Care Quality Commission

Outstanding ☆

Northumberland, Tyne and Wear NHS Foundation Trust

Community-based mental health services for older people

Quality Report

St Nicholas Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX4E4	St Nicholas Hospital	Newcastle West Older People's Community Mental Health Team	NE4 6BE
RX4E4	St Nicholas Hospital	South Tyneside Older Person's Community Mental Health Team	SR5 1NB
RX4E4	St Nicholas Hospital	Sunderland Cognitive Functionally Frail	SR5 1NB
RX4E4	St Nicholas Hospital	Morpeth Challenging Behaviour Service	NE61 2NU

Summary of findings

RX4E4	St Nicholas Hospital	Berwick Community Mental Health Team – Older People	TD15 1EQ
RX4E4	St Nicholas Hospital	Ashington Memory Assessment Service	NE63 8BL

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community based mental health services for older people as outstanding because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to patients. Staff were responsive to individual patient's needs and actively engaged in assessing and managing risk. Staff worked effectively together to share knowledge and deliver evidence-based treatment to patients.

- Staff empowered patients and carers to have an active role in their care and treatment. Staff developed positive relationships with patients and carers to ensure their needs and individual preferences were reflected in the planning of their care. Patients and carers reported staff went the extra mile and exceeded their expectations.

- The services were flexible, provided choice and ensured continuity of care for patients. Patients could access services in a way and at a time which suited them. Staff worked collaboratively with other services, within integrated person-centered pathways to ensure they met patients' needs.

- Staff were committed to continually developing their skills and competencies to ensure they delivered high quality care. Staff attended additional specialist training to enable them to acquire new skills and share best practice. Staff were encouraged to take an active role in research and innovative practices.

- Leaders had an inspiring shared purpose which succeeded in developing a strong, visible person-centered culture. Staff were highly motivated to offer high quality care and were proud of the service they delivered.

- Leaders consistently engaged with staff and actively encouraged them to raise concerns. Staff were open and transparent in reviewing incidents and learning lessons when things went wrong. Staff shared this learning across the trust and this was used to inform service development.

However:

- Staff caseloads were high in some services and some services felt they did not have sufficient administrative support. Managers were aware of this and were continually reviewing ways to develop systems and processes to address these issues. Managers had sufficient authority to increase staffing levels as required.

Summary of findings

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

Are services safe?   **Good** ●

We rated safe as good because:

- All six services had sufficient clinical staff to meet the needs of patients. Managers responded to vacancies with the appropriate use of bank and agency staff. Sickness levels were low in the majority of teams.
- Staff attended regular mandatory training and the overall compliance rate for all six services was 93%. This was above the trust target of 85%. Staff were trained in safeguarding, had good relationships with local safeguarding teams and understood when and how to make a safeguarding referral.
- Staff conducted risk assessments on every patient and reviewed them regularly. Staff used risk management plans where required to ensure that patients and their families knew how to access support in a crisis.
- Staff adhered to lone working protocols and procedures. The use of an electronic device gave staff additional protection when working in the community.
- Staff understood the duty of candour and were open and transparent in apologising to patients when things went wrong. Staff thoroughly investigated incidents and shared learning across the trust.

However:

- Staff had high caseload numbers in some of the teams. Managers were monitoring this and were taking action to change systems and processes where they could. The staff had escalated this to senior management level and placed it on their risk registers.

Are services effective?   **Good** ●

We rated effective as good because:

- The trust actively encouraged staff to acquire new skills and use innovative approaches to care. Staff were experienced and qualified and had regular access to clinical and managerial supervision.
- Staff proactively pursued opportunities to participate in research. Staff used new evidence-based techniques to support the delivery of high quality care. Staff provided pharmacological interventions and psychological therapies that were recommended for use with older people.

Summary of findings

- Staff were committed to working collaboratively to deliver joined up care to people who used their services. The teams worked effectively with a range of organisations to deliver a holistic service that reflected the patients individual circumstances and preferences.
- Staff had a good working knowledge of the Mental Capacity Act. Patient records showed staff assessed capacity when required and understood the importance of supporting patients to make their own decisions where possible.

However:

- In one service, staff had not reviewed the depot medication for two out of 11 patients within the last six months. This was actioned following our visit and across the other services, all depot medication reviews had taken place within the last six months.

Are services caring?   **Outstanding** ☆

We rated caring as outstanding because:

- All staff truly respected and valued patients as individuals. Staff treated patients with the upmost kindness, respect and compassion. Staff continually checked patient's understanding of their discussions and provided reassurance when needed.
- Staff were highly motivated and inspired to offer care that promoted people's dignity. Every member of the mutli-disciplinary team cared about their patient's wellbeing.
- Staff empowered patients as partners in their care, ensuring their voice was heard and that they were supported to realise their potential.
- Feedback about staff from patients and their carers was continually and overwhelmingly positive. They reported staff went beyond their expectations and that they delivered excellent care. Relationships between patients, their carers and staff were strong, caring and supportive.
- Staff were fully committed to working in partnership with patients and carers. They ensured people's individual needs and preferences were reflected in their care plan. Patients and carers understood their treatment and felt it met their needs.
- Staff actively sought feedback from patients and carers. They used this to inform service development and were committed to ensuring that patients' needs were embedded in their care and treatment.

Are services responsive to people's needs?   **Outstanding** ☆

We rated responsive as outstanding because:

Summary of findings

- Services were tailored to meet the needs of individual people. The teams responded quickly to referrals and did not operate waiting lists.
- Services were delivered to ensure flexibility and choice. Patient's individual needs determined which pathway and service they accessed. The services used their links with statutory and voluntary organisations to collectively deliver person centred care
- Staff worked flexibly to provide care that best met the needs of individual patients. Staff took a proactive and flexible approach to re-enagaging people who did not attend appointments.
- Staff took a proactive approach to deliver care that met the needs of different groups of people. Staff provided written information on treatment in a format that was accessible to all patients who used the service. Staff used communication aids to engage with patients who had difficulty expressing their views verbally.
- Staff actively reviewed complaints and provided feedback to patients on the outcomes. Staff shared learning from this and used it to inform service development.

Are services well-led?

Outstanding ☆

We rated well led as outstanding because:

- Leaders had an inspiring shared purpose that motivated staff to succeed. All staff spoke highly of the leadership within the trust. Staff knew the organisation's values and felt they were reflected in the care they delivered.
- Staff at all levels were actively encouraged to raise concerns. Staff reported an open, honest and supportive culture. Staff were proud of where they worked and the service they provided.
- Governance and performance management arrangements were used to drive continuous improvement and to ensure staff were accountable for delivering change. Staff were proactively encouraged to develop ways of improving the quality of care and people's experiences.
- Staff were encouraged to be innovative and there was a clear commitment to service development. The services were heavily involved in research and shared this learning across the organisation.
- Staff supported each other and spoke of mutual respect for each other's skills and experiences. Staff shared their workload, commenting that they loved their job and the people they worked with.

However:

Summary of findings

- Staff in some services felt they did not have sufficient administrative support. This was highlighted on the individual service and service line risk register. Senior managers were reviewing the tasks, systems and staffing levels to identify actions to address this.

Summary of findings

Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust provide community mental health services for older people across Gateshead, Newcastle, North Tyneside, South Tyneside, Sunderland and Northumberland. The trust covers 2,200 square miles and services a population of approximately 1.4 million. In 2014, the trust commenced a transformation programme which would result in the reduction of 90 inpatient beds. The aim was to focus on designing services around the needs of patients and their carers, to ensure community services supported people to help themselves and reduce the reliance on inpatient beds. The trust developed a number of pathway models within this transformation programme. The community mental health services for older people would operate under the cognitive pathway. This changed the way services worked with patients and outlined how a patient would move through the stages of their treatment journey.

We visited six community mental health services for older people during this inspection. These were:

- The memory assessment service in Ashington. This service works with patients of all age groups who present with mild memory problems. They provide an assessment and post diagnostic service before referring patients to the relevant service depending on their individual need.

- The challenging behaviour service in Morpeth is a team of qualified professionals including nursing and psychology. They provide specialist services to older adults who have an organic illness and display complex behaviours that carers find difficult to manage. The service works into care and nursing home environments to support staff who experience difficulties in understanding or managing complex behaviours for a person who has cognitive impairment. The team also provide a home service working with relatives or carers to support them to remain in their own homes.

- The cognitive functionally frail team in Sunderland offers support and treatment for individuals with

memory difficulties and those who are physically frail and suffer from a mental health problem. This includes services for younger people with dementia, a challenging behaviour team and the grange day hospital, which includes a community step up service.

- The older people's community mental health team in South Tyneside offers assessment, support and treatment for individuals over the age of 65 years. The service will offer assistance for individuals under 65 if that individual need is best met within this service.

The services include the older person's community team (which includes the younger people with dementia service and nursing home liaison service), the challenging behaviour team and the Jane Palmer day hospital.

