records that children and young people needs were being met, however care plans did not always reflect this. There was also evidence in other documents that care plans had been developed collaboratively with children and young people but this was not reflected in care plans.
- Consent to treatment and to share information was not recorded well. There was a mixture of paper forms, electronic formats and on some occasions no information. However, within children and young people's case notes there was evidence of clinicians checking children's understanding and consent at regular intervals.

## Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff were passionate about delivering good outcomes for children and young people.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Patients and parents and carers were involved in the design and delivery of the service. There was a children's and young people's participation group in each team. Children and young people were involved in the design of the service. Children and young people had chosen the décor of buildings being refurbished. Children and young people had input into new letter template design.

However:

- Children, young people, their carers and families complained that delays to access the service were too long and caused children to deteriorate whilst they were waiting.

# Specialist community mental health services for children and young people

## Is the service responsive?

**Requires improvement** ● ↓

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

- The service was not easy to access. There were long waits for specific treatments in both the emotional and neuro pathways. This was for both individual therapy and group work. Waits ranged from 5 months to 2 years. There were 6 month delays for comprehensive assessments in two locations.

However:

- The service ensured that patients, who would benefit from care from another agency, made a smooth transition.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Requires improvement** ● ↓

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

- Our findings from other key questions demonstrated that the service was not managed well.
- There were long waiting lists and the children and young people on these lists were not reviewed in relation to these risks.
- There were not enough staff to meet the needs of the children and young people and caseloads were excessively high in some teams.
- Environments were not always safe or fit for purpose in York, Selby and Redcar. However, the trust had active plans to rectify some of these issues.
- Managers did not know which children were waiting for treatment or which were receiving treatment.

However:

- Managers were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

# Specialist community mental health services for children and young people

- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

# Long stay or rehabilitation mental health wards for working age adults

Good   

## Key facts and figures

We inspected this core service provided by Tees Esk and Wear Valleys NHS Foundation Trust. The service is provided to people of working age. There were seven wards over seven locations.

The Orchards	<b>10 beds</b>	<b>Mixed</b>
Talbot	<b>5 beds</b>	<b>Male</b>
Primrose Lodge	<b>15 beds</b>	<b>Mixed</b>
Kirkdale	<b>16 beds</b>	<b>Male</b>
Oakwood	<b>8 beds</b>	<b>Male</b>
Lustrum Vale	<b>20 beds</b>	<b>Mixed</b>
Willow	<b>15 beds</b>	<b>Mixed</b>

The inspection was announced but staff did not know which locations we were inspecting and we were able to observe routine activity.

The inspection team consisted of two CQC inspectors, an assistant inspector, two specialist advisers, an occupational therapist and a nurse, and an expert by experience. An expert by experience is someone with experience of using similar services or caring for someone who uses similar services.

During the inspection, the inspection team:

- Visited all seven wards and looked at the quality of the environment
- Checked all seven clinic rooms
- Observed how staff provided care and treatment
- Spoke with 19 patients and one carer
- Interviewed the managers of all seven wards, one matron and one service manager
- Interviewed 12 registered nurses and health care support staff
- Interviewed three allied professionals including an occupational therapist and two psychologists
- Observed one ward round
- Observed two ward handover meetings
- Observed one community meeting
- Reviewed 18 sets of care records including Mental Health Act records

# Long stay or rehabilitation mental health wards for working age adults

- Reviewed 22 prescription charts
- Reviewed four staffing rotas
- Looked at records relating to the management of the service including audits, minutes of meetings and policies.

We also left comment cards on all seven wards for feedback. Eleven cards were completed. Comments were mainly positive, saying that staff listened to them, were friendly, approachable and helpful, that they were treated with respect and had received good care and treatment. They also commented that the wards were clean and tidy and the activities were good. Two made negative comments, saying that the staff were awful and they were not treated fairly.

We carried out a comprehensive inspection of rehabilitation wards in January 2017. We rated the service as requires improvement for safe. We rated effective, caring, responsive and well led as good.

Following this inspection, we issued the trust with one requirement notice for a regulatory breach that related to:  
Regulation 12 Safe care and treatment.

We carried out an inspection of Talbot and Oakwood wards in June 2018 but we did not rate the service.

We issued the trust with a further requirement notice for a regulatory breach that related to:  
Regulation 12 Safe care and treatment.

