Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Report

West Park Hospital, Edward Pease Way, Darlington,
County Durham, DL2 2TS
Tel: 01325 552000
Website: www.tewv.nhs.uk

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and PICU	Cross Lane Hospital	RX3LK
	Friarage Hospital Mental Health Unit	RX3XX
	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	Lanchester Road Hospital	RX3CL
	The Briary Unit	RX3YE
	Sandwell Park	RX3NH
Longstay/Rehabilitation for adults of working age	Primrose Lodge	RX3AD
	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	163 Durham Road	RX3WE
	Earlston House	RX3AE
	Park House	RX3PV
	Abdale House	RX3XK
Forensic inpatient/secure wards	Roseberry Park	RX3FL
Child and Adolescent Mental Health Inpatient wards	West Lane Hospital	RX3LF
	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
Wards for people with a Learning Disability or Autism	Bankfields Court	RX3NT
	Lanchester Road Hospital	RX3CL
	163 Durham Road	RX3WE
Wards for older people	Cross Lane Hospital	RX3LK

Summary of findings

	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	Springwood	RX3KW
	Sandwell Park	RX3NH
	Auckland Park Hospital	RX3AT
	Friarage Hospital Mental Health Unit	RX3XX
	Lanchester Road Hospital Alexander House	RX3CL RX3XL
Community services for adults of working age	Trust Headquarters	RX301
Crisis and HBPoS	Trust Headquarters	RX301
Community services for children and young people	Trust Headquarters	RX301
Community based services for older people	Trust Headquarters	RX301
Community LD and Autism	Trust Headquarters	RX301
Substance Misuse Services	Trust Headquarters	RX301
Adult Social Care	367 Thornaby Road Durham and Darlington Crisis and Recovery House	RX3LD RX3X5

This report describes our judgement of the quality of care at this provider. It 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.

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 services at this provider	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
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.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level which led to a rating of Good.

Mostly patients were protected from avoidable harm or abuse, but we found some patient safety issues that need to be addressed:

- There were breaches of same sex accommodation guidance on Earlston Ward, a 15 bed rehabilitation ward.
- There were some environmental and ligature risks identified on Ward 15, Cedar ward, Abdale House and Primrose Lodge. On the acute wards not all risks had an associated intervention plan.
- On Ceddesfeld and Hamsterley wards, medicines were being administered covertly, but the information about this was not recorded in line with the trust policy.

The trust strongly encouraged openness and transparency. The trust carried out a thorough investigation following serious untoward incidents. We did note that relatives and carers were not as engaged in the process as they should be. Other healthcare professionals and staff were engaged in the process of the review. Lessons were learned and improvements to safety were made and then monitored.

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. There was executive team leadership in safeguarding. The trust actively worked with other organisations and were engaged in local safeguarding boards and procedures.

Staffing levels were planned, reviewed and implemented to keep people safe. The trust published their staffing levels on their website.

Staff recognised and responded appropriately to changes in risks to people who use services. The trust had developed a physical restraint reduction plan and were using positive behaviour support to manage behaviours that challenge.

The trust had developed a strategy to minimise restrictive practices. We did however see some restrictive practices taking place in the trust although they were working towards improving this problem. We saw this in the acute wards and on Fulmar and Kirkdale rehabilitation wards.

Patients had good outcomes because their care and treatment was effective at meeting their needs. Patients had comprehensive assessments of their needs carried out at the point of admission. Care and treatment was planned and delivered in line with current evidence based practice. Information about patient care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. However in the learning disabilities wards patients did not have a comprehensive person-centred, holistic discharge plan in place to support commissioners and other authorities to find accommodation that will meet individual needs and preferences on discharge.

Patients that were detained had their rights protected. With the exception of the recording of seclusion on Ward 15, staff complied with the Code of Practice.

With the exception of 367 Thornaby Road, staff were in receipt of clinical and management supervision and appraisals. Learning needs were identified and training set up to meet those needs.

Issues about capacity and consent were mostly understood. However staff on Earlston House, the CAMHS community teams and the older peoples' wards did not fully understand how the Mental Capacity Act and Deprivation of Liberty Safeguards applied to their work.

Patients were respected and were partners in their care and treatment. We observed and saw records that demonstrated active patient engagement in all aspects of their care. Patients also contributed to the running of the wards and changes to services. The trust participated in the 'triangle of care'. Carers' were seen as an integral partner, alongside the patient and staff in the care and

Summary of findings

treatment delivered to the patient. Patients' privacy and dignity was maintained with the exception of Ward 15 and Cedar ward which were both located in acute general hospitals.

With the exception of 367 Thornaby Road, there was information available about advocacy services and Independent Mental Health Advocacy for detained patients.

Patients' needs were met through the organisation and delivery of services. Services were planned in collaboration and consultation with health and social care partners or commissioners. We heard that the trust was willing to engage in future strategy planning and delivery of services. However we noted that patients in the learning disability wards had been in the service between 2-14 years. The service struggled to discharge patients because external authorities did not identify suitable places for patients to move to. There were delays in funding from external authorities which meant patients remained in hospital longer than necessary.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met those needs and promotes equality. There were interpreting services that could be accessed easily if needed. Reasonable adjustments were made and action taken to remove barriers when patients found it difficult to access services. Lessons from complaints were discussed at 'daily report out' meetings, team meetings or clinical supervision. Feedback was shared with patients via the 'you said, we did' boards.