- The Newcastle West older people's community mental health team is a multi-disciplinary group of professionals working together to provide specialist, community focused, mental health services to older adults with mental health problems. They provide a service for two groups of patients. Some patients have a level of cognitive impairment that would benefit from specialist interventions until their condition and level of need could be managed in a primary care, GP or care setting. Other patients who are presenting with a functional illness with complex physical health needs may need longer-term treatment and interventions.

- The community mental health team for older people in Berwick works with all patients over the age of 65 years with both functional and cognitive problems. They also see patients of younger age presenting with memory difficulties.

This was the first inspection by the CQC under the current methodology.

Summary of findings

Our inspection team

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

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

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

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

Sandra Sutton, Inspection Manager (Acute) Care Quality Commission

The team inspecting community mental health services for older people comprised two inspectors, one consultant psychiatrist, two registered mental health nurses, and one social worker.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

- is it safe

- is it effective

- is it caring

- is it responsive to people's needs

- is it well led?

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

During the inspection visit, the inspection team:

- visited six community teams and looked at the quality of each environment, including two day units.

- spoke with the managers of the six services and one community clinical manager

- spoke with seven patients and 16 carers whose relatives or friends were using the services

- spoke with 36 other staff members; including doctors, nurses, psychologists, occupational therapists and support workers

- attended and observed 14 visits to patient's homes and four patient appointments in clinics

- carried out two observations in two day hospitals.

- collected feedback from 22 patients, carers, and staff using comment cards.

- looked at 30 treatment records of patients.

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

What people who use the provider's services say

We spoke to seven patients and 16 carers. We observed 14 home visits, four clinic appointments and two sessions in day hospitals where we spoke informally to patients and carers about the service they were receiving. All patients and carers spoke very highly of the care they

Summary of findings

received and the staff who delivered it. They felt they were treated with dignity and respect. They described staff as caring and compassionate and felt fully involved in their treatment.

Patients and carers were grateful to the staff who they felt went beyond what was required of them. Patients and carers understood the treatment they were receiving and staff continually checked for their understanding and consent when making decisions about their care. Patients knew how to complain and felt assured staff would respond to their concerns, but all those we spoke to had no complaints about the care they received.

Good practice

Staff were proactive in reviewing the service they delivered and seeking opportunities to develop and improve. Staff in the South Tyneside and Sunderland services had undertaken a rapid process improvement workshop to develop a 'new ways of working' model. This enabled patients and carers to speak with a consultant at the time of their initial assessment to formulate a plan of care. The service was developing this further to include the use of skype in this process.

Staff across all services were heavily involved in research and innovative practice. The challenging behaviour team had developed a model to support family carers. This had been presented at a national conference where the staff had been asked to speak about the model. They also developed a risk management model, which had been published in the Journal for Dementia Care and rolled out across the trust. The consultant psychiatrist in the

memory assessment service was the dementia lead for the trust. He was a key contributor to a national research study looking at how a patient's progress through their initial assessments at memory assessment services was related to their subsequent outcome assessments and episodes of care.

The trust encouraged staff to develop particular professional interests and supported them to attend specialist training. Staff then shared this learning across the trust, delivering training and clinical supervision to other teams to ensure patients across the localities had access to these interventions. An example of this was the psychologist and a nurse in the Newcastle West team who had a specialist interest in hoarding and supported staff in other teams to work with patients with this particular issue.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff caseload numbers are at a manageable level to enable staff to continue to provide quality care.

- The trust should ensure that the number of administrative staff are sufficient to meet the demands of the service.

- The trust should ensure they have a robust system in place to monitor the review of depot medication in line with best practice guidance.

- The trust should ensure that staff know who the Mental Capacity Act lead is and how to access them for support and guidance.

Northumberland, Tyne and Wear NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Memory Assessment Service, Ashington	St Nicholas Hospital
Challenging Behaviour Service, Morpeth	St Nicholas Hospital
Newcastle West – Older Peoples Community Mental Health Team	St Nicholas Hospital
Older Peoples Community Mental Health Team	St Nicholas Hospital
Sunderland Cognitive Functionally Frail	St Nicholas Hospital
Community Mental Health Team – Older People	St Nicholas Hospital

Mental Health Act responsibilities

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

Staff attended mandatory training in the Mental Health Act, with the overall compliance rate across the six services being 93% at the time of inspection. The trust had a Mental Health Act office and staff knew how to access them for support and guidance.

Detailed findings

Some of the consultants within the older people's teams were approved under Section 12 of the Mental Health Act to undertake Mental Health Act assessments.

A small number of patients were on a Community Treatment Order. Staff understood their responsibilities concerning this and the documentation was in order.

Staff knew how to access advocacy services for patients should they be required.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the mental Capacity Act and Deprivation of Liberty Safeguards. Compliance with this was 94% at the time of inspection.

Staff had a good working knowledge of the Act and patient records showed that staff continually assessed patients' capacity. Staff used the MCA1 assessment to document decisions about capacity. Staff felt they supported people to make their own decisions where possible by ensuring they involved the families and carers.

Staff worked closely with colleagues in the local authority to undertake joint assessments or when best interest decisions were required. Staff made recommendations to care home staff if they felt a deprivation of liberty safeguards assessment was required.

Staff could give clear examples of when they had needed to assess a patients capacity and understood that an assessment of capacity was decision and time specific.

Are services safe?

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

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

Our findings

Safe and clean environment

All six community teams had facilities for patients to attend appointments on site. Staff often shared these areas with other teams. All patient interview rooms had alarm systems in place. All of the areas were clean and well maintained. The environments were welcoming and accessible with adequate furnishings. One environment, Anderson Court in Berwick, was due to be refurbished the week after our visit. This was the first part of a refurbishment plan at various locations across the trust. The team would be based at another site until August when they would return to the refurbished Anderson Court. All staff felt positive about the planned changes. Staff at all locations primarily visited patients in their homes or held clinic appointments in the local day hospitals. We attended the Grange day unit at Monkwearmouth Hospital and the day hospital in Berwick Infirmary. Both environments were clean, well maintained and met the needs of the patients attending.

Each trust site had an annual fire risk assessment, asbestos assessment and a gas and oil boiler assessment. The trust also conducted quarterly cleanliness audits, which included a review of the general environment. The estates department was responsible for the testing of electrical equipment and the general maintenance of the buildings. The estates department had carried out portable appliance testing on the electrical kitchen items that we looked at. Managers reported that requests for maintenance and repairs to the premises were actioned in a timely manner. Staff had access to hand washing facilities and antibacterial gel at all sites. Hand washing notices were evident on the hospital sites and we observed staff adhering to infection control principles.

Some of the community teams had access to a clinic room on site. At Newcastle West, staff used the clinic room to store equipment and medication and patients did not access it. A key, that was stored in a key safe in the administrative office, accessed the clinic room. Staff took responsibility on a rota system for checking the clinic keys, monitoring the fridge temperatures and undertaking a weekly stock check. At the time of inspection, the temperature of the clinic was high at 33.2 degrees Celsius

and staff had a fan running to combat this. Staff reported this to estates every time the temperature exceeded the recommended limits of below 25 degrees Celsius. A review of the recent fridge temperature checks showed it had remained within recommended limits and staff had conducted a stock check on 31 May 2016. This was discussed at a recent managers meeting and options for moving the clinic room were being considered following the completion of the trust's accommodation review.

Pharmacy staff within the trust undertook an annual audit of the clinic. Equipment available to staff included scales and blood pressure machines. The physical health nurses were responsible for ensuring equipment was cleaned and that staff had returned it following visits to patient's homes. The administrative staff ensured that equipment was sent to be calibrated each year. The clinic room had no resuscitation equipment or emergency medication; this was available at other locations on the hospital site. A first aid kit was available and stocked in the clinic and staff carried first aid kits in their cars.

Some staff within the Sunderland cognitive functionally frail team worked into the Grange day hospital. This was on the trust site and used by the older people's wards and the community team. There were several patient interview rooms, a large communal area, dining facilities and a clinic room. Patients brought their own medication in dispensing packs that they ordered from the pharmacy. The registered nurse stored the medication in the drugs cupboard and kept the keys on their person at all times. The drug cupboard met with requirements and staff kept a controlled drugs book in accordance with trust procedures. The fridge was not in use but staff checked and documented the clinic room temperature daily. Staff had access to scales, blood pressure machines and electro-cardiogram machines to monitor patients' physical health. The day unit was clean and well maintained with good furnishings.

Safe staffing

Staffing levels varied across all six teams. The challenging behaviour service was fully staffed with no vacancies and had a low staff turnover rate of 0.6% in the 12 months prior to inspection. The sickness levels in this service stood at 5%. The trust average sickness rate was 5%.

Are services safe?

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

The memory assessment service appeared to have the highest substantial vacancy rate of 11%, which was above the trust average of 3%. This service also reported a 26% staff turnover rate in the 12 months prior to inspection. However, this was a small team in which two nursing staff had retired and returned two days per week as bank staff. The trust's retire and return scheme enabled teams to hold onto experienced staff who wished to retire and return to work part time. The team had one nursing vacancy, which was being filled by an agency nurse who had undergone an induction period and mandatory training. They had advertised for a clinical pathway lead, which would provide a deputy role to the manager and was an additional role under the new cognitive pathway model. The service had low sickness levels of 1%.