At this inspection, we found some of the issues from the previous inspections had been addressed. However, we have issued a further requirement notice for a regulatory breach that relates to:

Regulation 12 Safe care and treatment.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed.

# Long stay or rehabilitation mental health wards for working age adults

- The service worked to a recognised model of mental health rehabilitation. It was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Patients on Talbot ward did not have access to call alarms although the trust told us these would be installed during January 2020.
- At the Orchards, patients could not access take home medication when they went on leave unless it had been planned.
- On Oakwood it was not clear how staff identified medicines when the shelf life had been reduced due to high fridge temperatures.
- On Oakwood and Talbot wards, some patient care records contained the wrong ward names.
- At the Orchards, patients could not operate the vistamatic window from inside the room. This meant their privacy and dignity may be compromised.
- On Willow ward, we found little evidence of therapeutic activity.
- On Willow ward, care plans focused on patients' immediate support needs with no connection to a longer-term formulation of what was necessary for discharge.

## Is the service safe?

**Requires improvement**   

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

- Patients on Talbot ward did not have access to call alarms although the trust said these would be installed by the end of January 2020.
- At the Orchards, patients could not access take home medication when they went on leave unless it had been planned.
- On Oakwood it was not clear how staff identified medicines when the shelf life had been reduced due to high fridge temperatures.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. One ward had developed a 'mate crime' poster that described peer abuse.

# Long stay or rehabilitation mental health wards for working age adults

- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff at Kirkdale and Lustrum Vale had been trained in the occupational therapy model of creative ability, a developmental approach to working with patients to ensure each individual was engaged at an appropriate level and helped to bring about change themselves. The model had contributed to a reduction in length of stay for inpatients.
- Kirkdale and Lustrum Vale had held a quality improvement event to review the service model. This led to a move to an enhanced community service to enable the closing of locked rehabilitation beds.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.



# Long stay or rehabilitation mental health wards for working age adults

- There was positive work around research. The modern matron at Kirkdale and Lustrum Vale was a research champion, and on Talbot ward, patients had been involved in setting research priorities for the health and justice service.

## Is the service caring?

Good ● → ←

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients on most wards did not have excessive lengths of stay and discharge was rarely delayed.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Kirkdale and Lustrum Vale were working on the Royal College of Psychiatrists 'enabling environments' as part of the development path for the service.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. They had access to e-learning about issues facing transgender patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- On Willow ward, we found little evidence of meaningful activity.
- On Willow ward, we reviewed three care plans. The care plans focused on patients' immediate support needs with no connection to a longer-term formulation of what was necessary for discharge.

# Long stay or rehabilitation mental health wards for working age adults

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. Kirkdale and Lustrum Vale were working on the Royal College of Psychiatrists 'enabling environments' as part of the development path for the service.

# Community-based mental health services for older people

Good   

## Key facts and figures

Tees Esk and Wear Valleys NHS Foundation Trust provides community services for older people with mental health problems for men and women with organic and functional mental health conditions.

Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

They provide services across a large geographical area. Their main towns and cities are Durham, Darlington, Middlesbrough, Scarborough, Whitby, Harrogate, Ripon, Vale of York and there are numerous smaller seaside and market towns throughout the area.

The trust provides community services for older people with mental health problems from in 18 locations across the trust. During this inspection we visited nine teams across six locations:

- Huntington House
- Princess Road Clinic
- Aysgarth
- The Old Vicarage
- Sovereign House
- Derwent Clinic.

Tees Esk and Wear Valleys NHS Foundation Trust have been inspected on a number of occasions by the CQC since registration. We completed a comprehensive inspection of the community services for older people with mental health problems in January 2015. We rated the service as good overall.

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust. During the inspection visit, the inspection team:

- interviewed three senior managers and seven team managers
- visited six locations, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 13 patients who were using the service
- spoke with 9 carers of patients who were using the service
- spoke with 38 other staff members including doctors, registered nurses, healthcare assistants, occupational therapists, occupational therapy assistants, psychologists and student nurses
- reviewed 14 care records for patients who were using the service
- reviewed medication management processes
- attended and observed six multi-disciplinary team 'huddle' meetings, one team meeting and observed nine patient home visits and clinic appointments
- looked at policies, procedures and other documents relating to the running of the service.