The leadership, governance and culture were used to drive and improve the delivery of high quality patient-centred care. Leaders had an inspiring shared purpose, were determined to deliver and motivated staff to succeed. There was ownership of the vision, values and quality improvement system throughout the organisation. There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff felt engaged in the delivery and continuous improvement of services. The trust quality improvement system was embedded at every level across the organisation. The trust participated in external peer review and accreditation.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was a breach of same sex accommodation guidance on Earlston ward which is a 15 bed rehabilitation ward.
- During our inspection, a male patient who had been admitted as an emergency was admitted into a single bedroom on the female wing of Oak ward which is a ward for older people.
- There were some environmental and ligature concerns identified on Ward 15, Cedar ward, Abdale House and Primrose Lodge.
- On the acute wards not all risks identified for patients had an associated intervention plan.
- Medicines were managed safely across trust sites. On wards for older people we found that some medicines were administered covertly (disguised by mixing with food or drink) but authorisation for this was not recorded in patient notes in line with trust policy. This was on Ceddesfeld and Hamsterley wards.
- When something went wrong, there was a thorough review or investigation that involved all relevant staff. However it was clear that relatives and carers were not always engaged in this process, despite the trust trying to address this issue in the last year.
- Restrictive practices had been identified within the trust at a number of inspections and MHA monitoring visits prior to this inspection. The trust had developed a strategy to minimise restrictive practices. We did however see some restrictive practices taking place on some wards in the trust although they were working towards compliance with this issue.
- However we also found that :
- Lessons were learned and communicated widely to support improvement in other areas as well as services that are directly affected.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The board understood the duty of candour and their roles and responsibilities. Awareness training for all staff had been undertaken.
- Safeguarding vulnerable adults, children and young people was a given priority. The trust took a proactive approach to safeguarding.

Summary of findings

- Safety and risk were routinely monitored. The trust had an integrated assurance framework and risk register.
- Patients risk assessments were person-centred, proportionate and reviewed regularly.
- The trust had developed a physical restraint reduction plan and were using positive behaviour support to manage behaviours that challenge.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Are services effective?

Good

We rated effective as good because:

- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Patients had comprehensive assessments of their needs, which include consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Information about patient care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care.
- 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.
- Where patients were subject to the Mental Health Act 1983 (MHA), their rights were protected and staff complied with the MHA Code of Practice. There was an exception in the recording of seclusion on Westwood ward and Ward 15.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs.
- With the exception of 367 Thornaby Road, staff were in receipt of clinical and management supervision
- Staff work collaboratively and across teams to understand and meet the range and complexity of patient needs.
- With the exception of the wards for people with a learning disability or autism, patients were discharged at an appropriate time and when all necessary care arrangements were in place.

Most staff understood the issues relating to capacity and consent. The exceptions were Earlston House, CAMHS community teams and the older peoples' wards.

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Are services caring?

Good

We rated caring as good because:

- Feedback from patients who use the service, relatives and carers was positive about the way staff treat people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Patients' privacy and dignity was maintained with the exception of Ward 15 and Cedar ward.
- Patients told us and we observed that they were involved in all aspects of their care and treatment. Patients actively contributed to the running of wards and changes to the services.
- The trust are members of the 'Triangle of Care' project. Wards used triangle of care self-assessments alongside carer surveys to improve the partnership arrangements with carers. There were a number of carers groups and carer support groups throughout the trust.

Across the services, with the exception of 367 Thornaby Road, there was information visible and available about local advocacy services or Independent Mental Health Advocacy for detained patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Feedback from commissioners of services, clinical commissioning groups, local authorities and NHS England told us that the trust was very willing to engage in future strategy regarding planning and delivery of services.
- Commissioners told us that there was an opportunity for patients and commissioners to feedback on service planning and delivery of services each year for learning disability services.
- In the specialist community teams for children and adolescent, a gap had been identified in the provision of crisis services for children and young people. In response, the trust had developed a crisis service that was open seven days a week 8am to 10pm.
- The hours some of the children and adolescent mental health services open made them more accessible to young people out of school hours.
- We saw that services were planned in consultation with other health and social care partners to deliver services effectively.
- Staff had access to interpreting services. Services we visited had disability access and disabled facilities such as toilets and

Summary of findings

bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived.

- Information about raising concerns and complaints was available to all patients in the wards, health based places of safety and community mental health services with one exception. At 367 Thornaby Road, there was no visible information on how to make a complaint for the people living there or their carers. There were no records of complaints being made at the service.
- Lessons from complaints were discussed at 'report out' meetings, team meetings or clinical supervision. Feedback on lessons learned were shared with patients via the 'you said….we did' boards located in all the ward environments.
- However in the learning disability services some patients had been in hospital between 9 and 14 years. We looked at the discharge plans and saw the minutes of recent 'Care and Treatment' reviews stating they were ready for discharge. There was no written discharge plans in place and commissioners still had not identified any placements in the community for patients.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The trust had a clear vision, mission and quality strategy, supported by clear values. All staff in the trust understood these and had translated the visions and values into their own work.
- There was clear ownership of the vision and values throughout the organisation.
- There was a clear governance structure that ran through the organisation and was understood by all.
- Staff knew that there was a whistle blowing policy in the organisation and felt confident that if they needed to raise concerns, they could do so without fear of victimisation.
- Staff within the organisation were able to tell us who the senior leaders were and said they were visible and approachable.
- Staff feel engaged in the planning, delivery and continuous improvement of services. They told us that they were motivated and proud to work within the organisation.
- The trust had developed a quality improvement system which all staff routinely use. The trust use the quality improvement tools and methods to drive up quality, eradicate waste and improve services. We found that it was embedded at every level across the organisation.

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- The trust also participated in external peer review and accreditation and the majority of services that participated were accredited as excellent.
- The trust had achieved the 'Gold Standard' in Investors in People award.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive, South West London and St Georges NHS Mental Health Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Patti Boden, Care Quality Commission

The team included 11 CQC inspectors and a variety of specialists: consultant psychiatrists, consultant nurses, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, junior doctors, MHA reviewers, mental health social workers, nurses, occupational therapists, student nurses, pharmacy inspectors, psychologists, recovery co-ordinator, senior managers and specialist registrars.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We held listening events at each main hospital location for detained patients. We met with groups of carers prior to the inspection at a number of hospital locations. We held a focus group prior to the inspection, facilitated by a voluntary organisation, Darlington Mind on 16 January 2015. We carried out announced visits to all core services on 20, 21, 27, 28 and 29 January 2015. We carried out an unannounced visit to the forensic service at Roseberry Park at night on the 29 January and visited Brambling ward (MH) and Robin, Kingfisher and Heron ward (LD).

During the visit we held focus groups with a range of staff who worked within the service. This included nurses, doctors, psychologists, allied health professionals, and administrative staff. We met with 507 trust employees. We met with representatives from other organisations including commissioners of health services and local authority personnel. We met with 209 patients who use services who shared their views and experiences of the core services we visited. We observed how patients were being cared for and talked with carers and/or family members and reviewed 281 care or treatment records of patients who use services. We looked at a range of records including clinical and management records.