The Newcastle West older people's community mental health team had no vacancies and a low staff turnover rate of 2%. This team had the highest sickness rate of 7%. The manager reported there was no persistent short term sickness within the team but some planned longer term absences. The service did not use agency staff, but one staff member had retired and returned to undertake bank shifts to cover this absence.

South Tyneside older people's community mental health team had a low number of staff leavers in the last 12 months, with a rate of 1%. The team were very proud of their low sickness levels, which were at 0.4% at the time of our visit. This service had no vacancies.

Sunderland cognitive functionally frail team had one nursing vacancy and one nursing post which had recently been appointed to with the staff member due to start in July. The sickness levels in this team remained at below the trust average with 4%. One staff member was absent long term but another member of the team was temporarily filling this post. The team used bank staff that had retired and returned and had five agency staff at the time of inspection. The manager reported that posts were reduced following the transformation programme, however referrals had increased. The manager felt fully supported by senior managers to access bank and agency staff as required.

The community mental health team for older people in Berwick had no vacancies and one agency nurse at the time of inspection. The sickness levels within this team were below the trust average at 3% and the manager reported no concerns about staffing levels.

The services did not have a waiting list; therefore, every patient who had been referred was allocated to a care co-ordinator. The referral and access route varied depending on the function of the team and whether the service had been through the transformation programme. As a result, the average staff caseload varied across the teams. Each team manager or clinical lead monitored staff caseload numbers through monthly managerial supervision. This information was easily accessible through the electronic care records system, RIO.

The average caseload size per team varied; Newcastle West had an average caseload size of 37; Sunderland had 44; South Tyneside had 39; Berwick had 15 and the challenging behaviour service had 14. The memory assessment service provided a very specific function of assessment, diagnosis, post diagnostic support and discharge. Care co-ordinators in this team did not deliver treatment interventions to patients, but ensured they moved through the assessment pathway and onto the service that best met their individual needs.

The manager in the South Tyneside community team identified some caseloads were high with one staff member carrying a caseload of 70 patients. This was reflected on the team's risk register and had been escalated to the service line risk register. The manager in the Sunderland cognitive functionally frail team also felt staff caseloads were high, with the highest being 157 patients for one nurse. Caseloads varied depending on the staff role, so those in the step up service worked more intensively with patients and therefore had lower caseloads of around 25. The manager felt the high caseload numbers were partly due to the process of embedding the transformation programme. This team had also received increased referrals in recent months. In the previous service model, staff had dedicated roles such as assessing new patients or running titration clinics. Titration is the incremental increase in drug dosage to a level that provides the optimal therapeutic effect. In the new model, staff care co-ordinated a patient throughout their treatment and each staff member took responsibility for titrating each patient on their caseload. Following this, caseload numbers had increased. The pathway lead in South Tyneside had mapped out what was required to sustain the service based on the numbers of referrals received in comparison to the number of weekly assessment slots available. She had made a proposal to recruit additional staff based on this although this had not yet been approved.

Are services safe?

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

In response to caseload numbers, the South Tyneside and Sunderland services had undertaken a rapid process improvement workshop in December 2015. This was to address issues such as the time it was taking from assessment to treatment, which was delaying discharges and in turn contributing to high caseload numbers. As a result, the teams developed 'new ways of working', which commenced in April 2016. The team re-instated titration clinics for patients, which staff were allocated to run one day per week. They also changed the assessment process. The nurse would asses a patient at home, have a 30 minute consultation with the consultant over the phone and provide an immediate plan of treatment to the patient and their family. The benefits of this were a quicker assessment to treatment process for patients, the opportunity for patients to discuss their treatment needs with a medic at the time of assessment and reduced caseload numbers for staff. Staff working under this model had an average caseload of around 30 patients at any one time. Managers reported they could see this process had started to work and was improving the flow of patients through the service whilst reducing staff caseload numbers.

The trust reported that caseload numbers could be high due to staff care coordinating patients in inpatient wards and acting as points of contact for patients waiting for assessments. They also identified that some staff were providing on-going support for patients who were awaiting transfer of care to another service. The existing caseloads were managed through clinical supervision completed by the clinical supervisor. This included an understanding of the complexity of cases across the caseload of each individual worker. The services were proactively seeking feedback from patients and staff on this process and would continue to monitor and review caseloads. Staff did not raise concerns about caseload numbers and all services were meeting their referral to assessment targets. The managers were pro-actively reviewing caseloads on a monthly basis. Psychology and occupational therapy staff reported manageable caseload numbers, which allowed quality work to be undertaken with patients.

Senior managers acknowledged that they used potentially more agency and bank staff than they would like across some of the services. They felt this was due to the population and an ageing workforce, as a number of staff had retired. The trust was undertaking a recruitment campaign in Scotland for those teams in Northumberland close to the Scottish border. The trust was also looking at recruiting agency staff into permanent posts and had set up the retire and return scheme. Staff reported that vacant posts were quickly responded to with the appropriate use of agency and bank staff. We observed in one team the arrangements for annual leave, identifying that only a certain number of each profession of staff could be on holiday at any one time. Managers temporarily filled posts where staff were on long term absence.

All teams had access to a psychiatrist who specialised in older people. The memory assessment service had identified that due to working hours, access to a psychiatrist in school holidays could be limited. This was on the risk register. The psychiatrists took part in regular multi-disciplinary meetings, visited patients at home and held clinics across the trust sites. Staff reported good access to a psychiatrist when required. The services operated only on weekdays between the hours of nine and five. Patients would access services outside of these hours via the crisis teams or initial response services. Staff in the South Tyneside and Sunderland community teams had identified that the out of hours services did not have access to a consultant that specialised in older people. In response to this, they had devised a rota for their specialist consultants to provide an hour slot each day. This would be for staff in the initial response service and general practitioners to seek advice and guidance about potential referrals and treatment for older people. This was due to commence in August 2016. The initial response service did have two band six nurses and one band five nurse that specialised in older people.

The trust had 19 essential and mandatory training courses that staff had to attend as part of their induction and then at varying frequency throughout their employment. These included information governance, prevention and management of violence and aggression breakaway, dual diagnosis, infection prevention and control and equality and diversity. Staff monitored their own training needs through their personal dashboard on the computer system. This would highlight training that was due and could be monitored by the team managers. The overall compliance rates across all six services were 93%, which was above the trust target of 85%. The lowest compliance rates were the Newcastle West older people's community mental health team and the memory assessment service, both with 89%. This was still above the trust target.

Are services safe?

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

The memory assessment service had achieved less than 75% compliance for six courses, including medicines management, moving and handling and health and safety. This was a small team and one member of the team had fallen behind with their mandatory training requirements due to a period of absence. An action plan to address the situation had been agreed at a recent supervision session and much of the training would be completed by July 2016, with the remainder up to date by September 2016.

Assessing and managing risk to patients and staff

Staff undertook a risk assessment of every patient at the first appointment. Staff used the functional analysis of care environments risk assessment tool or completed a narrative risk assessment depending on whether the patient was under an enhanced care programme approach or not. The care programme approach is a national approach, which sets out how mental health services should help people with mental illness and complex needs. A patient on an enhanced care programme approach will usually require the input of more than one service and have more complex mental health needs, potentially posing more risk to themselves and others. In such cases, staff completed the more detailed functional analysis of care environments risk tool. Staff reviewed a patient's risk assessment as part of their care programme approach or multi-disciplinary review, or following a change in risk status or circumstances. Staff reviewed patients risk at a minimum every six or twelve months depending on their level of need and complexity. We reviewed the care records of 30 patients. Staff had not undertaken an initial risk assessment of one patient. This was raised with the manager at the time of inspection. The staff member had written the risk assessment in the patient's notes but had not completed the risk assessment tool. Staff completed this two days after our visit. In the remaining 29 records, staff undertook a narrative or functional analysis of care environments risk assessment of each patient and reviewed them as required.

The trust care coordination and care programme approach policy stated that risk management plans were an integral part of the care plan that would be developed when the level of risk was significant, serious, or imminent. Staff used risk management plans to manage the risk of more complex patients and therefore not all patients required one to be developed. Of the records we reviewed, 19 contained a risk management plan. Examples included identifying people to contact if help was required out of

hours and details about what a relapse in behaviour looked like for an individual patient. Staff clearly involved a patient's family and carers in risk assessments and risk management plans.

The services did not have waiting lists and patients were allocated a care co-ordinator and sent an appointment within the same week of the referral being received. However, there was then a four to eight week wait from referral to initial assessment depending on the team. Following initial assessment, patients would then receive appointments for certain scans and tests in the acute hospital, which could also take up to eight weeks to be completed and results given. During this period, patients and their carers could contact the allocated care co-ordinator if their health deteriorated, but the services did not actively monitor the patient during this time. Staff in the South Tyneside community mental health team had identified this as a possible area for development and were considering ways to monitor patients during this period. Staff reviewed on a weekly basis any patients that were awaiting input from psychology. In the Newcastle West team, this amounted to two patients at the time of inspection and patients would wait around three weeks to access psychology in the Sunderland team.

