Outstanding ☆

Northumbria Healthcare NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Rake Lane
North Shields
Tyne and Wear
NE29 8NH
Tel: 08448118111
Website: www.northumbria.nhs.uk

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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)
RTF	Rake Lane Hospital	Community Learning Disabilities	NE29 8NH

This report describes our judgement of the quality of care provided within this core service by Northumbria Healthcare 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 Northumbria Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northumbria Healthcare 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?	**Outstanding** 
Are services effective?	**Outstanding** 
Are services caring?	**Outstanding** 
Are services responsive?	**Good** 
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

- There was a proactive approach to anticipating and managing risks to people who use the services. This was embedded and recognised as being the responsibility of all staff. People who use and those close to them were actively involved in managing their own risks.
- There was a holistic approach to assessing, planning, and delivering care and treatment to people who use services. The use of innovative approaches to care was actively encouraged. New evidence based techniques and technologies were used to support the delivery of the service.
- There was continued development of staff skills, competence, and knowledge. Staff were proactively supported to acquire new skills and share best practice.
- The service was committed to working collaboratively and had developed innovative and efficient ways to deliver more joined-up care to people who use the service.
- There was a holistic approach to planning people's discharge, transfer, or transition to other services. Arrangements fully reflected patient needs.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, and supportive. These relationships were highly valued by staff and promoted by leaders
- People's individual needs and preferences were central to the planning and delivery of services. The services were flexible, provided choice, and ensured continuity of care.
- Leaders had an inspiring shared purpose, and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.
- There were high levels of staff satisfaction across the service. Staff were proud of the organisation as a place to work and spoke highly of the management and culture. Staff at all levels were actively encouraged to raise concerns.

Summary of findings

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

Are services safe?

Outstanding ☆

we rated safe as outstanding because:'

- Facilities were clean and well maintained.
- There was a genuinely open culture where staff were clear about their roles and responsibilities for reporting incidents. Incidents were reviewed and investigated by managers as part of learning and improvement.
- A proactive approach to managing risk was embedded into the service. Staff completed and risk assessments, and updated these when necessary, in collaboration with services users and carers.This allowed staff to encourage positive risk taking.
- There were clearly defined and embedded systems, processes, and standard operating procedures to keep people safe and safeguarded from abuse.
- Effective personal safety protocols for staff including lone working policies were in place.
- The service had a proactive approach to anticipating potential future problems including staffing levels and staff absence.

Are services effective?

Outstanding ☆

we rated effective as outstanding because:'

- A holistic approach to assessing, planning, and delivering care and treatment was evident across the service. Assessments were holistic and included physical and mental health conditions, function of behaviour, and environmental factors.
- The service used innovative approaches to deliver care and treatment. Evidence based techniques were being used to support the delivery of high quality care.
- The service provided care that reflected the Transforming Care new model of support.
- Patients were receiving comprehensive annual health assessments, and were supported with general health care needs.
- Staff worked collaboratively to deliver joined up and efficient interventions to patients, which met their individual needs.
- Staff were actively engaged in activities to monitor and improve quality and outcomes, this included benchmarking and research.
- Staff development was recognised as being integral to ensuring high quality care. Staff were supported to develop new skills and share best practice.

Summary of findings

Are services caring?

Outstanding 

we rated caring as outstanding because:'

- The service ensured that patients' emotional and social needs were valued and listened to.
- There was a strong, visible person centred culture. Staff were highly motivated to offer care that was kind and promoted dignity. Relationships between staff and patients were strong and supportive.
- Patients and their families spoke consistently highly of the service and staff.
- Patients were empowered to identify, understand, and manage their health needs. Staff were using creative ways to overcome obstacles and ensure that patients had accessible information.

Are services responsive to people's needs?

Good 

we rated responsive as outstanding because:'

- Patients' individual needs and preferences were central to the delivery of services. The service was flexible, provided choice, and ensured continuity of care.
- The involvement of other organisations and the community was integral to meeting patients' needs. Patients were being discharged appropriately and safely to ensure their needs were continually met.
- There was a proactive approach to understanding the needs of patients.
- Patients and their families knew and understood how to make a complaint. Complaints were actively reviewed and responded to.

However:

- North Tyneside were not meeting the 13 week target for referral to face to face contact. The service had failed to meet this target six months over a 12 month period.

Are services well-led?