Information about the provider

Tees, Esk and Wear Valleys NHS Foundation Trust provides a range of mental health, learning disability and substance misuse services for the people of all ages living in County Durham; Darlington; the four Teesside boroughs of Hartlepool, Stockton, Middleborough and Redcar and Cleveland; Scarborough, Whitby, Ryedale, Hambleton, Richmondshire and Harrogate districts of North Yorkshire and the Wetherby area of West Yorkshire.

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The trust also provides learning disability services to the population in Craven and regional specialist eating disorder services to the North East and beyond.

Tees, Esk and Wear Valleys NHS Foundation Trust was authorised foundation trust status on 1 July 2008.

The trust serves a population of 1.6 million people and have more than 6000 staff working in over 150 locations. Their annual income is £290 million. The trust's services are commissioned by eight clinical commissioning groups and NHS England and they work with seven local authorities.

Tees, Esk and Wear Valleys NHS Foundation Trust was first registered with CQC on 1 April 2010. It has 21 locations that are registered with CQC.

There have been 28 inspections at registered locations of Tees, Esk and Wear Valleys NHS Foundation. These inspections have occurred at 10 locations.

Roseberry Park was last inspected on the 26 March 2014 and was not meeting the essential standards relating to care and welfare of people who use services (regulation 9) and safeguarding people who use services from abuse (regulation 11). These compliance actions were inspected as a part of this comprehensive inspection. The action plans were not all due for completion at the time of the inspection so we only reviewed those actions that the trust informed us were completed.

163 Durham Road was inspected on 10 May 2014. It was found not to be meeting the essential standards relating to care and welfare of people who use services (regulation 9) and safeguarding people who use services from abuse (regulation 11). These compliance actions were inspected as a part of this comprehensive inspection.

Roseberry Park has been inspected on four occasions, while Auckland Park Hospital, Lanchester Road Hospital and Bankfields Court have all been inspected on 3 occasions.

The trust provide the following core services:

Mental health wards:

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

Community-based mental health and crisis response services:

- Community-based mental health services for adults of working age.
- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community mental health services for people with learning disabilities or autism.

We also inspected the following services that the trust provide:

- Substance misuse services
- Adult social care services

In addition the trust also provides eating disorder services, IAPT (Improving access to psychological therapies) and provide mental health services to six prisons.

What people who use the provider's services say

We spoke with 209 patients during the inspection. Nearly all of the patients we spoke with were very happy with the quality of the care and treatment they were receiving, with the approach of the staff and they felt involved in the decisions about their care. We include their comments in the core service reports

Community Mental Health Patient Experience survey

The CQC Community Mental Health survey is sent to people who received community mental health services from the trust.

Summary of findings

Similar surveys of community mental health services were carried out in 2010, 2011, 2012 and 2013.

However, the 2014 survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. This means that the results from the 2014 survey are **not comparable** with the results from the 2010-2013 surveys.

Community Focus Groups

Before the inspection, we held a focus group in Darlington. The focus group was hosted by Mind. We did this so that people who use, or have used, the services provided by the trust, could share their experiences of care. It was a small group with only five attendees.

The group provided responses to the five questions we always ask about services.

Participants on the whole were positive. They talked about caring staff and attending meetings with doctors. One person said that their CPN was very supportive and increased frequency of meetings when they felt the person needed it to keep safe. People felt the service was well led but could be more responsive. Two of the attendees said they knew how to make a complaint and two did not know. The other attendee felt that it would be a waste of time complaining.

Patient Opinion

Patient opinion offers people who use services a forum for honest and meaningful conversations between patients and providers.

The information on the Patient Opinion website offered that the following is good about the trust:

- **Caring staff who reassure and respect patients** Newberry, Holly Unit, Auckland Park Hospital, Oak Lodge.
- **Patients and families included in decisions** about care provision.

However there were also some negative comments:

- **West Park Crisis Team**: Poor/ rude telephone manner on Crisis help line and difficulties making initial contact in general, with calls not returned,
- **Lack of care provision** due to low staff capacity (West Park Hospital).
- **Rude and insensitive staff** (West Park Crisis Team, Cedar and Maple Wards)
- **Little contact with key nurse** (Newberry)
- **Staff require training** with regards to safeguarding and understanding mental health issues (West Park Hospital)

During our inspection, with the exception of staff not receiving mandatory training in the Mental Health Act, we did not find evidence to support the negative comments posted on the patient opinion website.

Comment cards

Before and during the inspection, we left comment cards in all in patient wards and areas where patients might spend time. This was so that they could write their comments down about their experiences of care within the trust services. People posted their comments in sealed boxes which we opened and looked at as part of the inspection.

- 346 comment cards received
- 151 (43%) were positive
- 82 (26%) were negative
- 62 (17%) were mixed
- 41 (11%) were blank or illegible.

Out of the 97 boxes issued to the trust 40 (11%) were received back with no comments in.

Top ranking wards with the most comment cards were:

1. Tunstall Ward (Lanchester Road) 36 (10%)
2. Parkside 22 (6%)
3. Unknown (no location) 20 (5%)
4. Cedar Ward 20 (5%)
5. CAMHS Rosewood 15 (4%)
6. Overdale Ward 11 (3%)
7. Unit 2, Bankfields 11 (3%)

Positive Comments:

- 62 (41%) were all in relation to Staff – very good, welcoming, professional, excellent, caring, hardworking and 1st class.
- 32 (21%) were in relation to the excellent treatments/ service provided by the trust - appointments are on time, treatment was what was required.
- 31 (20%) were in relation to the Environment – It was safe, clean, and hygienic.