Staff were required to attend mandatory safeguarding adults, safeguarding children and safeguarding children level two training. Across the six services, 93% of staff had attended the safeguarding children training and 94% had attended the safeguarding adults training. The managers reported good working relationships with the local safeguarding teams and they used their threshold tool to determine whether to make a safeguarding referral. Staff had a good understanding of what constituted abuse and how to recognise and report this. Staff felt that visiting patients at home was crucial to ensure they were aware of patients presenting a risk to themselves or being at risk from others.

The trust had issued staff in community teams with a reliance protect identicom device. The identicom device was a lone worker device disguised as a standard identity card holder, worn on a lanyard or lapel clip. It provided a discreet means of alerting the 24/7 manned reliance alarm receiving centre to a situation. If staff pressed the button on the device, staff in this centre could listen in to and record everything that was taking place during an incident. The most appropriate response could then be initiated based

Are services safe?

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

on incident severity. Managers received a monthly report indicating whether staff were using the device. This report did not indicate what the level of expected use would be or how many visits a staff member had undertaken that month. The manager in the South Tyneside team had met with each clinician to agree when the device should be used. She ensured the staff understood how to use the device and explained stage one and two of the policy that identified the action managers would need to take if staff did not use the device. This was then discussed in monthly managerial supervision to ensure staff recorded their location each time they visited patients.

Each service also had local lone worker protocols in place. Staff had to sign in and out using a whiteboard stating the address and patient details of the visit. Staff recorded an estimated time of return. If staff did not return at the expected time, administrative staff would begin ringing the staff member and escalate as needed depending on whether a response was received. If staff had to work outside of office hours, they would identify a buddy to contact once their visit was over. If they did not make contact at the expected time, the same process would be followed to escalate this as needed.

Nursing staff were not provided with lockable bags by the trust but provided their own for transporting drugs and equipment for depot injections. At the time of inspection, the trust were looking at providing appropriate standardised equipment for this.

Track record on safety

Staff in the community teams used an electronic reporting system to complete incident reports to report serious incidents to the strategic executive information system. The trust reported 149 serious incidents between 1 January 2015 and 31 December 2015. Of these, one related to the Berwick community older person's team and was reported to the strategic executive information system. This incident concerned a patient death in the community.

The death of a patient in South Tyneside in 2015 had resulted in a serious case review. Recommendations for the community mental health service were that staff should complete robust Mental Capacity Assessment documentation including best interest decisions. A further recommendation was that staff should adhere to physical health monitoring in respect of anti-psychotic medication in line with trust policy. Team meeting minutes showed the manager had shared the outcome of this case review and

identified lessons learned. Staff had received training in the Mental Capacity Act and this was being reviewed in clinical supervision. The clinical lead planned to review physical health checks in supervision routinely as part of caseload monitoring.

Reporting incidents and learning from when things go wrong

Between 1 April 2015 and 30 April 2016 inclusive, the trust reported 34,658 incidents. Four hundred and fifty four of these were reported by community based mental health services for older people. Fifty-one percent of the incidents reported by community based mental health services for older people were patient deaths. This was followed by safeguarding incidents at 21%. Staff would complete an incident report if they had requested the involvement of another agency to support a patient's needs, but there had been a delay in that patient receiving input from that service.

Staff understood how to report incidents and what incidents required reporting. Staff understood the meaning of the duty of candour and spoke positively of being open and transparent with patients when something had gone wrong. One team manager explained a recent incident where a patient letter had gone to the wrong address. The staff reported this breach of confidentiality using the electronic incident reporting system. The manager then contacted the patient who should have received the appointment, explained the situation and offered an apology. Both parties received this in writing along with information on the complaints procedure if they wished to complain. The manager investigated the incident to find that a standard letter template had been used and the patient address had not been changed. This was discussed with all staff in the team meeting. The office address was subsequently stamped on the back of all letters to ensure letters could be returned without being opened if they were sent to the wrong person. Staff in other teams gave this incident as an example of learning when things go wrong, indicating that lessons learned were shared across trust teams and locations.

The trust achieved the sharing of lessons learned with the use of 'key cards'. These were sent electronically following an incident, outlining the incident and lessons that were learned. The trust also carried out after action reviews to ensure lessons learned following incidents were embedded into practice. Managers reported there was no blame

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culture and that this was a supportive process. Staff had access to de-brief following incidents. They also shared learning during team meetings and peer supervision sessions. Staff felt fully informed and supported by managers in reporting incidents and learning from when things went wrong.

Are services effective?

Good ●

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

Our findings

Assessment of needs and planning of care

The trust was rolling out a transformation programme across its services at the time of inspection. The older people's mental health services would be working under a cognitive pathway. The Sunderland and South Tyneside teams had been through this transformation; however, the Newcastle West and Berwick teams had not transitioned yet. As a result, the teams worked slightly differently but all staff completed the same assessment documentation on the electronic case management system and used the same care planning tool.

All 30 records contained a comprehensive assessment of the patient's needs. We observed initial assessments taking place in patient's homes, first assessments by psychiatry, occupational therapy and psychology and appointments of ongoing care. Each assessment was thorough and detailed involving the patient and their family or carer. Staff explained the purpose of their visit and undertook the assessments at the patient's pace. The assessment involved a consideration of the patient's presenting needs, capacity and consent, carers views, current medication, social situation, family history and mental state.

Although care plans varied in their purpose and level of detail, all were found to be personalised and holistic where expected. Some care plans were used to aid staff in care homes with the management of a patient's behaviour and therefore were almost a set of instructions as opposed to a person centred plan. In these cases, the plan still contained a range of problems, interventions and desired outcomes that were personal to that patient. In care plans for more complex patients in the community mental health teams, staff had addressed a variety of issues that were individual to the patient and they were written in the patient voice from their perspective. Staff had discussed patients' well-being and functioning and care plans showed that staff had offered patients a choice of treatment interventions. Care plans often contained input from the care homes, families and carers and other services where they were involved in the patient's care.

The assessment pathway depended on the function of the team. In the memory assessment and challenging behaviour service the intervention was specific and time limited. The memory assessment service worked with patients early on in their illness and would then refer the

patient to the appropriate service if they required longer term care. The challenging behaviour service worked with patients who were already care co-ordinated by the community mental health team. This was known as an augmenting service, in that they provided additional intensive and specific support to patients who were presenting with challenging behaviour. The team would devise a care plan with the family and care home staff to enable them to safely manage the patient's behaviour.

In the other four community teams, patients received longer term care and a range of interventions from the staff. The South Tyneside and Sunderland community mental health teams had developed 'new ways of working'. Once a patient was referred through the initial referral service, staff would allocate the case and provide the patient with an appointment for an initial assessment. A nurse would visit the patient at home to complete the assessment and any necessary cognitive tests. The nurse would then have a telephone appointment with the consultant, where the family could speak to the consultant if they wished to do so. The nurse and consultant would discuss possible diagnoses, request any scans or further tests required and formulate a care plan with the family. We observed the home visit for initial assessment and the telephone consultation with the psychiatrist, which was done through loud speaker so the family could be involved. The patient and carer found this to be very thorough, much quicker than they expected and reported it was very helpful to be included in the conversations with the psychiatrist.

All community teams used electronic records on a password protected laptop. Staff took their laptops with them when they moved between sites. Paper information was locked securely in offices and during inspection; we did not observe patient paperwork being left on desks or in patient areas. When visiting patients at home, staff kept paperwork in secure bags if they made paper notes. The trust provided a digital dictation service. This allowed the staff to dictate their assessment into their phone that would then by typed into the assessment document on RIO the same day. Staff had to review the document for accuracy then sign it off.

Best practice in treatment and care

Staff in the community mental health services could explain how they followed national institute for health and care excellence guidance when delivering treatment interventions to patients. The trust policies referenced best

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practice guidance and clinical staff were actively involved in research to ensure they were delivering quality treatment and care. The community mental health services for older people adhered to guidance CG42: Dementia: supporting people with dementia and their carer's in health and social care. In the memory assessment service, clinical staff commenced patients on a prescription of donepezil if appropriate. This was recommended by the national institute for health and care excellence for managing mild and moderate Alzheimer's disease. Across the services, staff sought dementia screening tests through general practitioners, such as testing for vitamin B12 deficiencies, sodium levels and thyroxine levels. Staff assessed patient's memory using recognised and validated tools, such as the Mini Mental State Examination and the Addenbrooke's Cognitive Examination. Both of these are brief neuropsychological assessments of cognitive functions and are widely used with dementia patients. Staff offered patients computerised tomography scans or magnetic resonance imaging where appropriate to ensure a thorough diagnosis. Staff then followed best practice guidance in monitoring those patients prescribed medication and started with a low dose gradually titrating upwards. This was increased to the maximum tolerated dose using a minimum of four weekly titration steps. Medical staff operated under a shared care protocol with primary care staff to ensure the safe monitoring of patients who were prescribed lithium and anti-psychotic medication.