Outstanding 

we rated well led as outstanding because:'

- A systematic approach was taken to improve care and outcomes for patients.
- Effective governance systems were in place to monitor caseloads, incidents and any other service level risks.
- The use of key performance indicators was embedded in the service and all staff had an understanding of their individual and team performance objectives.

Summary of findings

- Staff were involved in a range of local and national clinical audits, with any improvement actions taken forward within the service.
- There were high levels of staff satisfaction and a strong collaboration of support. Staff spoke highly of service level managers and senior managers.
- There was a clear commitment to quality improvement and a genuine enthusiasm for innovation.
- Leaders had an inspiring shared purpose, and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

Summary of findings

Information about the service

Northumbria Healthcare NHS Foundation Trust provides community mental health services for people with learning disabilities across Northumberland and North Tyneside. The trust is commissioned through two clinical commissioning groups. Therefore, two separate teams delivered services, which work differently in each area.

Northumberland:

Northumberland Clinical Commissioning Group commissions a learning disability community nursing service. This service operates under a partnership arrangement with Northumbria Healthcare Foundation Trust and Northumberland County Council, to provide an integrated service to adults with a learning disability who live in Northumberland. Northumbria Healthcare Trust delivers the service across four localities and employs registered nurses and support workers.

North Tyneside:

North Tyneside Clinical Commissioning Group commissions a community learning disabilities service for adults and young people. The service includes the behaviour assessment and treatment services, forensic support and acute and primary care liaison nursing service. The trust delivers community learning disability nursing, psychology, speech, and language therapy and occupational therapy.

Consultant psychiatrists are employed by Northumberland Tyne and Wear NHS Foundation Trust and work alongside members of the multidisciplinary team. They provide a holistic approach to treatment and interventions. The consultant psychiatrist provides guidance to the teams and gives direction to GP's in relation to treatments required, including medication.

Our inspection team

The inspection team was led by Victoria Anderson, CQC inspector.

The team comprised two CQC inspectors, one inspection assistant and two learning disabilities nurses.

Why we carried out this inspection

Northumbria Healthcare NHS Foundation Trust is primarily an acute and community health Trust, which had a comprehensive inspection in November 2015. The trust was rated as Outstanding overall.

The Community learning disabilities service was not inspected as part of the comprehensive inspection. This was a focused inspection of this core service.

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, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited services at three locations across Northumberland and North Tyneside.
- spoke with seven patients and their carers who were using the service
- spoke with the managers for each of the teams

Summary of findings

- spoke with 22 other staff members; including doctors, psychologists, nurses and support workers, occupation therapists, and speech and language therapists.
- spoke with the heads of service with responsibility for these services
- attended and observed five home visits
- attended and observed the dynamic risk register meeting in Northumberland
- attended and observed the adult and young person's referral meeting in North Tyneside
- attended and observed four multi-disciplinary meetings
- looked at 20 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 their carers who told us they were happy with the care they received from the service. They told us that staff were always polite and friendly and they felt supported by them. We were told that staff were easily accessible when needed. One carer told us the service they have received was exceptional and another told us that she did not know where she would be without them.

Patients and carers confirmed that needs were always catered for and appointments take place at a convenient time and place for them. They all felt involved in the care they or their relative received and all but one patient had received a copy of their care plan.

Everyone we spoke to confirmed they had received relevant information from the service, including details on how to complain and advocacy services.

Responses from the North Tyneside two minutes of your time patient survey in April, May and June 2016 showed that 100% of people would recommend the service.

Good practice

The Northumberland service could access specific funding for each patient to support with care plans. This could be used to help those people identified on the dynamic register. The register was used by Northumberland to identify and monitor those people being in the greatest need in terms of risk. The register was monitored weekly at a multi-agency meeting.

There had been a significant reduction in hospital admissions. Assessment and treatment was being provided in the community in social care settings and individuals' homes without hospital admission being required. Learning disability beds had been reduced significantly, there were currently two commissioned beds across the service area. In instances where a hospital admission was needed, then this was appropriately planned to ensure the shortest possible stay with a clear discharge plan in place. Staff from the community team maintained close working links with hospital staff and the patient during any episodes of in-patient admissions

An acute liaison service was in place. The service worked across the four hospitals in Northumberland and North Tyneside. Patients were provided with an assessment within 48hours of admission to ensure that they were supported during their stay in hospital. The post assisted with advocating the needs of people with a learning disability and supported acute staff. This included communication and easy read information for patients and helped with discharge planning.

Data on population, locality, and trends was gathered to help develop service provision. This included mortality

reviews to establish any patterns for learning disabilities patients. This information was also used to assist the community services to ensure they were able to respond to any demands.