# Community-based mental health services for older people

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

## Is the service safe?

Good   

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

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

# Community-based mental health services for older people

- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Interview rooms at Aysgarth and the Old Vicarage did not have alarms available for staff to summon assistance in the case of an emergency.
- Out of hours crisis arrangements were not in place for patients with an organic illness meaning staff would work extra out of hours to prevent patients accessing emergency services for support.
- Where multiple teams accessed a shared clinic room at Huntington house, there was not an agreement in place detailing who took the lead role in monitoring the clinical environment which resulted in some omissions in the recording of the fridge temperatures.

## Is the service effective?

Good   

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

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care including doctors, registered nurses, healthcare assistants, occupational therapists, occupational therapy assistants, psychologists and student nurses. Managers made sure that staff had a range of skills needed to provide high quality care. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

# Community-based mental health services for older people

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

## Is the service caring?

Good ● → ←

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The disabled toilet at Aysgarth did not have a call alarm should anyone require assistance.
- Interview rooms at the Old Vicarage were not soundproof.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

# Community-based mental health services for older people

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.



# Wards for people with a learning disability or autism

Good   

## Key facts and figures

Tees, Esk and Wear Valleys NHS Foundation Trust provides inpatient assessment and treatment, and respite care to patients with learning disabilities and/or autism in York, Durham, Stockton and Middlesbrough.

- Oak Rise, in York, is an eight-bed acute assessment and treatment inpatient unit for male and female adults with both a learning disability and complex needs. There were five patients on this unit during the inspection.
- Bek-Ramsey ward, in Durham, is an 11-bed acute assessment and treatment inpatient unit for male and female adults with a learning disability and/or autistic spectrum disorder. There were five patients on this unit during the inspection.
- Aysgarth ward, in Stockton, is a six-bed respite service for male and female adults with learning disabilities who can have complex needs or present with behaviours that challenge. There were three patients on this unit during the inspection.
- Bankfields Court in Middlesbrough provides assessment and treatment for adults with learning disabilities who also have associated mental health problems, challenging behaviour or severe epilepsy. It contains five smaller units:
  - Number Two Bankfields Court is a five-bed short-term respite care unit for male and female adults with learning disabilities, complex health needs and/or behaviours that challenge. There were four patients on this unit during the inspection.
  - Number Three Bankfields Court is a six-bed inpatient assessment and treatment unit for male and female patients with learning disabilities. There was one patient on this unit during the inspection.
  - Number Four Bankfields Court is a six-bed inpatient assessment and treatment unit for male and female patients with learning disabilities. There were six patients on this unit during the inspection.
  - The Flats at Bankfields Court is a six-bed inpatient assessment and treatment unit for male and female patients with learning disabilities. There were four patients on this unit during the inspection.
  - The Lodge at Bankfields Court is a single occupancy inpatient assessment and treatment unit for male or female patients with learning disabilities. There were zero patients on this unit during the inspection as the unit was being modified for the needs of a new patient.

At the last inspection in January 2015, the service had one key question (responsive) rated requires improvement and one key question (safe) rated as outstanding. The service was rated as good for effective, caring and well led.

During this inspection we inspected all key questions across this core service. Our inspection was announced (staff knew we were coming to inspect the core service).

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited all eight wards to look at the quality of ward environments and observe how staff were caring for patients
- spoke with 10 patients and 13 families or carers that were using the service

# Wards for people with a learning disability or autism

- spoke with ward manager, deputy ward manager or senior nurse on each ward
- spoke with 29 other staff members; including doctors, nurses, support workers, pharmacists, modern matrons, service managers, associate practitioners, occupational therapists, nursing associates, housekeeping staff and psychologists
- observed two handover meetings, completed one short observational framework for inspection and one quality meeting
- reviewed 14 records including risk assessments, care plans and Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards documentation
- carried out a specific check of medication management on all wards, including reviewing 25 prescription cards
- looked at a range of policies, procedures and governance documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Except for environmental risks, staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Although two wards did not meet the mixed sex accommodation requirements as specified in the Mental Health Act Code of Practice, staff understood and discharged their other roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason or lack of suitable placement for the patients.
- The service worked to a recognised model of mental health rehabilitation.

However:

- Staff had not assessed and managed all potential risks posed by the environment on Aysgarth ward.
- Two wards did not meet the same-sex accommodation guidance specified in the Mental Health Act Code of Practice.
- Staff did not always maintain the confidentiality or secure information held about patients.