Negative Comments:

Summary of findings

- 35 (38%) were in relation to staff – dismissing patients, not interacting with patients, staff attitudes. The biggest concern was staffing levels
- 16 (17%) were in relation to the environment/facilities – places are old and lack modern facilities, old, unhygienic, mice, shower rooms have broken seals.
- 14 (15%) were in relation to medication/treatment - refusal of medication, no monitoring of medication, side effects of medication, no proper diagnosis after 9 months, no care plan or follow up plan

Good practice

- Each location had a report out meeting every morning. We observed several of these meetings. These were attended by all staff disciplines. Each patient was discussed using a visual display board. The team considered current care and risk factors and tasks were set for staff for the day. We attended a 'report out' meeting on each hospital site and found these to be an effective system for ensuring care was patient focussed, therapeutic, informed by risk and formulated with discharge as a focus.
- The learning disability and autism service had a steering group and champions for positive behaviour support. The role and purpose of the group and champions was to embed teaching and learning across the locations to ensure positive behaviour support was an effective tool to manage complex behaviours which challenged.
- The trust had implemented a Naloxone programme, within the substance misuse services, specifically for those identified as high risk of opiate overdose. Naloxone is an opioid antagonist used to counter the effects of opioid overdose; this can be injected directly into the muscle. Staff have been trained to deliver Naloxone kits and instructions on use to those identified to reduce deaths by overdose. Although there are no formal mechanisms to collect outcomes for the use of these kits, staff had informally been advised they had prevented a number of deaths in the community.
- Staff on both Holly and Baysdale (CAMHS LD wards) liaised with the community services to provide the most appropriate services needed at the time for the patients and families. Staff worked flexibly to enable this to happen.
- In the wards for older people service specifically on Springwood and Rowan Lea they were using specialist computer programmes to enable staff to interact with people with memory problems in a positive way.
- The street triage team captured people's feedback instantly through using tablet devices.
- There were excellent examples of some crisis teams encouraging advance directives to help people determine their future crisis care needs.
- A clear assessment and comprehensive physical health check was undertaken, usually by a paramedic, on arrival to the health based place of safety.
- Initiatives such as the retreat which all staff could request to participate in.
- The pharmacy team had worked with some of the wards to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.
- We found some good examples of how the rehabilitation teams had developed good working relationships with partner organisations both internal and external of the trust. This included the use of volunteers through a voluntary agency to support patients and good links with community mental health teams, housing organisations and the trust wide recovery college.
- The CAMHS teams in Durham and Darlington had recognised there was a gap in provision of crisis intervention for young people and children. In response using patients' feedback to shape the service the teams had developed a crisis service, open seven days a week 8 am to 10 pm, and piloted overnight. The service had good working relationships with the local police and had resulted in a reduction of admissions to hospital by over 50%. We were told this model was to be adopted in other areas.
- The hours some of the CAMHS services open made the services more accessible to young people out of

school hours. For example, Stockton opened till 8 pm twice a week and would open at weekends to alleviate waiting lists. South Durham reported opening 8 am to 8 pm and home visits from 7 am when requested.

- Middlesbrough CMHT showed us information on the recovery support groups which had been developed by the psychologists and run by a qualified nurse with a support worker. The CMHT set up the first recovery group in Middlesbrough and all recovery groups were linked to the trust's recovery college, 'cognitive stimulation therapy pathway'. This was available for dementia patients and developed by a student nurse on a placement. All student nurses' were now required to produce a service improvement project as part of their placement.
- Patient involvement in clinical governance meetings, events planning, training and research activities in the forensic services was substantial. The recovery and outcome team had a significant impact in driving involvement.
- The administration of the Mental Health Act was considered to be of a very high standard.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

The provider must review the covert administration of medication without reference to the pharmacist or through a best interest meeting on Ceddesfeld and Hamsterley.

The provider must ensure that administration records for medication for patients on Hamsterley Ward are signed as the medication was administered.

The provider must ensure that in the acute wards, current risks have an associated intervention plan which clearly outlines measures to manage the risk with the input of the patient.

The provider must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels.

The provider must ensure an effective quality monitoring system is in place for joint working with partner NHS trusts where services are provided from.

The provider must ensure that Earlston House is compliant with the Department of Health guidance regarding Same Sex Accommodation (SSA) to ensure patients privacy and dignity is protected.

The provider must ensure that each patient in the learning disability wards has a comprehensive discharge plan which is holistic and person-centred.

Action the provider SHOULD take to improve

The process of frequent documented checks of medicine prescription and administration records by nursing staff should be embedded into routine practice on all wards to reduce the incidence of medicines omissions

The provider should take steps to ensure where patients ,in the wards for people with a learning disability or autism, have complex needs and require additional support they have routine access to psychology, speech and language therapists (SALT) and occupational therapy

The provider should make sure that staff always complete the correct documentation and the documentation should contain a clear step by step account of any episodes of seclusion in every instance and ensure the records adhere to the Mental Health Act Code of Practice.

The provider should continue to monitor the use of restraint and reduce prone restraint on Newberry and Westwood.

The provider should make sure that ward managers have an accurate record of staff supervision to demonstrate that trust policy is being followed.

The provider should ensure that same sex accommodation guidance is followed on Elm.

The provider should ensure that privacy and dignity is maximised in the bed bays of ward 15 and Cedar at the Briary Unit.

The crisis teams should consistently evidence patient involvement in their intervention plan and ensure people receive a copy of their intervention plan.

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The provider should ensure conditions of CTOs provide clarity about the lack of compulsion for treatment for mental disorder whilst people are in the community.

The provider should ensure that the restrictive practices on Kirkdale ward and Fulmar ward are reviewed to make sure they are based upon patients individual risk assessments. These include; searching patients following a period of unescorted leave, the locking of bedroom windows and access to the internet and mobile phones on these ward.

The provider should ensure that staff at Earlston House fully understand the principles of the Department of Health Same Sex Accommodation (SSA) guidance and issues in relation to the Mental Capacity Act on the ward.

The provider should ensure that where evidence indicates that a patient does not have capacity, that a capacity assessment is completed in accordance with the Mental Capacity Act.

The provider should ensure that the clinic room is relocated on Earlston House to ensure the privacy and dignity of patients on the ward.

At Abdale House, the provider should ensure that special instructions regarding the administration of medicines are recorded on all patients' medicine administration records.

The provider should ensure patients who lack capacity at Abdale House are referred to the advocacy service and information regarding the IMHA service is available to them.

The provider should make sure all the team managers monitor the uptake of supervision in the CAMHS services, to ensure it meets the new supervision guidance fully.

The provider should ensure the environment is safe for people to visit for treatment and care. In particular at the Old Vicarage with regards to the doors which should be kept locked at all times and the hot water geyser next to the patient area.