Northumbria Healthcare NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Northumberland Community Learning Disabilities Service	Rake Lane Hospital
North Tyneside Community Learning Disabilities Service	Rake Lane 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.

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

Knowledge and understanding of the Mental Health Act was good and staff knew the process for requesting Mental Health Act assessments. Consent and capacity to consent had been considered by staff and documented in service user's notes.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust delivered training in Mental Capacity Act levels one and two and deprivation of liberty safeguards as part of mandatory training. The trust was meeting the target for staff completion of these courses.

Consent to care and treatment was being obtained in line with legislation and guidance. People

were supported to make decisions and, where appropriate, their mental capacity was being assessed and recorded. When people aged 16 and over lacked capacity to

make a decision, 'best interests' decisions were made in accordance with legislation involving families were where appropriate.

Staff within both the Northumberland and North Tyneside teams had a good understanding of the Mental Capacity Act and how this should be applied to patients. We were given examples of where both services had used the Mental Capacity Act around specific decisions in relation to patients they were working with. We found that these decisions were recorded on the patient's electronic record.

The process for seeking consent was appropriately monitored.

There were no patients subject to deprivation of liberty safeguards.

Outstanding ☆

Are services safe?

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

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

Our findings

Safe and clean environment

We visited the Oxford Centre, which was the main base for the North Tyneside service and we visited two of the three community bases for the Northumberland team. The Northumberland bases visited were Eddie Ferguson House in Blyth and the Alnwick district office in Alnwick. Patients were not seen at these premises. Although we did not visit the Hexham office, we were able to speak to staff that worked in this area and review a sample of patient files. We found all environments to be safe, clean, and tidy. All offices had adequate staff kitchen facilities and hand washing facilities.

The oxford centre was a public building, which housed other public services and had a library and a café. The learning disability service was located in offices across two floors and was accessible through a shared waiting area. The service could be accessed through a locked door, which had a telecom to the administration team.

The oxford centre was used mainly as a staff base although there were some small meeting rooms, which were used to see patients. We found that the rooms were not soundproof but that where possible patients were seen in rooms, which adjoined cupboards to maintain privacy.

Safe staffing

Due to the separate commissioning arrangements, the two teams had significant differences in terms of staffing. A wide range of professions including nurses, support workers, psychologists, occupation therapists, speech and language therapists, and administrators were employed by the trust to work in North Tyneside. Nurses, support workers, and administrators were employed by the trust to work in Northumberland. A hospital liaison nurse worked across both the teams linking into the four main hospitals in the area. The post was based at North Tyneside general hospital and managed through the safeguarding team.

Staffing levels were based on the workforce development plan in the transformation model. We found both teams to be fully staffed with no vacancies or sickness. Managers had the autonomy within their budget to assess and manage staffing requirements.

There had been no use of bank or agency staff across the service in the last 12 months.

Northumberland Learning Disability Service

- Clinical lead (1 x Band 8a)
- Lead nurse (4 x Band 7)
- Lead nurse liaison, primary & mental health (1 x Band 7)
- Registered nurses (14.67 x Band 6)
- Registered nurses (3 x Band 5)
- Community support workers (6 x Band 3)

North Tyneside community learning disability service

- 30 staff members (27.4 whole time equivalents)
- Professional lead / clinical manager (1 x Band 8b)
- Learning disability nurses (5.4 x Band 7, 5.6 x Band 6, 1 x Band 5)
- Senior support workers / healthcare assistants (3 x Band 4, 1 x Band 3)
- Clinical psychologists / assistants (1 x Band 8b, 1.2 x Band 8a, 2 x Band 5)
- Occupational therapist (0.8 x Band 6, 0.6 x Band 5)
- Administrators (0.9 x Band 4, 2.9 x Band 3, 1 x Band 2)

The services operated Monday to Friday 9.00-17.00. However, there was flexibility in the service to work evenings and weekends as and when necessary.

Flexible working was embedded into the working week in Northumberland so that staff could meet the needs of the individual patients. Out of hours and at weekends there was a planned and urgent response facility. This involved working in conjunction with the initial response team and universal crisis team.

North Tyneside offered some flexibility outside of the core hours as required. An example was given if a patient required assistance with morning or bedtime routines. This was particularly relevant to the young people they were working with.