# Wards for people with a learning disability or autism

- Staff did not always identify incidents or record and report them appropriately.
- Systems and processes were not fully established to support all wards with the transfer of patients to psychiatric intensive care units if a patient required more intensive care.
- Governance processes did not always ensure that care delivered met national guidance.

## Is the service safe?

**Requires improvement** ● ↓↓

Our rating of safe went down. We rated it as requires improvement because:

- Two wards did not meet same-sex accommodation guidance. Male and female sleeping areas were not segregated and patients had to walk through an area occupied by the opposite sex to reach toilets or bathrooms. There was no designated, separate day room for female patients on respite wards.
- Staff did not always identify incidents or record and report them appropriately. On Aysgarth ward, staff had not reported the loss of patient data when the ward camera that had photographs of patients was lost. On Bek-Ramsey ward staff had incorrectly logged the people involved in an incident and this had not been identified during the quality check process. Staff did not always record the duration of restraints as recommended in Department of Health and trust guidance.

However:

- All wards were safe, clean, well equipped, well-furnished and maintained.
- Excluding risks posed by the environment at the respite wards, staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- The wards had a good track record on safety. The service mostly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).

# Wards for people with a learning disability or autism

## Is the service effective?

Good   

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies and support for self-care and the development of everyday living skills, and meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Although respite services did not meet the mixed sex accommodation requirements as specified in the Mental Health Act Code of Practice, staff understood their roles and other responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

# Wards for people with a learning disability or autism

However:

- Staff did not always maintain the confidentiality or secure information held about patients. Confidential patient information was accessible by patients, visitors and other staff at Aysgarth and Oak Rise wards.

## Is the service responsive?

Good  

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Although some patients had excessive lengths of stay the service was working continuously to find suitable placements.
- Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy on the wards.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Systems and processes were not fully established to support all wards with the transfer of patients to psychiatric intensive care units if a patient required more intensive care.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued by their immediate line managers and colleagues. They reported that the provider provided opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local quality improvement activities.

However:

- Leaders and managers had not identified issues with mixed sex accommodation guidance, security of patient information or risks posed from the environment.

# Specialist eating disorders service

Good 

## Key facts and figures

The trust provides one eating disorder ward for adults. Birch ward was a 15 bed mixed gender ward located in Darlington at West Park hospital.

During this inspection we looked at all five key questions: was the service safe, effective, caring, responsive and well led? This inspection was unannounced, so staff did not know we were coming, to enable us to observe routine activity.

Prior to the inspection, we reviewed information that we held about the service. During the inspection we did a tour of the ward and talked with a number of staff along with reviewing documentation.

In total, during this inspection we:

- spoke with 4 patients
- spoke with members of the nursing team including 2 nurses and a support worker
- spoke with members of the multi-disciplinary team including a nurse consultant, occupational therapist, student occupational therapist, psychiatrist, psychologist and the dietician
- interviewed the ward manager and the service manager
- reviewed three patient care records
- reviewed four patient prescription records
- carried out a tour of the ward and review of the environment including associated risk assessments
- carried out a review of the clinic and treatment facilities
- observed a multidisciplinary team patient review meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.
- reviewed 15 records of patient and carer feedback to the service
- received written feedback from 12 completed feedback cards
- looked at incident records
- reviewed records of meetings
- looked at records about the use of physical restraint
- spoke with a clinician from a visiting team.

The Eating disorder service use to be part of the acute service. The ward had not been inspected before.

## Summary of this service

We rated it as good because:

# Specialist eating disorders service

- The service provided safe care and treatment for patients under its care and there were enough nurses and doctors to facilitate this. The ward environment was safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices and managed medicines safely.
- The staff team included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff had access to training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward including community teams who would have a role in providing aftercare.
- Staff developed comprehensive holistic, recovery-oriented care plans which were informed by a comprehensive assessment which involved a number of professionals. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Though there were clear processes for reviewing incidents and complaints, the awareness of three of the staff we spoke with about lesson sharing was limited.
- Though risk management plans were captured through individual patient risk assessments, the ligature risk assessment used by the service did not include management plans for each risk or detail contingencies respectively on the ward ligature risk assessment.

## Is the service safe?

**Requires improvement** ●

We rated it as requires improvement because:

- Though all risks were documented on the environmental ligature risk assessment used by the service they did not include management plans for each risk or detail contingencies for the risks identified.
- The awareness of three of the staff we spoke with about how lessons were shared with the whole team and the wider service was poor.
- The compliance rates for training courses the service provided as part of its mandatory training in key skills to all staff varied for all the modules, with six below the trusts target. The compliance rate for two modules was below 80%, at 77% and 71% for both Positive Approaches training modules.