The provider should ensure that all teams and staff members have clinical and management supervision. At Derwentside supervision had not been occurring for functional community psychiatric nurses.

Tees, Esk and Wear Valleys NHS Foundation Trust

Detailed findings

Requires improvement

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

Summary of findings

We rated safe as requires improvement because:

- There was a breach of same sex accommodation guidance on Earlston ward which is a 15 bed rehabilitation ward.
- During our inspection, a male patient who had been admitted as an emergency was admitted into a single bedroom on the female wing of Oak ward which is a ward for older people.
- There were some environmental and ligature concerns identified on Ward 15, Cedar ward, Abdale House and Primrose Lodge.
- On the acute wards not all risks identified for patients had an associated intervention plan.
- Medicines were managed safely across trust sites. On wards for older people we found that some medicines were administered covertly (disguised by mixing with food or drink) but authorisation for this was not recorded in patient notes in line with trust policy. This was on Ceddesfeld and Hamsterley wards.
- When something went wrong, there was a thorough review or investigation that involved all relevant staff. However it was clear that relatives and carers were not always engaged in this process, despite the trust trying to address this issue in the last year.
- Restrictive practices had been identified within the trust at a number of inspections and MHA monitoring visits prior to this inspection. The trust had developed a strategy to minimise restrictive practices. We did however see some restrictive practices taking place on some wards in the trust although they were working towards compliance with this issue.
- However we also found that :

Requires improvement

Are services safe?

- Lessons were learned and communicated widely to support improvement in other areas as well as services that are directly affected.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The board understood the duty of candour and their roles and responsibilities. Awareness training for all staff had been undertaken.
- Safeguarding vulnerable adults, children and young people was a given priority. The trust took a proactive approach to safeguarding.
- Safety and risk were routinely monitored. The trust had an integrated assurance framework and risk register.
- Patients risk assessments were person-centred, proportionate and reviewed regularly.
- The trust had developed a physical restraint reduction plan and were using positive behaviour support to manage behaviours that challenge.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Please refer to the 'Actions we have told the Provider to take section'

Our findings

Track record on safety

The strategic executive information system (STEIS) records serious incidents and never events.

A never event is classified as such because they are so serious that they should never happen. Trusts have been required to report any never events through STEIS since April 2011. Between the 1 December 2013 and the 30 November 2014, the trust reported 0 never events.

Serious incidents are those that require an investigation. A total of 59 incidents were reported by the trust between 1 December 2013 and the 30 November 2014. Of those incidents 41 related to the unexpected death of community patients who were in receipt of care and treatment at the time of their death. The highest number of serious incidents occurred within the patient's home.

The most common location by clinical area where serious incidents occurred was adult mental illness. Forty five unexpected deaths occurred in that clinical area between 1 December 2013 and 30 November 2014.

Of the incidents reported, 51 were categorised as Grade 1 with a 45 day investigation deadline. 37 of the serious incident investigations were overdue. All those investigations had been submitted to commissioners, the delay was with commissioners not closing the cases on STEIS.

The oldest serious incident open on STEIS had been open for over 12 months (identified on 18 December 2013) and was regarding an unexpected death of a community patient (in receipt). Only 6 serious incidents had been closed on STEIS at the time of our inspection.

The trust reported that a total of 68 serious incidents which required further investigation occurred between 14 September 2013 and 24 August 2014. The majority of serious incidents reported were unexpected or avoidable death or severe harm to one or more patients, staff or member of the public (52), of which 33 were unexpected death (outpatients). These serious incidents were reported at 55 different locations at the trust.

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning system (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS.

A total of 6435 incidents were reported to NRLS between 1 December 2013 and 30 November 2014. There were 51 incidents categorised as deaths during this period.

Between 1 October 2013 and 31 March 2014, the trust reported 3,167 incidents, a reporting rate of 17.6 per 1000 bed days. The median reporting rate for this timeframe was 26.7 incidents per 1,000 bed days and compared to 56 similar trusts the trust was in the lowest 25% of reporters.

The incident category that was most frequently reported was 'self –harming behaviour'. The majority of these incidents were regarding self-harm and the trust reported 2231 incidents.

Requires improvement

Are services safe?

There were 832 incidents of aggression reported which includes patient to patient. The trust had categorised 98% as no or low harm with only 11 incidents being categorised as moderate harm.

The service reporting the most incidents was older people.

We identified that 24% of all incidents reported over the 12 month period had resulted in 'low' harm to the patient.

The proportion of incidents that were moderate or higher in severity was low across all specialities.

The exception to this was the 'community teams' where 40% of incidents were moderate and 'drug and alcohol service' where 26% of incidents were moderate or above in severity.

Nationally, 69 % of incidents are reported as no harm, and just under 1% as severe harm or death.

Every six months, the Ministry of Justice publish a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

There were no concerns regarding the trust in the most recent report (October 2012 – March 2013).

Learning from incidents

The trust had made arrangements to ensure that lessons were learnt from incidents.

Incidents were reported through datix. Datix is an electronic risk management system. Incident reports were fed through datix to the patient safety team for level three incidents. Level four and level five incidents, that had the potential to become serious untoward incidents, were reported directly to the patient safety team by telephone.

Clinical directorate quality assurance groups were in place and reported at locality level. The terms of reference for these groups were made available for the inspection team. These highlighted that a key function of the groups was to evidence that lessons are learned and good practice shared across the directorate. The minutes reviewed identified lessons learnt for that locality. The minutes were available to all staff on the trusts shared drive.

Minutes from the directorate quality assurance groups were shared at locality management and governance groups and up to the trust wide quality assurance committee. Minutes reviewed showed that incidents were discussed. Lessons learned were shared through the minutes which were available on the trusts shared drive.

We reviewed 13 serious untoward incident investigation reports and 10 operational review reports as part of the inspection process. We saw that staff and other professionals involved in the patients care had been given the opportunity to be included in the investigation process. In only one of the 13 SUI investigation reports did we see that relatives/carers had been invited to be part of that process. Many of the reports identified that families/carers had not been in touch since the incident had taken place so had not been engaged in the investigation. This was supported by a focus group of stakeholders who identified that the trust engagement with families and carers was not as good as it could be. We spoke with the director of nursing, who recognised this issue. They described how they had been working hard on this issue over the last year. An action plan was developed and put into place but a reaudit in September 2014 demonstrated that there was not as much impact as expected. The trust subsequently invested in a cohort of trained investigators to liaise with families. Informal feedback to date has been positive, but formal evaluation is due to take place in March 2015.