Northumberland had reduced caseload sizes to a maximum of 10, which enabled them to work with complex patients and those who were in crisis. North Tyneside were working with 443 patients and individual team members had an average of 16 cases each. Caseloads were continuously monitored and managed through staff supervision.

Outstanding ☆

Are services safe?

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

Staff were receiving and were up to date with mandatory training with an overall completion rate of 95%. The trust had a range of mandatory training which included; information governance, fire safety, infection prevention and control, records management, health and safety, risk management, safeguarding children and young people levels one, two and three, safeguarding adults level one and two, Mental Health Act, Mental Capacity Act level one and two, deprivation of liberty, dementia awareness, moving and handling, and basic life support.

Assessing and managing risk to patients and staff

Staff completed assessments and risk assessment with all new patients. In Northumberland, a lead professional or care coordinator for those on a care programme approach was appointed to each patient. The care coordinator or lead professional ensured that appropriate specialist assessment and interventions were completed. The service had crisis and contingency plans for managing risk. All new referrals had a care act assessment from a social worker. The nurses would carry out physical healthcare assessments. Any patient at risk of a hospital admission would be referred to the multi-disciplinary meeting known as the dynamic risk register. There was nightly electronic sharing of information between the two electronic systems used by the two different trusts. This enabled a patient's crisis plan to be shared with relevant professionals in a timely manner.

In North Tyneside the most appropriate person in the team was appointed to the patient to carry out the initial assessment. A standardised risk assessment tool was completed for each patient which covered violence, suicide/self-harm, severe self-neglect, mental health, risk to others, at risk from others, engagement and transport risks.

We reviewed 20 care records and found that assessments and identification of risks were comprehensive and timely. Each new referral into the service was discussed during weekly multi-disciplinary meetings. During these meetings, any risks to staff or patients were identified and discussed. Any identified risks were mitigated and managed within the teams.

All staff understood their responsibilities in relation to safeguarding. There were excellent links with the local authority safeguarding teams and the trust safeguarding contacts. Staff were able to give us examples of where they had experienced safeguarding and how they had dealt with this.

Northumberland used a 10-step process in relation to safeguarding. Staff discussed any concerns with the team manager in the first instance. There was an alert on the electronic system, which triggered staff to complete further information if they had any safeguarding concerns. Staff would attend strategy meetings where appropriate. North Tyneside also had safeguarding processes in place, which included alerts on the electronic system. Supervision for safeguarding children was delivered every six months.

A lone working policy was in place, this had recently been revised and now ensured that formal arrangements were in place. The previous policy relied heavily on a buddy system while the new system required office based administrators to have a more active role.

Track record on safety

Data provided by the trust showed 12 incidents had been reported overall for the service between June and November 2016. There were no specific themes arising from these incidents. No serious incidents had been reported for the service during this period. The governance steering group had oversight of all incidents and an annual report was produced on any themes arising from safeguarding.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system to record incidents. All staff knew how to complete a report on the system and the circumstances under which a report should be made.

Incidents were reviewed by the manager in each service and shared with staff during team meetings. North Tyneside service had eight incidents recorded in the previous six months and Northumberland had four. All incidents were recorded onto a spreadsheet, which included the outcome of incident and any further action.

All staff demonstrated a good understanding of the principles of the duty of candour. Staff were clear about the importance of an apology after an incident.

Are services effective?

Outstanding ☆

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

Our findings

Assessment of needs and planning of care

A holistic approach to assessing, planning, and delivering care and treatment was embedded across the service. An open referral system was in place receiving referrals from a range of sources including GPs, social care, care providers, education, family members, as well as self-referrals. Referrals came through a single point of access and were processed in line with local procedures. All referrals needed to have the person's consent, either personally or for those patients unable to consent to treatment, by someone acting in their best interest. Northumberland worked with adults while North Tyneside worked with adults and young people. Patients had a comprehensive assessment of their needs completed, which included mental health, physical health, and wellbeing.

Northumberland had implemented transforming care. Therefore, caseload sizes were set at 10 to enable them to work with the most complex patients and respond to those in crisis. Weekly meetings were held to manage referrals and cases. This was part of a process known as the dynamic register and enhanced referrals pathway meetings. Staff from the different providers attended these meetings. The Northumberland service manager chaired the meetings and ensured that all actions were completed.

North Tyneside held weekly referral meetings for adults and young people. Referrals were discussed at these meetings and then allocated to the most appropriate person to carry out initial assessment and risk assessment. The service manager from North Tyneside also chaired these meetings.