However:

- The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.



# Specialist eating disorders service

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. When restrictive practices were used staff reviewed and reflected on the events leading to these to help develop their own practice and better inform care planning.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The service managed patient safety incidents well. Most staff recognised incidents and reported them appropriately and managers investigated incidents.

## Is the service effective?

**Outstanding** 

We rated it as outstanding because:

- There was a holistic approach to assessing, planning and delivering care and treatment to people who use the service. New evidence-based techniques were used to support the delivery of high-quality care. Patients received care and treatment that met their needs.
- Staff actively engaged in activities to monitor and improve quality and outcomes.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. A consultant psychiatrist worked between the ward and a neighbouring trust service, with close links forged between the two services.
- A specialist liaison nurse completed pre-admission assessments for patients and attended pre-admission referral meetings. They maintained links with community teams for patients, including when patients were admitted from out of the trust area.
- Staff across teams within the service worked collaboratively with each other and externally to deliver joined up care for those using the service. There was effective liaison with the local acute hospitals trust to manage physical complications, there were specialist staff who worked in the unit to ensure prompt actions in case of physical health deterioration. All patients from the service would, if necessary, be admitted to one particular ward where staff had some understanding of eating disorders.
- Patients had access to a dedicated physical health team who completed monitoring plans for all patients. They regularly reviewed patients and ensured access to other specialists as needed, including arranging bone mineral density scanning and other scans which required working with other agencies and organisations. They also maintained primary care monitoring including arranging ongoing dental treatment as needed.
- Patient's physical health was assessed immediately on admission by medical staff. A junior doctor and senior nurse from the acute hospital trusts gastroenterology team was based on the ward during the week. They ensured effective liaison and action if patients physical health became compromised or there were concerns at admission.
- We found there was a holistic approach to planning and delivery of care in which the needs and personal preferences of each patient were considered in the planning of care from triage to discharge.

# Specialist eating disorders service

- Discharge and transfer planning started at the earliest opportunity including when transfer or transition to other services were needed, including the acute hospital.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. A full-time nurse consultant with a specialist interest in eating disorders was based on the ward, who worked with individual patients and supported staff and service development.
- 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 in thematic group supervision sessions. There were regular teaching sessions provided by specialist staff, which alternated between physical health conditions such as osteoporosis, cardiac complications and mental health conditions, including personality disorder and self-harm.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new and temporary staff.
- Majority of staff understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Some staff members could not demonstrate confidence in understanding of the principles of the Mental Health Act and Mental Capacity Act.

## Is the service caring?

**Good** ●

We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care or treatment.
- Staff supported and enabled patients to make decisions on their care for themselves.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Good** ●

We rated it as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

# Specialist eating disorders service

- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However:

- Though we found evidence of concerns and complaints being investigated and shared in meetings and electronic staff briefings, three staff seemed unclear of these in terms of how they were shared with the whole team and wider service and could not give examples of these.

## Is the service well-led?

**Good** 

We rated it as good because:

- Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed.

However:

- Trust leaders were not visible in the service and approachable for patients and staff.
- Staff were unclear about the provider's vision and values.

# Mental health crisis services and health-based places of safety

Requires improvement  

## Key facts and figures

Tees Esk and Wear Valleys NHS Foundation Trust provides mental health services across County Durham and Darlington, Hambleton and Richmondshire, Harrogate and Craven, Scarborough, Whitby, Ryedale and Teesside and Vale of York.

The trust has 11 mental health crisis and home treatment teams and six health-based places of safety based. Teams are structured slightly differently across localities, some contain street triage teams, and some operate separate street triage services.

As part of this inspection we visited crisis teams and health-based places of safety at the following sites:

- Cross Lane hospital,
- Peppermill Court,
- Harrogate District hospital,
- West Park hospital,
- Lanchester Road Hospital,
- Roseberry Park.

This included all the health-based places of safety that this trust operates.

This inspection took place between 24 September 2019 and 3 October 2019. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We previously inspected this service in January 2015. We rated the service as good overall with effective as outstanding and there were no breaches of regulation found.

Prior to the inspection, we reviewed all the information we held about the service. We also held a range of focus groups with staff and patients in the several months prior to the inspection.