In the Newcastle West team, all staff were trained to administer depot injections to patients and two staff were trained to administer flu vaccinations in the winter months. The manager stated that medical staff reviewed patient's depot medication at a minimum every six months as per best practice guidelines. A review of 11 prescription charts showed that two patients were overdue that review. One patient had been admitted to an inpatient ward and their medication was being reviewed there. Regarding the other patient, following our visit the manager completed an incident form documenting this. A consultant reviewed and re-prescribed the depot medication and the nurse updated the depot care plan. The manager added the checking of depot prescription charts to the weekly checklist of checking expiry dates to ensure that this error did not occur again. In the other community teams where depot injections were administered, all patients had been reviewed within the last six months.

Alongside the use of pharmacological interventions, the community mental health teams offered patients access to psychological therapies. The challenging behaviour service used the Newcastle model to provide advice on managing challenging behaviour in patients with cognitive impairments. The Newcastle model was a psychosocial model that provided a framework and process in which to understand behaviour that challenged in terms of needs which are unmet. The aim was then to suggest a structure in which to develop effective interventions that kept people with dementia central to their care. The staff within the service had developed a new pathway for the trust that was in draft form at the time of inspection. It outlined the use of psychosocial, medical and physical interventions, all of which were rooted in best practice guidelines and involved the use of recognised assessment tools to improve outcomes for patients. Staff in the challenging behaviour teams provided clinical supervision to nursing staff in other teams working with patients who presented with challenging behaviour. In the memory assessment service, staff did not deliver psychological therapies due to the specific remit of the team. The psychologist supported patients adjusting to their diagnosis and offered an average of three sessions where required.

Each community mental health team had input from psychologists and in some teams psychological therapists. All those that we spoke to had a detailed knowledge of national institute for health and care excellence guidance and best practice. Some psychology staff had additional training in family therapy, mindfulness, cognitive behaviour therapy and cognitive analytical therapy. All of these were recommended for use in older people experiencing problems with their cognitive functioning. Psychology staff assessed patients using recognised assessment tools, such as the Beck Depression Inventory. This is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. Psychology staff in the memory assessment service were developing a battery of neuropsychological assessment tools, taking into account current research and evidence to achieve consistency of assessment across patients and localities.

Nursing staff would deliver some cognitive behavioural therapy to patients and received supervision from the psychologists to support this. Psychologists used neuropsychological techniques to support patients on a one to one basis in managing their illness and engaged in

Are services effective?

Good ●

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family therapy. They also supported staff to use case formulation techniques to help a patient to understand what their difficulties were, where they originated, and what kept them going. Psychologists provided clinical supervision and peer support to nursing staff. We observed a home visit to a patient by a psychologist in the Newcastle West community team. The patient had a wellness and recovery action plan, which identified strengths and distraction techniques that were individual to that patient. The psychologist had liaised with housing services, social services and the patient's general practitioner in ensuring a holistic approach to the patient's treatment.

Staff used the mental health clustering tool to assess patients' progress and to inform their treatment planning. The mental health clustering tool enables services to offer specific evidence based treatment interventions to patients and to assess the effectiveness of them. In some services, staff were using the Neuropsychiatric Inventory with Caregiver Distress scale to benchmark the effectiveness of the service. This was in the early stages and therefore had not yet been analysed to produce any information about outcomes for patients. Staff in the challenging behaviour service felt they were not using enough assessments that demonstrated change. In response to this, they were starting to use the agitated behaviour in dementia skills assessment. Staff were heavily involved in research and development but highlighted they were keen to take part in more clinical audits at a local level.

Staff worked closely with the patient's general practitioner to ensure patient's physical health needs were met. Staff requested tests and scans where required and each patient's care record showed staff continually monitored patient's physical healthcare. The services had access to the acute trust database in order to quickly review test and scan results. Staff followed guidelines to undertake additional monitoring of the physical health of patients prescribed anti-psychotic medication. Staff documented the monitoring of medications such as lithium and clozapine on RIO. This involved regular checks of patients body mass index and the development of exercise plans to combat weight gain where appropriate. The Newcastle West team had two designated physical health champions. They attended a trust wide physical health meeting every two months and fed this back to the team. Recent meetings had focused on the development of the Lester tool and the

physical health commissioning for quality and innovation targets. The Lester Tool is a summary poster to guide health workers to assess the cardio metabolic health of people experiencing psychosis and schizophrenia.

Skilled staff to deliver care

Psychiatrists in the teams specialised in old age and were actively involved in research in the field. They had access to weekly educational meetings and study leave, a quarterly continuous professional development group and an annual appraisal. All psychiatrists had been revalidated in the 12 months prior to inspection. All community mental health teams had input from occupational therapists. They acted as care co-coordinators for some patients and as an additional support to nursing staff for others. Occupational therapy staff reported good working relationships with other disciplines in the teams. They were involved in patient review meetings and had input into risk assessments and crisis plans. Occupational therapists used the Model of Human Occupation Screening Tool to assess patients' needs and to formulate treatment plans. This tool allowed the therapists to gain an overview of the patient's occupational functioning and monitor improvement or deterioration in this.

Each team had a detailed trust and local induction for agency and bank staff to undertake which ensured they were familiar with the patient group and the running of the service. The induction pack included orientation to the site and facilities, policies and processes, access to computer systems, a training checklist and the staff handbook. The staff handbook contained detailed information on the trust values and vision, payroll and human resources information, the staff survey and training details. Each site also had an induction folder that outlined the service profile and the locality.

The Newcastle, South Tyneside and Sunderland services had developed a training star, which was a wish list of training that each clinician would be able to access. This had been led by psychologists within the teams with input from staff. At the time of inspection, managers were undertaking a gap analysis to identify what additional training they needed to source for staff. The trust supported staff to undertake additional specialist training for their role. In the challenging behaviour service, staff were undertaking degrees, master's degrees, and courses in family therapy and cognitive behavioural therapy. In the Newcastle West community team, the occupational

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therapist had undergone additional training in assessment and motor process skills. In the South Tyneside team, the occupational therapist had completed a 12 month course in psychodynamics supported by the trust and had received their accreditation to mentor students. Staff were supported to access conferences where appropriate to keep updated with current and best practice in their professional fields.

Staff received monthly managerial and clinical supervision. This could be delivered together or separately depending on the needs and wishes of the staff member. For staff in those teams who had been through the transformation programme, the pathway lead conducted managerial supervision and the clinical lead conducted clinical supervision. The two roles worked closely together to supervise staff and ensure the day to day running of the service. Staff had access to specialist clinical supervision; for example, the staff delivering family therapy in the challenging behaviour service accessed clinical supervision from a psychologist in another service who specialised in family therapy. Staff engaged in regular peer supervision, both formally and informally. In the Newcastle West team, staff had set up a community psychiatric nurse forum. All community mental health teams for older people in that locality attended the monthly forum. The purpose was to discuss clinical practice in a supportive environment, to ensure cohesive team working across the locality and to share lessons learned. Recent agenda items included revalidation, physical health monitoring and discussions about the nursing and midwifery council code of conduct. They also invited guest speaker from other teams and services to speak and kept a log of actions each month.

Trust policy indicated that staff were to receive an annual appraisal. The total appraisal rate for non-medical staff across all six services as of 30 April 2016 was 91%. The lowest rate was in the Berwick team with 85% of staff having received their annual appraisal. The appraisal rates for medical staff across the six services as of 30 April 2016 was 95%. In four of the teams, 100% of medical staff had received their annual appraisal.

Multi-disciplinary and inter-agency team work
The memory assessment service in Ashington was developed one year ago in response to an increase in referrals of patients with mild memory problems. Three staff moved from the community mental health team to focus on assessment, diagnosis, titration and post

diagnosis support. The service had assessed over 500 patients since it started and worked with all age groups. Staff worked very closely with the community mental health team. Each morning they had a brief 'huddle' where staff from both teams reviewed referrals to work out which team best met the needs of that patient. If staff intended to transfer a patient's care from the memory assessment service to the community team, they would undertake a joint visit to ensure a smooth transition for that patient and their family. An after action review identified the close working between these teams as a positive lesson to be learned and shared following the review of a patient death.

The services also worked closely with statutory and voluntary agencies in the area. They often referred to organisations such as The Alzheimer's Society or Talking Matters for additional support for patients. In Berwick, the local dementia advisor occasionally attended the team meeting to provide staff with up to date information about her work. Staff in the older people's service worked closely with colleagues in learning disability services and the working age adult community mental health teams. They would seek specialist advice from each other and carry out joint assessments. Patient records showed staff liaising closely with other services involved in patient care, such as social services and general practitioners.

The Sunderland Vanguard project involved the development of five Sunderland locality integrated teams, which were hosted by primary care. The service manager and clinical lead from the older people's services had attended the project groups. The project outcomes were to ensure services worked together to support the older adult with a range of mental and physical health needs that could be treated in the community rather than as an inpatient.