There was a shared approach to planning of care involving all members of the multi-disciplinary team, service users, families, and carers and any relevant external organisations. Staff were continuously looking at innovative ways to work with patients.

We reviewed 20 care records from across both the services. In Northumberland, this included a sample from each of the teams covering north, central and west. We found that all care plans were up to date, personalised, and holistic. Electronic systems were being used and information was securely stored and accessible to staff.

Both services were carrying out comprehensive health assessments. North Tyneside worked closely with the GP lead for North Tyneside clinical commissioning group.

Primary care liaison nurses were employed within the team who worked closely with GPs to ensure patients had physical health needs addressed. This also included routine appointments for smear tests, vaccinations, and general health issues. Training around learning disabilities was being delivered to other organisations and the service was available to give advice and support in relation to patients. The Northumberland team had a 'link worker' assigned to each GP practice. The workers role was to promote and advocate on behalf of their patients to ensure that the full range of screening programmes were offered and taken up to meet the physical health needs of patients.

Northumberland were delivering a step up approach, which was seen as an alternative to a hospital admission. This involved a more intense or prolonged approach to treatment where a range of interventions and support was delivered. Professionals who knew the patient and their carer mainly provided this step up approach within the care pathway. This was delivered as an urgent response, package of care or a planned intervention to provide home based treatment. In North Tyneside, this would be done in collaboration with social care colleagues.

Best practice in treatment and care

The teams worked closely with psychiatrists who were employed by the mental health trust to complete psychiatric assessments and review of medicines. In North Tyneside, there were occasions where qualified nurses were required to administer medication to clients within the community, i.e. depot injections. Ordering of medication was done by the individual's GP. Storage of medication was done at the patient's home. All qualified nurses received yearly updates regarding medicine management. The services were working closely with GPs around the stopping overmedication of people with learning disabilities programme. The aim of the programme was to improve the quality of life of people with a learning disability by reducing the potential harm of inappropriate psychotropic drugs that may be used wholly inappropriately, as a "chemical restraint" to control challenging behaviour.

Joint clinics were facilitated with psychiatry and nursing for service users requiring medication reviews. This included signposting for physical health checks and facilitation, antipsychotic health monitoring as appropriate (before and after prescribing), and the monitoring of side effects and medication concordance.

Are services effective?

Outstanding ☆

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

The services were following national guidance around health checks and screening for various cancers such as breast, bowel and cervical. Patients were receiving annual health checks and ongoing physical health needs were being addressed. The service proactively worked with patients to ensure health needs were being met. This included de-sensitisation work with patients to prepare them for attending medical appointments. The services used innovative ways to prepare and support people. This included having bloods taken at GPs services and attending outpatient appointments for other medical conditions.

Patients were receiving input from speech and language therapists. The trust was responsible for delivering this service is North Tyneside. There was ongoing support to produce resources to aid communication and understanding. A range of communication methods such as talking mats and first level dysphasia assessments were being used. In addition, Northumberland were looking at foundations of language development training for all nurses.

A range of pathways was being delivered in North Tyneside, which included autism spectrum disorder, positive behavioural support, dementia, and epilepsy. Northumberland were delivering three main pathways, which were, mental health, physical health and positive behavioural support.

North Tyneside employed a team of psychologists who delivered a range of therapies including direct therapy to patients and families. The team had responded to emerging needs and were developing a programme for patients with borderline personality disorder. Psychological therapies were delivered by another trust in Northumberland who worked closely with the service. Interventions included cognitive behavioural therapy, dialectical behaviour therapy and adapted acceptance and commitment therapy.

The services had developed a baseline assessment tool to assess themselves against national institute of clinical guidelines. The service was meeting 98% of the recommendations for clinical guideline NG11 challenging behaviour and learning disabilities.

The service was meeting 87% of the recommendations for mental health problems in people with learning disabilities: prevention, assessment, and management (NICE clinical guideline NG54).

North Tyneside had introduced an outcomes monitoring tool in March 2016, this was based on the health inequalities framework. This measured outcomes for people with a learning disability based on the determinants of health inequalities. The use of the tool had been audited with recommendations to reassess patients every three months or when discharged.

Skilled staff to deliver care

A full range of disciplines worked within the North Tyneside team. This included psychologists, speech and language therapist, occupational therapist, nurses, support workers and administrators. The social work team were based within the same building and although not part of the team, there were excellent working relationships in place.

In Northumberland, the team included nurses, support workers, and administrators. Psychology, speech and language therapy and occupational therapy were delivered by partner organisations and excellent working relationships were in place.