During our review, it was clear from the reports, how learning from incidents was to be shared across the organisation. This was in line with the trust policy 'Incident reporting and Investigating policy' version 7(5). The policy stated that lessons learnt that required instant dissemination would be through the trust safety alert broadcast system.

When a serious incident occurred within the trust, a SBARD (situation, background, assessment, recommendation, decision) briefing was sent to all wards to ensure that learning occurred.

Arrangements were in place to ensure that medicines incidents were reported, recorded and fully investigated through the trust governance arrangements. There was an open culture around the reporting of medicine errors and omissions in order to change practices and to share lessons learned. For example, one serious untoward incident relating to insulin had led to the preparation and issue of a

safety bulletin throughout the trust, the issue of guidance on the management of diabetes, a new insulin prescription and administration record and the availability of an e-learning module to support ward staff.

We saw on all the wards and community teams that learning from incidents took place via a variety of methods to ensure all staff were captured. The trusts safety alert broadcast system, e - mail bulletins were issued, the trust's intranet was utilised and team meetings were regularly used to discuss incidents and changes made in response to improve patient care and experience. Minutes of team meetings confirmed this.

Staff on the wards and in the community were aware of the quality assurance groups and were able to give examples of learning from incidents that had taken place.

Safeguarding

The trust had systems in place to ensure safeguarding incidents were reported and investigated.

The trust related to seven local authorities in relation to safeguarding procedures and seven safeguarding boards. The trust had a ratified safeguarding adults protocol (CLIN-0048-v5 (2)) dated November 2013. The protocol was designed to supplement the multi-agency policy and procedures and ensure staff safeguarded adult patients across the trust. The policy hyperlinked to each agencies' policies and procedures so staff were clear about their responsibilities whichever local authority they had to relate to.

There was also a trust safeguarding children policy (CLIN -0027-v5) dated 6 August 2014. This document set out staff roles and responsibilities, identified how staff would report an incident and contained links to the local safeguarding children's boards policies and procedures.

The trust had a safeguarding adult assurance group and a safeguarding children assurance group, both chaired by the trust's Director of Nursing and Governance. These groups fed into the trust wide quality assurance committee. The groups met quarterly. The minutes of these meetings identified that the trust were represented at all of the local safeguarding boards and that feedback from these boards were a regular agenda item at the assurance groups. We saw that action points were created and reviewed for completion at each meeting.

Training statistics for safeguarding were monitored and discussed at the assurance group meetings. Where improvements needed to be made, actions were identified and taken forward for review at the next meeting. The safeguarding lead informed us that level 2 training is available to all staff but that it is not currently mandatory due to insufficient capacity. In the interim take up is monitored and the trust target teams where take up has been poor. This was confirmed in the meeting minutes.

We saw that across the wards and the community teams, staff were knowledgeable about safeguarding. They knew who the safeguarding lead was in the trust and where to find the policies and procedures should any safeguarding issues arise.

Assessing and monitoring safety and risk

The trust had an integrated assurance framework and risk register in place. The document identified the responsible owner and the timescales for completion of identified actions. We could see that this was a 'live document' with risks being closed and emerging risks being added. Minutes of board meetings confirmed this as they demonstrated full discussions taking place every two months. We observed a board meeting during our inspection and the integrated assurance framework and risk register were discussed fully and actions reviewed.

A focus group with operational directors, confirmed that safety and risk are monitored through the directorate quality assurance groups at each locality. These are then escalated, reviewed and monitored at locality management and governance boards. Minutes of the meetings were available for staff to review.

Incident forms were reviewed by ward managers/team managers and modern matrons to assess severity of risk. Following review, lessons learned were shared at local team level but also at directorate level.

On admission the majority of patients received a comprehensive, holistic and individualised risk assessment. These were reviewed 72 hours after admission. We saw that risk assessments were updated monthly or following an incident. The exception to this was at 367 Thornaby Road, a residential care home. There were no individual risk assessments in place for people using the service. In the community mental health teams, risks were assessed, managed and monitored on a daily basis.

Requires improvement

Are services safe?

Risk management/intervention plans were in place for the majority of patients. There were exceptions to this. In the substance misuse services there was a lack of detail about how to manage risks. On two acute wards, Elm and Ward 15 we found some instances of a lack of intervention plans to mitigate risks. At 367 Thornaby Road, where there were no intervention plans in place.

Safe and clean environments

- There was a breach of same sex accommodation guidance on Earlston ward which is a 15 bed rehabilitation ward. Two female bedrooms were located on the male corridor opposite the clinic room. Male patients queued outside the female bedrooms when waiting for their medication. This could compromise the privacy and dignity of these patients.
- During our inspection, a male patient who had been admitted as an emergency was admitted into a female bed on Oak ward which is a ward for older people. We raised this as a concern and the trust took immediate action to ensure the patient was moved to a male bedroom.

However in all of the other wards we visited, the trust complied with same sex accommodation guidance. We saw that the trust had a policy on 'Privacy and Dignity and the Elimination of Mixed Sex Accommodation'. This was dated February 2012 and was in line with current national guidance. Where there where breaches of same sex accommodation, staff had to complete datix.

All of the locations, including community team bases we visited, were clean and well maintained. Cleaning schedules were visible or available in the majority of ward environments. Cleaning audits were carried out regularly to ensure standards were maintained and we saw examples of these during our inspection.

Environmental risk assessments had been carried out in all areas. All wards carried out annual ligature risk assessments and risks escalated onto the trust risk register where required. The trust had taken action to address many of the ligature points and environmental concerns.