The challenging behaviour service worked closely with care home staff .They developed a collaborative assessment and personal profile for each patient and held formulation meetings with staff, the patient and their family. Staff in this team encouraged care home staff to develop a person centred care plan incorporating suggestions about how to manage patients complex behaviour. The aim was to avoid the placement breaking down and prevent unnecessary admissions to hospital. The team hoped the techniques they were recommending would enable staff to develop similar person centred care plans for other patients if required. They had also delivered training to over 200 staff

Are services effective?

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to support them in managing challenging behaviour. We observed a member of the team discussing two patients with a care home manager. It was clear that both staff members understood the needs of the patients and the problems faced by the staff in managing the challenging behaviour. It was a caring and respectful discussion with the aim of shared learning to achieve the best outcome for the patient and staff.

The trust requested an additional visit from the inspection team to the Memory Protection Service in South Tyneside. The inspection team made a brief unannounced visit to this service. The service was set up three years ago as a collaborative commissioning exercise which involved the trust, the clinical commissioning group and some local voluntary organisations such as Age UK. The service included special interest general practitioners as part of their multi-disciplinary team and delivered clinics in primary care settings. The clinical lead from this service had attended the local Bangladeshi Centre to facilitate referrals. Medical staff were involved in setting up a clinical network with neurology colleagues in the local acute hospital with the aim of forming joint clinical pathways for patients.

Each service held regular referral and allocation meetings, sometimes daily and sometimes weekly depending on the nature of the service and the referral process. All staff disciplines and grades attended weekly or monthly team meetings and minutes were typed and circulated for those who could not attend. Staff reviewed patients as a multi-disciplinary team each week. The frequency at which patients would be reviewed depended on their level of need and risk. Care co-ordinators were responsible for ensuring each patient on their caseload was reviewed at least every six months.

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

The trust had recently combined training in the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were required to attend this training every three years and it had been updated to reflect the changes in the revised code of practice.

Compliance across all six teams with the previously separate Mental Health Act training as at May 2016 was 93%. The challenging behaviour service and memory

assessment service both achieved 100% compliance for staff trained in the Act. The Newcastle West older people's community mental health team had the lowest compliance rate with 73%.

Staff had a working knowledge of the Act although felt it was not often used in their day to day work with patients. However, some of the consultant psychiatrists were approved under Section 12 of the Mental Health Act and would be involved in Mental Health Act assessments. A doctor who is approved under Section 12 of the Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders'. Doctors who are approved clinicians are automatically also approved under Section 12. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under Section 2 and Section 3 of the Mental Health Act.

There were a small number of patients on a Community Treatment Order, three in the Sunderland team and one in the Berwick team. Staff understood their responsibilities with regards to Community Treatment Orders. Patient records indicated that staff used a second opinion appointed doctor to assess capacity and review patients on a community treatment order who were prescribed memory enhancing drugs.

Staff knew of the local advocacy services and could assist patients in accessing them if required. Staff were aware of the Mental Health Act office within the trust and who to contact for advice and guidance.

Good practice in applying the Mental Capacity Act

The compliance rate with Mental Capacity Act training across all six services as of May 2016 was 94%. The team with the lowest compliance rate was the memory assessment service with 70%. The trust had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards that staff could access on the computer system.

The initial assessment document on RIO asked specific questions about a patient's capacity. The staff we spoke with had a detailed understanding of the Mental Capacity Act. Staff could identify the five statutory principles of the Act and understood how they would decide when to overturn presumption of capacity. They understood the importance of giving all necessary support to ensure the patient could make their own decision. If that was not possible, they would undertake a capacity assessment

Are services effective?

Good ●

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whilst keeping the patient at the centre of the decision making. All staff followed the standardised assessment process using the MCA1 assessment form and psychiatrists provided a narrative description of their assessment in clinical letters. Staff would undertake joint assessments with colleagues in the local authority and would be involved in best interest assessments where required. Some of the psychiatrists in the teams were best interest assessors. Staff could identify the factors to be considered when identifying whether a best interests decision or an advanced directive was needed for patients.

Staff in the challenging behaviour service gave clear examples of when a patient's capacity may need to be assessed. They stated that in all cases they would need to consider what the least restrictive option was, what was in the patient's best interests and they would always involve the patient's family. Staff gave examples of when they had

been involved in assessing a patient's capacity to consent to treatment and to make decisions. On occasion, staff had been involved with the court of protection, independent assessors and the Caldecott guardian if the patient's family did not agree with their assessment of capacity.

Staff had a good understanding of the use of the deprivation of liberty safeguards and in some cases would advise care home staff to make an application to the local authority for assessment.

Staff could not name the Mental Capacity Act lead for the trust. In the Newcastle West team, one nurse had been involved in a project to audit the use of the Mental Capacity Act in services. They had undergone some training but the project had not developed any further at the time of inspection.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke to seven patients and 16 carers, attended 14 home visits to patients, observed four clinic appointments and observed staff and patient interactions in two day units. Patients and carers spoke highly of the staff and the service provided. They described staff as courteous, supportive, dedicated, kind, caring, respectful, compassionate and professional. One patient stated that their nurse had improved their life so much and that they had never been treated with anything other than the upmost care and respect.

We observed staff visiting patients in their homes. Patients told us they could not have managed without the help of the staff in these teams and that they would be lost without the support they received. Staff had a good rapport with patients, using humour, smiling and speaking to them in a reassuring tone of voice. Staff were continually checking patients understanding, asking open questions and had a detailed knowledge of their patients. Staff had a genuine interest in the patient's wellbeing, reminding them of upcoming appointments and making suggestions about managing their physical health. On one visit, staff asked the patient if they had been out of the house and provided gentle encouragement to get out for fresh air and to occupy their mind. On every visit, staff asked the patient and their carers whether they had any worries or concerns and gave plenty of opportunity to ask questions. Staff encouraged patients to focus on the positive and on the progress they were making.

Carers said they felt supported and that help and advice was easily accessible from staff should they need it. One carer felt staff had offered more support to her than expected and went beyond what was required. Carers spoke of the excellent care they felt their family members received from the community mental health teams.

We observed a visit to a patient in a care home. The staff member from the challenging behaviour service had a good rapport with the patient, made good eye contact and ensured she sought the patients consent in meeting with their family at a later date. The approach was collaborative, well planned and caring.

In the Grange day unit in Sunderland, staff were engaging patients in a discussion about countries they had visited.

They had a map on the wall and were pointing to the locations that patients spoke about. They used humour to engage patients in this discussion and ensured every patient in the room had the opportunity to share their memories. They then moved on to completing a group crossword on the blackboard. Staff encouraged patients to choose which question to answer next, gave hints and tips about possible answers and offered praise when patients answered correctly. One patient commented quietly that they could not see the board clearly and staff responded immediately moving the board closer and repeating the questions. One patient appeared to be falling asleep and a staff member quietly approached them to check they were okay and encourage them to take part. There was lots of laughter amongst the patients and the staff. A patient had arrived unwell earlier that day, expressing suicidal ideations and staff had responded quickly. The patient was being seen by the doctor with the possibility of a Mental Health Act assessment. Staff were maintaining the privacy and dignity of that patient and the other patients were unaware and unaffected by the situation that was occurring.

In the Berwick day unit, we completed a short observational framework for inspection tool. This is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. This showed a high level of good interactions between staff and patients. A practical therapist was making clay pots with patients, a nurse was chatting to patients individually about their week and a doctor was reviewing patients in another area. One patient appeared quite unhappy and staff were quick to respond. Staff understood the reasons behind the patient's presentation that day and could clearly articulate these. Staff knew the history of the patients attending, such as their previous employment and brought this into conversation. There was lots of laughter and familiarity between the staff and patients. The two patients we spoke to told us they enjoyed attending.

The involvement of people in the care that they receive

We observed staff interacting with patients in a very person centred way. They encouraged patients to decide what they wanted to achieve or what outcomes they hoped from their treatment, rather than this being led by the practitioner. Patients reported they were involved in their

Are services caring?

Outstanding ☆

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

care plan and could have a copy if they wished. Patient records showed that treatment goals were mutually negotiated and involved the views of family members with the patients consent.

Staff undertook a 'getting to know you' assessment with carers to ensure they identified the carers needs. Staff would refer carers to community mental health services or voluntary organisations for support in their own right if it were required. Staff would refer carers to the local authority for carer's assessments to receive financial or respite support. Psychology staff in the Ashington service ran a patient and carer memory support group once a month for six months. Psychologists also provided family therapy where appropriate. In Ashington, staff referred patients and carers to the local dementia café ran by The Alzheimer's Society. In Sunderland, staff assisted patients and carers to attend a memory café each month. In Newcastle West, staff provided a monthly evening support group for carers with topics such as looking after yourself, welfare rights and managing challenging behaviour. The trust also delivered a training session on dementia for patients and carers. This aimed to increase understanding of what dementia is and how people can live well with dementia.

Carers reported staff regularly kept in touch with the patient and themselves. Occupational therapy staff in the South Tyneside service used talking mats to ensure effective communication with patients. Talking Mats is a communication framework that enables people who have difficulty communicating to express their views. This ensured patients were active partners in their care.