Psychiatrists were employed by Northumberland Tyne and Wear NHS Foundation Trust to work with the service. The service provided to patients was seamless as the staff were effectively integrated despite being employed by different providers. North Tyneside had one adult psychiatrist and one young person's psychiatrist. Adult psychiatrist caseload sizes were high in the North Tyneside. The team manager was supporting the psychiatrist to reduce the caseload number by reviewing and discharging anyone who no longer needed a service. There was evidence that this was being done in a structured and safe way. There were three psychiatrists working in Northumberland.

All staff were having an annual appraisal of their performance against agreed competencies from their job description. As part of this process, each member of staff agreed with their manager, objectives for the forthcoming year and had a personal development plan in place.

All new staff including agency staff, students, and trainees had a set induction into the service. All staff were given the opportunity to have clinical, managerial and caseload supervision.

Are services effective?

Outstanding ☆

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

Staff were encouraged to keep up to date with best practice and current legislation. Staff were supported to maintain their professional registration where applicable. All staff members were required to attend specific training events to enhance their professional development and strengthen the skills of the team and the overall service. During the inspection, we attended a staff briefing session where staff who had attended a positive behavioural support conference were sharing what they had learnt. This was common practice within the teams.

We saw evidence that staff were actively engaged in monitoring and improving the service. A range of audits had been carried out. These included

- audit of staff supervision
- recording of duty entries on system one
- comparison of behaviour assessment and treatment performance against NICE challenging behaviour quality standards
- audit of case records using the monitoring tool
- dementia audit
- adult social care assessment audit
- record keeping audit

Multi-disciplinary and inter-agency team work

Weekly referral meetings for adults and children were held in North Tyneside. The meetings reviewed initial assessments, waiting lists, and allocations. Nurses, psychologist, psychiatrist, speech and language therapist, occupational therapist, assistant psychologist, and support workers attended these meetings.

We observed these meetings and found them to be well attended and well structured. Each referral was discussed in detail and then allocated to the most appropriate person within the team. Bed management was discussed in terms of looked after children. Plans were agreed and actions assigned to individuals. Actions from previous meetings were signed off at each meeting.

Northumberland held weekly meetings to review the dynamic risk register. This was a cross trust weekly meeting which included representatives from :-

- Community nursing / social care
- Positive Behaviour Support team
- Child and Young person's service
- Disability children's team
- Crisis team
- Psychiatrist Mental Health
- Clinical commissioning group

Individuals who may be at risk of hospital admission due to challenging behaviour and or mental health were discussed. People were assigned enhanced support from the pathways and monitored in the dynamic register until they were no longer at risk. Care treatment reviews were arranged as part of this process. Operational staff worked closely together and attended weekly meetings to discuss patients. We observed this meeting to be very dynamic, and task orientated. Individuals left the meeting with specific tasks, which were discussed at the next meeting to ensure that they had been completed. The quality of partnership working was outstanding largely facilitated by the service manager from the Northumberland team.

Crisis meeting were held to discuss any difficult cases and any potential hospital admissions. Individuals and teams were tasked with actions and patients would remain on the agenda until they were no longer on the list.

Weekly multi-disciplinary meetings were held in both areas which then led to individual multidisciplinary meetings where required. There was continuous multi-disciplinary working to ensure the best outcome for the patient.

Excellent relationships existed with external providers and training was delivered to other agencies on learning disabilities where this was required. This included work with GPs, and accommodation providers. The service was available to offer advice and guidance to other agencies. The services worked very closely with accommodation providers and ensured that patients were effectively supported at home.

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

Staff demonstrated a good working knowledge of the basic principles of the Mental Health Act and how community treatment orders could support service user's care. Staff explained how they could request a Mental Health Act assessment in the community and what this involved. All staff had received training in the mental health act.

Are services effective?

Outstanding ☆

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

Good practice in applying the Mental Capacity Act

Staff had a good understanding of the Mental Capacity Act. The Act was used appropriately when it was felt that a person lacked capacity to make a certain decision. We saw the use of the Mental Capacity Act recorded in records and were given various examples of where staff had used the Act. An example included a patient with diabetes; the nurse felt that the patient did not understand the implications of unhealthy eating on her diabetes and weight gain. The nurse used the Mental Capacity Act and asked the patient a number of questions relating to healthy eating which led to a best interests meeting. The outcome was that the patient was supported to make healthy choices and was able to manage their condition.