There were however some concerns identified during the inspection:

- Ward 15 at the Friarage Mental Health Unit was located in an old medical ward on an acute hospital site owned by South Tees Hospitals NHS Trust. There were a number of ligature points that had been identified and placed on the risk register by the trust. The trust had raised the risks with South Tees Hospitals NHS Trust. This included suspended ceilings which housed piping and electrical work. This had not been actioned.
- Primrose ward and Abdale House, both rehabilitation units had low level bannisters on the stairwells which posed a risk to patients. We raised this issue with the trust at the time of our visit and the trust completed the required work and boxed in the banister so patients could not jump or fall over this.
- Cedar ward at the Briary Unit was located in a medical ward on an acute hospital site owned by Harrogate Hospitals NHS Foundation Trust. There were non anti ligature beds in use on the ward. The temperatures on Cedar ward were variable which patients and staff found difficult. It was either too hot or too cold. This had been escalated to the estates team, but was a consequence of the heating system in the hospital and the trust could not fix this issue.

The trust were developing plans for the relocation of both Cedar ward and Ward 15. The ward managers of both units were aware of the environmental shortcomings and had escalated this to the corporate risk register. We concluded that it was difficult for the trust to ensure appropriate environments were always maintained as they were reliant on the estates departments of other NHS trusts to take action. We also saw in the trust quality strategy 2014-19 that the trust aimed to ensure that by 2017/18 all the trusts acute assessment and treatment beds would be in single en-suite bedrooms.

The trust informed us that more than £100m had been spent on new inpatient facilities over the past decade which had led to 95% of all inpatient beds being in single rooms with 90% of those having en-suite facilities. The trust recognised that the two admission wards in both Briary Unit at Harrogate and at the Friarage Hospital need replacing and have upgraded the environment as much as possible within the space available."

There were clear lines of sight in most of the wards we inspected. Where this was not the case, mirrors or cctv were used to mitigate the risks.

Seclusion

We identified some environmental concerns with the seclusion room on Ward 15:

Requires improvement

Are services safe?

- Blind spots where patients could remain out of sight – we were told a mirror had been requested to be installed but the South Tees NHS Foundation Trust estates department had not actioned this.
- No two way communication system.
- Ligature risks on the door frame and showerhead. We were told there was an environmental risk management plan in place but no plans to remove these risks.

There were no environmental concerns identified in the other trust locations that had seclusion facilities. Where there where known issues such as those in the forensic services there was a clear plan of action to address the concerns.

Seclusion records were both in electronic and paper format. The records reviewed did not provide a complete step by step account of the seclusion. This was the case on the Westwood Centre which is a child and adolescent mental health service and Ward 15. This was raised with the trust who responded with an immediate action plan to ensure robust compliance with the MHA Code of Practice.

The trust had a seclusion and segregation policy (CLIN-0019-001 v1) dated September 2014. Overall seclusion practices were carried out in line with the trusts procedure. There were 49 incidents of use of seclusion across 13 locations across the trust between1 April and 31 September 2014. Seventy five percent of seclusion took place in wards at Roseberry Park which provides forensic services.

Restraint

The trust had a policy entitled 'Positive approaches to supporting behaviour that challenges' (CLIN -0019 v5) dated 3 September 2013. The policy sets out the trust's expectations of how behaviour that challenges will be managed in a positive way and to use the least restrictive, intrusive approach as possible. It sets out the values and behaviours that it expects staff to exhibit. Across the inpatient areas, we saw that restraint was carried out in line with the trust policy which identifies the use of physical interventions as a 'last resort'.

All patients, who may exhibit challenging behaviours, had a care plan in place which had been written by the MDT and took into account their individual needs. All episodes of restraint were recorded as an incident and contained clear and detailed information.

1561 incidents where restraint was used were recorded between 1 April to 31 September 2014. These occurred within 83 patient wards, units or teams. 120 of prone restraint incidents resulted in rapid tranquilisation.

Between June 2014 and November 2014 the trust recorded 407 episodes of prone restraint. Prone restraint is when patients are restrained face down. The trust were aware of the high incidence of prone restraint and had developed a trust wide physical restraint reduction plan for 2014/2015. This plan identifies that the trust will ensure that 'Face down restraint or restraint that impacts on airway **must not** be deliberately used'and the target date is the end of March 2015. It was clear on the action plan that patients who have chosen the intervention of 'face down restraint' will need to have their care plans reviewed and amended. When we spoke to staff, they were clear that prone restraint was not best practice. They always involved the physical healthcare team following prone restraint and ensured that those patients who had physical health issues had comprehensive care plans in place.

Restrictive practices

Blanket restrictions had been identified at the last inspection at Roseberry Park in July 2014 and in a number of MHA monitoring visits to wards across the trust. The trust in response to these concerns developed a strategy to minimise restrictive practices. Minutes of the 'review of restrictive practices in forensic services' dated 30 July 2014, confirmed the trust were committed to this approach. An action plan was developed from this event and monitored at the forensic quality assurance group. A subsequent review of restrictive practices took place in November 2014 and introduced the 'Framework for restrictive practices' which sets out the guidance and approach for staff working within the forensic services.

During the inspection we saw that there had been a reduction in blanket restrictions across the trust. However there continued to be a number of restrictive practices in place, although the trust was working to a clear timetable to reduce these. The trust continues to work towards compliance with restrictive practices. We acknowledged, at the inspection, that the date for completion of the action plan was after the comprehensive inspection had taken place.

Medicines management

Requires improvement

Are services safe?

We found that the medicines management team was effective, innovative and well led. Pharmacists and extended role pharmacy technicians were fully integrated into clinical teams to support and ensure best outcomes for the use of medicines.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management. Nursing staff told us that these were readily accessible along with regular access to pharmacist advice and an out of hour's pharmacy service.

Pharmacy staff reconciled patients' medicines on admission and regularly exceeded the trust performance target.

On wards for older people we found that some medicines were administered covertly (disguised by mixing with food or drink) but authorisation for this was not recorded in patient notes in line with trust policy. This was on Ceddesfeld and Hamsterley wards.

Patient Group Directions (PGDs) were in use in some clinical areas in the trust. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked two PGDs used by the crisis team and saw that they were up to date and had been authorised by appropriate health care professionals. The trust clinical audit plan for the final quarter of 2014/15 included an audit of PGDs to confirm compliance with legal requirements around their management.

Medicines management was regularly audited across the trust and robust action plans ensured any improvement actions were addressed in a systematic way across the organisation.

Safe staffing

Staffing levels, both required and actual for each ward, were published on the trust website.