On one visit, we observed a psychologist in the Sunderland team undertaking a review with a patient. Following their assessment, they had written to the patient to reflect their findings and treatment plan. The psychologist checked the accuracy of this with the patient and amended it as appropriate. The psychologist continually checked the

patients understanding and reflected back what they had said to ensure he understood their situation clearly. The psychologist sought the patients consent to invite their family member into the room and agreed manageable goals with the patient and their carer.

One carer commented they were staggered at how thorough the assessment process was and that they felt every step was clearly explained. They felt that staff were very empathic to the patient's needs and that it was an outstanding service. Another carer felt the service was tailored for the individual and that staff were helpful and honest. Carers we spoke with could explain the effects of the medication the patient was receiving and how long it would take to have an effect. They were given the opportunity to ask questions and felt staff discussed every aspect of the patients care with them.

Staff gave patients and carers information on how to complain and they felt assured that if they needed to complain, action would be taken by the service. In the South Tyneside and Sunderland services, they proactively sought feedback from patients and carers. Staff had identified that the return rate of the 'Points of You' questionnaire was low amongst their patient group. Each week, a support worker would contact a couple of patients and ask if they could visit specifically to get their feedback on the service. The support worker then produced geographical charts displaying the results for staff to see in the office corridors. In the Newcastle West team, two staff were designated carers champions. They led a monthly carers group on the day unit for older people, focusing on the sharing of information about services and key topics such as the power of attorney. Staff worked with carers to educate them about the patient's illness and suggest strategies to help manage any associated behaviours and care for the patient.

Are services responsive to people's needs?

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

Our findings

Access and discharge

The access route into services differed depending on whether they had been through the transformation programme. All services accepted self-referrals as well as referrals from other professionals and accepted referrals from all ages. In Sunderland and South Tyneside, all referrals were received into the initial response service who then triaged them to decide which were urgent and which service best met the patient's needs. Patients were then split into two tiers. Those in tier one were referred for cognitive assessments and a diagnosis. Staff worked with patients to titrate medication and offered some post diagnostic support. Those patients in tier two had more complex mental health needs and received longer term treatment and support.

In Newcastle West, the team received referrals direct and each day an allocated triage worker decided if the referral was urgent, substantial, or moderate. Staff would see urgent referrals within 24 hours, substantial referrals within seven days and moderate referrals within 28 days. The trust had an overarching target of referral to assessment that was set at 18 weeks. Between February and March 2016 all teams hit 100% target for patients seen within 18 weeks. In April, two teams hit 99%, which was still above the trust requirement of 95%. The trust did not set assessment to treatment targets for these services. The time taken from assessment to treatment often depended on which further tests or scans were required. Staff usually expected to provide patients with a diagnosis and commence treatment eight weeks after initial assessment.

Each service had localised targets. The memory assessment service had a five week target for referral to assessment, the Newcastle West and South Tyneside teams had four weeks, the Sunderland cognitive functionally frail team had eight weeks and the Berwick team had six weeks. The challenging behaviour service was seeing patients within two weeks of referral but could also respond to a crisis if required. The teams were hitting these targets.

Each team provided referral and discharge information for the period 1 June 2015 to 31 May 2016. The Sunderland cognitive functionally frail team had the highest number of referrals and received 1463 referrals with 1252 patients discharged from the service. The Berwick community mental health team had received the lowest number with

237 referrals and 239 patients discharged in that period. All six teams showed the throughput of patients with the number of referrals received being relative to the number of discharges in the 12 months prior to inspection.

Staff closely monitored the number of patients that did not attend appointments. When the memory assessment service was first developed, it was clinic based with patients attending appointments at the local mental health hospital site. Staff quickly identified that patients either did not want to attend due to the stigma of attending a mental health hospital, or found it difficult to get there due to physical frailty. Staff were supported by managers to deliver appointments in patient homes to ensure good access to services.

The services operated a general rule of offering patients three appointments before they would discharge them. However, the teams took a very individualised and risk based approach to this. If a patient was not deemed high risk and the staff had consent to contact them by phone, they would call and encourage them to allow staff to visit them at home. If the patient lacked capacity or insight into their illness, staff would contact the family or carer to see if they could arrange a joint visit to the patient's home. If staff could not contact a patient or carer, or another service that was working with the patient and they had concerns about the safety of a patient, they would contact the police and request a welfare check.

We observed a home visit in the Newcastle West team by a psychologist who was reviewing a patient for discharge. Although the patient was initially concerned about being discharged, the psychologist reviewed the wellness and recovery plan focusing on the positive changes the patient had made. The psychologist explained in detail what other support was available and how the patient could access those services. The psychologist took time to reassure the patient, to identify next steps and to ensure the patient felt positive about their discharge, Staff provided details of other services on discharge letters and sent copies to the general practitioner. In Newcastle West, a liaison nurse worked into the inpatient wards to support a patient's discharge back into the community.

The community mental health services operated a day service at their local mental health or acute hospital. This allowed staff to observe patients for longer periods of time if they had concerns about how they were managing. It was also used as a transition from inpatient services to see how

Are services responsive to people's needs?

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a patient would cope upon discharge. During our inspection, we visited two day units. On both occasions, staff were seen responding quickly to patients who appeared to be deteriorating in their mental health. Medical staff were on site and would review and observe patients in a more informal environment.

Patients and carers reported that staff rarely cancelled appointments. If staff did have to cancel, they would inform the patient in advance and rearrange the appointment as soon as possible. Staff were flexible in arranging appointments with patients, often visiting in their homes and at times when family or carer's could be present if required.

The facilities promote recovery, comfort, dignity and confidentiality

The majority of visits occurred in patients homes. Some of the sites did have facilities to see patients, which were accessible by patients with mobility problems. The interview rooms at Anderson Court in Berwick were not soundproofed and staff played music in the reception area to try to maintain confidentiality. This site was undergoing a full refurbishment shortly after our visit. The memory assessment service shared premises with the community mental health team. The waiting area had a wide range of information available for patients and a staff noticeboard with pictures of the team and their role. The interview rooms were sound proofed. The Newcastle West team was based at the Centre for Ageing and Vitality. Again, the waiting area had plenty of information for patients on treatment and local services with adequate space to see patients on a one to one basis.

The challenging behaviour service was based at St George's Park hospital site. It was a purposely designed building to fully meet the needs of the staff group and patients who visited there. The Sunderland and South Tyneside teams were based at Monkwearmouth Hospital. Staff only saw patients in the day unit on this site or in their homes. From August 2016, the South Tyneside team would be able to see patients at a new location. The Alzheimer's Society were also based there and it was called Haven Court. Staff could deliver titration and diagnosis clinics there, undertake psychology appointments with patients and book rooms for initial assessments.

Meeting the needs of all people who use the service

Each service provided a detailed information pack to patients and their families and carers. The information pack for patients contained leaflets on each potential diagnosis and treatment options, lasting power of attorney and on the role of certain staff within the service such as occupational therapists. Staff provided patients with a feedback form and stamped addressed envelope and information on how to make comments, suggestions, compliments and complaints. Carers received a pack containing the carer's charter, the trust's commitment to carers and confidentiality and a resource guide. The resource guide listed details of other agencies and services that could assist the patient and their carers. All leaflets were available in different languages and easy read formats. In the Berwick community service a member of staff could lip read and staff could access specialist communication equipment from within the trust. Services had access to interpreters if required.

Listening to and learning from concerns and complaints

The community older people's mental health services received four complaints between 1 May 2015 to 20 April 2016. Two of these were upheld and no complaints were referred to the ombudsman. Every patient and carer we spoke with had been provided with information on how to complain if they needed to. They all felt comfortable raising concerns and were certain staff would address them. At each home visit we attended with staff, staff asked the patient and carer if they were happy with everything and if they had any concerns about their treatment.

Staff gave examples of how they would respond to complaints, which included undertaking a detailed investigation, being open and honest with the patient throughout, and providing an apology for the distress caused. Staff used team meeting and peer supervision sessions to share learning and feedback from patients. Staff shared the results of any patient feedback surveys, displaying it on the wall in some staff offices. The managers meeting in Newcastle West had a standing agenda, with complaints and lessons learned discussed each month.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and values

All managers and staff that we spoke with knew the trust's values and felt they were an integral part of the care they delivered. Team managers spoke positively of the support received from their immediate managers and those above them up to chief executive level. Every member of staff spoke highly of the chief executive. He had visited the teams, held open events to meet and speak with staff and was viewed by all as highly accessible. Staff were able to email him directly with any feedback on the services they provided. Staff felt he wanted to hear what they had to say and was committed to delivering high quality patient care. An example of this would be in the Newcastle locality a resource centre ran by local authority staff was due to close. The staff in the team were concerned about the impact of this on patients and raised their concerns with the chief executive. This was escalated and those staff were made part of a scoping exercise to look at the complexity of patients attending that resource centre and the potential impact of its closure on their health and wellbeing.