The services used a range of resources to aid and demonstrate understanding to patients. An example was that monopoly money was being used to help patients plan finances.

Outstanding ☆

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 their carers who told us they were happy with the care they received from the service. They told us that staff were always polite and friendly and they felt supported by them. We were told that staff were easily accessible when needed. One carer told us the service they have received was exceptional and another told us that she did not know where she would be without them.

Patients and carers confirmed that their needs were being met and appointments were taking place at a convenient time and place for them. Patients felt involved in the care they or their relative received and all but one patient had received a copy of their care plan.

Staff were assisting patients and families to cope emotionally with their care and treatment. People's social needs were clearly understood. People were supported to maintain and develop their relationships with those close to them, their social networks, and the wider community. Staff enabled patients to manage their own health and care where possible. Everyone we spoke to confirmed that they had received relevant information from the service. This included details on how to make a complaint and information on local advocacy services.

The involvement of people in the care that they receive

Patients told us they felt involved in their care and treatment. Patients were given easy read literature in formats that they could easily understand. Staff worked with patients individually and tailed treatment to meet each individual's needs. Staff were continually finding innovative ways of developing communication aids and methods of working with patients. We saw an example of where a patient had difficulty in telling the time and so any appointment letters were sent in pictorial format with a picture of a clock and the time of appointment. Another patient was assisted with a pictorial format of the central heating to ensure that their home was always at a comfortable temperature after the team identified their home was always cold. The service used storyboards and various other communication methods.

There was evidence that care plans were discussed with patients and easy read versions were developed.

Northumberland used a holistic assessment document and person centred planning. Body board assessments were used for emotional literacy where patients could select pictures to portray how they were feeling.

Annual patient and carer surveys took place with a high return rate. Patients had been involved in recruitment.

There was evidence of patient consultation and feedback at Café Events and via the friends and family test. Young people were involved in 'You're Welcome' Accreditation working towards young people friendly services.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

A target of 13 weeks following referral in which to make face-to-face contact with patients and for a comprehensive assessment to be undertaken was in place in North Tyneside. In many cases, patients were seen within the 13-week target. However, over a 12 month period there were six months were this target had not been met which resulted in the following;

May 2016 86% (78 patients)

July 2016 92% (44 patients)

August 2016 94% (35 patients)

October 2016 93% (39 patients)

November 2016 86% (100 patients)

February 2017 85% (88 patients)

The manager had carried out a dashboard analysis, which identified the main reasons for the target not being met. An action plan was in place with ongoing work to look at caseload sizes and determine patients who were ready for discharge. This would allow more time for new referrals to be seen within the target time. Some patients that fell outside of this target had not yet moved into the service area and were therefore unable to receive face-to-face contact.

Northumberland responded to people in crisis and therefore had no waiting times. Referrals were discussed at weekly meetings of the dynamic risk register and responded flexibly.

All patients across North Tyneside and Northumberland had a pathway document within their care records. This outlined the referral to discharge pathway. The service had a range of different pathways that could be applied to patients depending on their condition, including specific dementia and epilepsy pathways. The pathway document was the same for each patient.

Staff took active steps to engage with patients who had not attended their appointments or were reluctant to engage with the service. Staff visited patients, their carer's and families at home, at GP surgeries or arranged to meet them at a venue of their choice such as a café or restaurant. Patients were not routinely discharged if they did not attend appointments and staff made every effort to re-engage patients back into the service. We saw evidence of a guidance flow chart that staff could refer to if a patient remained disengaged.

At both services, we saw that patients and carers preferences for appointment times and locations were met wherever possible. No appointments had been cancelled by the services.

Patients had a plan for discharge back to primary care or an appropriate care provider on entry into the service. Discharge planning was communicated with the patient and their carer as part of the care and treatment plan. The GP received a discharge summary.

Contingency plans such as relapse plans, behaviour support plans, and health action plans formed a part of the discharge process. These plans indicated how to re-enter the service if required. As part of the inspection, we observed a discharge meeting where the patient was being discharged to the accommodation provider. This was done in a structured supportive way and gave reassurance that the learning disability service was there if the patient required.

The facilities promote recovery, comfort, dignity and confidentiality

Patients' individual needs and preferences were central to the delivery of the service. Appointments with patients were usually offsite at a time and location that suited the patient. In the rare occurrences that patients and their carers visited the service sites, accessible rooms were available which took into account the person's needs, such as wheelchair access.