During the inspection visit, the inspection team;

- visited six crisis and home treatment teams and carried out a tour of the environment at each,
- visited all six health-based places of safety,
- spoke with six patients using the service and three carers or relatives,
- spoke with six managers of the services and two service managers,
- spoke with 22 other staff including; doctors, nurses, advanced nurse practitioners, healthcare assistants, occupational therapists and approved mental health practitioners,
- looked at the care and treatment records of 18 patients,
- observed a range of meetings including patients' appointments, team huddles, handover meetings and planning meetings,
- reviewed a range of policies, procedures and other documents relating to the running of the service.

# Mental health crisis services and health-based places of safety

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not effectively manage risk to patients. In 13 of the 18 care records that we looked at risk assessment and risk management records were brief and generic, staff were not always making use of the safety summary section of the care record,
- Staff were not managing the safe storage of medication effectively at two locations we visited,
- In 13 of the 18 care records that we looked at it was not clear that staff had developed individual care plans and updated them when needed,
- We found that there were delays to assessment of patients admitted to health-based place of safety because of staff availability,
- There were several issues that compromised the privacy and dignity of patients being admitted to health-based places of safety,
- A number of governance processes did not operate effectively,
- The multi-agency arrangements in place to support the operations of the health placed places of safety were not always effective.

However:

- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and were suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition,

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Staff did not effectively manage risk to patients. In 13 of the 18 care records that we looked at risk assessment and risk management records were brief and generic, staff were not always making use of the safety summary section of the care record,
- There was an inconsistent use of crisis plans across the different localities, several teams did not use them at all,
- It was not clear where consent to treatment and consent to share information was recorded and this could not be found in most of the care records we looked at,
- Staff were not managing the safe storage of medication effectively at two locations we visited. Room temperature checks were not being carried out at one site and at another no action had been taken following the recording of temperatures above that which the medications stated they should be stored.

# Mental health crisis services and health-based places of safety

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support,
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

## Is the service effective?

Good  

Our rating of effective went down. We rated it as good because:

- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.

However:

- Although patients and staff had devised strategies and were clear about the direction of care, in 13 of the 18 care records that we looked at it was not clear that staff had developed individual care plans and updated them when needed. Care plans did not reflect the work that was being undertaken with patients and the information contained within the detailed notes,
- Specific training for staff working in the health-based places of safety was not available to all staff.

## Is the service caring?

Good   

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

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

However

- Some patients said they did not know how to complain,

# Mental health crisis services and health-based places of safety

- Although it was clear from the detailed notes that patients were involved in planning their care, in 13 of the 18 care records we looked at there was a lack of patient involvement evidenced within the care plans and patients were not routinely offered a copy of their care plan.

## Is the service responsive?

**Requires improvement** ● ↓

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

- We found that there were delays to assessment of patients admitted to health-based place of safety because of staff availability. We also found that patients that were admitted to the health-based place of safety who had drunk alcohol were not being always being assessed in a timely manner,
- The referral routes into crisis services differed from site to site meaning that patients from different localities had different access to support from crisis teams,
- There were several issues that we felt compromised the privacy and dignity of patients being admitted to health-based places of safety. These included eyesight toilet observations for all patients admitted at one site, window and door glass panels that could not be covered at another site, CCTV streaming into offices at two sites and an arrangement where on occasion patients would have to share the toilet of one health-based place of safety.

However:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

**Requires improvement** ● ↓

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

- Our findings from other key questions demonstrated a number of governance processes did not operate effectively. These issues included the documentation of risk and risk management, safe management of medicines, operations of the health-based places of safety and privacy and dignity in the health-based places of safety,
- The multi-agency arrangements in place to support the operations of the health placed places of safety were not always effective to ensure that patients needs were always being met. For example delays to treatment because of approved mental health practitioner availability.

However

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff,
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team,
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression,
- Staff felt able to raise concerns without fear of retribution,

# Mental health crisis services and health-based places of safety

- Staff felt respected and valued and were given feedback when they did their jobs well.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

Jane Ray, Head of Hospitals Inspection, led this inspection. Two executive reviewers one director of nursing and one director of strategy, an equality and diversity specialist advisor, a safeguarding specialist advisor, and a Mental Health Act reviewer supported our inspection of well-led for the trust overall. The team included 29 further inspectors, 24 specialist advisers, one Mental Health Act reviewer, and seven experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.