Staff felt if they raised concerns, senior managers would take action. Staff across all services reported that senior managers were visible and often visited the teams. In Berwick, the community clinical manager spent one day per week at the staff office with the aim being that they remained visibly connected to teams. The senior managers spoke highly of their access to higher level managers and attended monthly leadership meetings. They felt well supported and comfortable to raise issues and concerns.

Good governance

The Newcastle, South Tyneside and Sunderland services had implemented a training star, which was original developed in rehabilitation services. The training star was a list of training that each clinician would be able to access. This has been led by psychologist within the teams with input from staff. Staff had identified a range of training including input on personality disorder, psychological interventions, family therapy, recovery and clinical supervision. At the time of inspection, managers were undertaking a gap analysis to identify what additional training they needed to source for staff.

Each service had their own risk register that they discussed in team meetings and kept up to date. Examples of items on the risk register included mandatory training that had

been cancelled by the training department, access to psychiatrists during holiday time and concerns about the sufficient administrative resources. Staff had identified appropriate action to be taken to mitigate these risks.

In the memory assessment service, staff felt that they lacked sufficient administrative support and this was on their risk register. In the Newcastle West team, staff spoke of a high number of temporary administrative staff over the previous year that had impacted on service delivery. This was reflected on the staff stress assessment. In the South Tyneside and Sunderland teams, they had administration pathway co-ordinators who managed and organised the work of the remainder of the administrative team. Staff reported this worked well, however the number of administrative staff did not always reflect the patient population of the team. Under the new model, both the South Tyneside and Sunderland teams had equal numbers of administrative staff, yet the Sunderland team were caring for over double the number of patients.

The trust provided details on how the administrative staffing levels had been established and stated this was continually under review. Based on the type of work and tasks that would be required, the number of clinical staff and the sizes of staff caseloads, the trust would increase staff numbers or amend systems accordingly. In Sunderland and South Tyneside they had undertaken a formal review of operational administrative services one year after the transformation programme in October 2015. This identified whether there were blockages to standard operating procedures and whether the number of administrative staff was sufficient. The review identified a number of actions to be taken to ensure administrative staff had a clear remit and dedicated time to carry out the core functions of their role. The community clinical managers were aware of the issues and felt they had a good grasp of the areas that were pressured in the localities. One possible improvement was that the digital dictation service would use voice recognition software instead of relying upon administration staff to type the assessments. This system was in place in Sunderland and South Tyneside. The information would go straight into the electronic record system and staff would then edit and validate it. Although staff working in the teams felt administrative staffing levels were not always sufficient, it was clear this was being raised and discussed at senior manager level and that the trust were continuing to review this.

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Across the services, both the staff teams and managers met monthly and documented these meetings. The purpose was to share learning and cascade information across the locality. The structure of the meetings in South Tyneside and Ashington followed the five key questions that the CQC asks of services on inspection; safe, effective, caring, responsive and well led. It was clear managers worked cohesively across the organisation and within each locality's management structures. In the North of the trust, the managers had organised two team away days in 2015 to ensure the services worked closely together to develop and implement their shared objectives. A further away day was planned for older people's services across Newcastle and Northumberland with the aim of ensuring a shared sense of purpose across the localities.

The older people's services monitored five commissioning targets, three of which focused on patients under a care programme approach. Staff had to ensure they reviewed and risk assessed each patient and had developed a crisis or contingency plan every 12 months. For the months of February, March and April 2016, each service was performing at between 92% and 100% on each of these targets. All staff had a personal dashboard on the computer, which flagged up if any of these reviews were due.

Managers undertook regular auditing of patients care records on RIO with staff in monthly managerial supervision. This included reviewing whether care plans had been signed and shared with patients, whether staff had reviewed medication and whether physical healthcare was being monitored and recorded. The manager in Sunderland completed an annual quality monitoring tool. This looked at all the patient records of every qualified staff member to ensure the notes were signed and dated, did not contain jargon and that staff had assessed the capacity of the patient.

In South Tyneside, the pathway manager had requested monthly performance reports to monitor the performance of the staff within the team against additional indicators, such as the number of referrals and the number of patients that did not attend appointments. The results of these were displayed in the staff corridors for staff to see how the service was performing and take some ownership of the targets. The manager also discussed compliance against these and training targets in the team meetings.

Leadership, morale and staff engagement

In all services, staff felt proud of the work they did. They believed they had a positive impact on patient care and felt supported by their organisation to do so. Staff spoke of mutual respect for each other's skills and experiences. We observed energetic, motivated and committed staff that were keen to develop themselves and the service they provided. Staff stated they had excellent managers, brilliant opportunities and more training in the time they had worked for the trust than in their whole careers. Staff engaged in reflective practice and were continually reviewing ways to improve services. Staff also had access to a leadership programme within the trust.

Staff reported that when they felt stressed they could turn to their colleagues for support and the work load would be shared. The services were conducting stress assessments for staff and escalating any concerns raised through the process to senior management teams. Staff reported there was no bullying or harassment within teams and many commented they loved their job and the people they worked with. Staff felt there was a culture of openness and that they would happily raise concerns with their managers and more senior managers within the trust. Staff knew there was a whistleblowing policy and attended training on 'raising concerns'. Staff were aware that the trust had identified whistleblowing leads to support staff and that there was a hyperlink on the computer system to raise an issue or concern.

Staff in some teams felt concerned about the impending transformation programme. They had attended an away day but did not feel their questions were answered. Concerns centred on a reduction in staff and consequently the level of care they could offer patients. Staff in services that had been through the transformation felt the trust had learned important lessons about its roll out. During this process, the senior management team had met with staff and addressed their concerns. The trust acknowledged they were taking things slower with the roll out of the transformation in other teams and listening to feedback.

Commitment to quality improvement and innovation

Memory problems can interfere with someone's ability to organise themselves and their belongings. In 2013, hoarding was classified as a mental illness. Hoarding is the compulsive purchasing, acquiring, searching, and saving of items that have little or no value. Following this, one of the

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psychologists and a nurse in the Newcastle West community team led on the development of collaborative working with environmental health officers, social services, housing officers and the fire department to work with patients who were hoarders. The psychologist and one of the nurses joint worked patients in the older person's teams and supported other teams with hoarding patients. Both staff members negotiated protected time from their substantive posts to do this, which was supported by the trust. They also provided teaching on the subject of hoarding to staff within the trust and other voluntary and statutory agencies.

The consultant in the memory assessment service was the trust lead for dementia research. He had been a key contributor to the Cygnus research project along with colleagues across the country. The Cygnus project aimed to analyse patients referred to community memory assessment services, to provide a real-world cohort for whom standardised assessments and outcomes would be collected. The study would then collect data from clinicians, patients and their carers and determine how such data could be used to improve diagnosis, treatment and care of future patients. The data collected would be used to evaluate how a patient's progress through their initial assessments at memory assessment services was related to their subsequent outcome assessments and episodes of care. The study was at the point of enrolling its first patients at the time of inspection.

The challenging behaviour team in Morpeth had developed the service to deliver training to care home and community staff. This was to assist staff to meet the needs of patients who presented with high levels of distress and verbal or physical aggression during interventions for essential personal care. The team had spoken at conference across the country about this work and it had been included in a number of publications in the Journal of Dementia Care. Over the last two years, the team had also developed a model to support family carers who were managing challenging behaviours in the home. This cognitive behavioural therapy based model recognised the impact that dealing with distressing behaviours could have and supported carers to think differently and understand the behaviour. The therapeutic focus of this work was with the carers and the position that they took within the caring

relationship. Following the development of the model within Northumberland, all nursing staff within Older People's Services had received training on the model. The model was presented at The 8th UK Dementia Congress, held in Telford in 2015.

Staff in the challenging behaviour team had also developed a risk management model focussing on identifying escalating distress and contingency plans with dementia patients. This traffic light approach to person centred risk management had been published in an article in the Journal of Dementia Care in 2010. This model had then been rolled out for use across other teams and localities. Staff in this team also identified that a number of referrals requested support for people who had advanced dementia with complex physical health problems and were experiencing high levels of distress. Using a needs-led assessment and formulation process, the staff identified the need for comfort and interventions developed within a comfort care plan. Staff trialled this development involving collaborative work with the North Northumberland Hospice. The community mental health teams were considering using these care plans to provide a framework to support the clinician. The Journal of Dementia Care had also expressed an interest in a proposed article about this development. The team had also developed the challenging behaviour service to deliver training to care home and community staff. This was to assist staff to meet the needs of patients who presented with high levels of distress and verbal or physical aggression during interventions for essential personal care. The team had spoken at conference across the country about this work and it had been included in a number of publications in the Journal of Dementia Care.

Staff in the Sunderland team were undertaking a research programme into the impact of dementia into family life. A number of patients and carers who were deemed capable of giving informed consent had agreed to participate in the project. In Sunderland and South Tyneside, they were expanding on the initial development of the new ways of working model. Rather than the staff and patients having a phone conversation with the consultant at the point of assessment, staff would be able to do this via skype on their mobile laptops.