Meeting the needs of all people who use the service

There was a proactive approach to understanding the needs of patients so that care and treatment could be delivered to meet their needs. Information was available in a variety of different formats and information leaflets were given to patients and carers at their first appointment. The leaflet gave details of their rights, what the service offered, the importance of annual health checks and how to complain or feedback about the service. These included versions in easy read, braille, and different languages. Staff could access interpreter services, although this was rarely required.

Are services responsive to people's needs?

Good

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The acute liaison service had done some population gathering across the service area to identify locality information and trends. This information was used to assess the potential need of the service and focus resources.

Listening to and learning from concerns and complaints

The service had received three formal complaints in the last 12 months. The complaints related to communication with patients and their families. Two of the complaints were partially upheld and one was not upheld. All three complaints were dealt with locally.

Information was available to people who used the services about how to make a complaint or raise concerns. Packs were issued to patients and carers on admission to the services. This included advice on how to make a complaint. Both teams had access to local advocacy. North Tyneside did not routinely give their patients information on advocacy; however, the staff we spoke to told us that if they felt the patient required access to an advocacy service they would provide them with information and support them in making contact. This meant that patients who were unable to make a complaint by themselves could be helped to do so by an advocate.

The staff we spoke with across both services knew how to escalate any complaints received. The service managers dealt with these in line with the trust's complaints procedures. Any lessons learned from complaints were discussed in team meetings and during supervisions.

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

There was a clear statement of vision and values, which was known and understood by staff.

The trust had five values:

- Respect
- Everyone's contribution counts
- Responsibility and accountability
- Patients first
- Safe and high quality care

All staff we spoke to said they felt part of the trust and were kept up to date with developments. There was a shared intranet page and staff were very positive about the trust vision and values. All staff were able to describe the trust vision and values and were genuinely on board to deliver these values when working with patients.

A philosophy that learning disability patients should have access to mainstream provision was clear to see across the service. We saw evidence that people were supported to integrate into society and access community services. The trust had significantly reduced hospital admissions for learning disabilities patients, which had resulted in a reduction in the need for inpatient beds. Robust community services and effective working practices with accommodation-based providers had resulted in this positive reduction.

Good governance

Effective governance systems were in place. Each service used a performance dashboard and monitored key performance indicators weekly. The service had a local risk register, which fed into the wider service risk register. Clinical business meetings were taking place, which were attended by the managers from each of the teams.

All staff were receiving supervision and appraisals. Staff were up to date with mandatory training and were supported to develop in specialist areas. Staff felt that they could identify personal development needs and were encouraged with professional development.

All staff knew how to report incidents and although the service had reported few incidents these were discussed within teams. All staff understood their responsibilities around safeguarding and systems were in place to identify and respond to any safeguarding concerns. Both teams understood and appropriately applied the Mental Capacity Act and used best interests when needed.

Leadership, morale and staff engagement

Staff morale was excellent across both teams. All staff we spoke to were extremely happy in their roles and said there were excellent working environments. All staff spoke highly of the local leadership and this was evident across both teams. The Northumberland team had been through a period of significant change in recent months. This had been managed well with staff feeling that they had been fully involved in the changes. There was an environment of openness and transparency and all members of staff felt valued and part of the team.

Team meetings were held weekly. The meetings were divided into clinical debrief, information sharing / communications, referral and risk register debrief. We saw that team meetings were well attended with a structured agenda. Business meetings were held monthly for all staff to attend, for the purpose of information sharing and quality initiatives.

Commitment to quality improvement and innovation

Northumberland had introduced a seven-day enablement to support patients in crisis. This ensured that there was absolute flexibility to work with patients when they needed it. This way of working had led to the significant reduction in hospital admissions. As part of this, an urgent financial uplift to support the patients' care plan was available.

A doctor first system was being piloting in Northumberland to provide reasonable adjustments for patients with a learning disability. This included an alert on the system and training for reception staff. Learning disability patients would be offered a face-to-face appointment rather than a telephone consultation to determine if an appointment was required.

There had been collaborative work with maternity units and local children's safeguarding boards to look at birth plans. This had resulted in timely birth plans being available out of hours. Clear instructions were made available to acute hospital staff regarding plans for

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supervision and access of parents and family members, following delivery. Social workers and Midwives were following the same plans and parents were fully involved and aware of the expectations upon them.

Both services were involved in the cervical and bowel cancer screening programmes. These programmes were looking at the low uptake from learning disability patients and identifying new ways of working to support people to take part in screening programmes.