A paper to the board of directors was reviewed, dated May 2014. The paper presented a review of nurse staffing establishments and deployment in 2013/14. One of the terms of reference was to clarify the funded nursing establishment position and skill mix allocated to each inpatient team. A conclusion from the review was that the funded establishments provided enough capacity to support the planned nurse staffing rosters.

On the acute and psychiatric intensive care wards, staffing levels both expected and actual, were displayed at the entrance to each ward.

Overall we saw that staffing levels were in line with the trust's expected staffing establishments for each ward. These were regularly reviewed and monitored to keep patients safe and to meet their needs. The majority of community teams reported safe staffing levels and manageable caseloads that kept patients safe. The exception to this was the community mental health services for children and young people. These teams, particularly in North Yorkshire had experienced high levels of sickness for consultant psychiatrists and a reported 50% underfund by local commissioners resulting in staff posts not being filled when people left. However we saw that the trust had responded positively to these issues and all staff stated that the services remained safe. The trust provided us with updated information to say that additional funding had been supplied to teams in North Yorkshire to support additional workloads.

The trust were using an e-rostering system. We heard that in some areas of the trust, staffing recruitment was very difficult. The trust described this during their presentation to the inspection team and identified the measures they were taking to address this, including targeted recruitment campaigns and reviews of deployment of staff and skill mix.

There were vacancies within all the community mental health teams and wards. The trust had its own bank and utilised this to cover vacancies and sickness. This meant that patients received continuity of care and staff were fully aware of their individual needs. On occasions the trust had to use agency staff. Due to the specialist nature of some of the community mental health teams, bank and agency staff were rarely used.

Potential risks

In 2013/14, there were 48 bed-days of patients aged under 18 admitted to adult wards. During the inspection we reviewed the details of these admissions. There were 15 patients admitted between August 2013 and September 2014. All the patients were aged between 16 and 17 years of age. There were recorded clinical reasons for these admissions. In three cases admission was due to a lack of nationally available CAMHS beds.

The trust had implemented a Naloxone programme, within the substance misuse services, specifically for those

identified as high risk of opiate overdose. Naloxone is an opioid antagonist used to counter the effects of opioid overdose; this can be injected directly into the muscle. Staff have been trained to deliver Naloxone kits and instructions on use to those identified to reduce deaths by overdose. Although there are no formal mechanisms to collect outcomes for the use of these kits, staff had informally been advised they had prevented a number of deaths in the community.

Emergency equipment and medicines were placed in clinical areas and checked in line with the trust policy. Records reviewed confirmed this. This ensured it was fit for purpose and could be used effectively in an emergency. Staff were trained in the use of the equipment which included automated external defibrillators.

The trust had an external major incident plan in place which had been updated in December 2014. This informed staff how to respond in the event of a major incident being called by the emergency services or NHS England regional teams. There were clear flowcharts in place and detailed contact numbers so that staff knew precisely who and when to contact people.

Duty of Candour

The director of nursing had run sessions with the board and for nursing and allied health professionals and the chief executive had run sessions with consultant medical staff and senior managers and clinical leaders, in July and August 2014 to raise awareness of the requirements of the duty of candour regulations. Information about duty of candour had been circulated by service managers so that all staff could review and action.

Team managers reported that they had received awareness training in 'duty of candour'. The chief executives reflections on the trust website talked about the importance of duty of candour and the new regulations that NHS trusts would need to be compliant with. We saw in the core services that staff were open and transparent when things went wrong. One example was on the forensic services where we saw a ward manager writing to a patient where an error had been made to apologise and to explain the situation. We saw another example in the substance misuse services following dual prescribing. Staff offered an immediate apology and were transparent and open with the patient.

Good

Are services effective?

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.

Summary of findings

We rated effective as good because:

- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Patients had comprehensive assessments of their needs, which include consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Information about patient care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care.
- 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.
- Where patients were subject to the Mental Health Act 1983 (MHA), their rights were protected and staff complied with the MHA Code of Practice. There was an exception in the recording of seclusion on Westwood ward and Ward 15.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs.
- With the exception of 367 Thornaby Road, staff were in receipt of clinical and management supervision
- Staff work collaboratively and across teams to understand and meet the range and complexity of patient needs.
- With the exception of the wards for people with a learning disability or autism, patients were discharged at an appropriate time and when all necessary care arrangements were in place.

Most staff understood the issues relating to capacity and consent. The exceptions were Earlston House, CAMHS community teams and the older peoples' wards.

Our findings

Assessment and delivery of care and treatment

We found that across the inpatient areas and the community teams, patients had their needs assessed and their care planned and delivered in line with evidence based practice.

In the child and adolescent wards, we saw that staff collected information about the patient's care needs before admission. Care plans were recovery focused across all the inpatient areas. All patients received a comprehensive risk assessment

Discharge planning took place and records we saw confirmed this was implemented in line with best practice. The exception to this was the wards for people with a learning disability and autism. Staff told us this was because of a lack of suitable accommodation and input from the local authorities. We saw that the trust had developed an action plan entitled 'Back to Life/ Winterbourne action plan' dated February 2014 and updated in January 2015. This action plan identified that the trust were working to reduce the length of stay, promote purposeful inpatient stays, develop responsive community services that prevent admissions and prompt access to appropriate pathways of care. Senior managers advised us that there was still considerable work to be undertaken with commissioners of the learning disability services. This meant there was a risk people could remain in hospital longer than was necessary.

Where patients had behaviours that challenged, functional assessments had been completed which meant that staff were able to understand the target behaviours and better support patients. We saw that where required, positive behaviour support plans were in place for patients who had behaviour that challenged.

Good

Are services effective?

The trust had a policy entitled 'Physical Healthcare Assessment of Patients (Admission, Annual and Ongoing)' (CLIN/0052/v3) dated February 2013. We saw that across the trust physical healthcare assessments took place in line with the policy. The trust had recently introduced a physical healthcare team to further support the ongoing physical healthcare needs of patients across the services. This included developing appropriate pathways into acute healthcare settings when it was needed.

All patients in the learning disability and autism services had a comprehensive health action plan in place that was monitored and reviewed. When patients needed to see their GP, the wards made every effort to take the patients to the GP they were registered with in the community. A clear assessment and comprehensive physical health check was undertaken, usually by a paramedic, on arrival to the health based place of safety.

The medicines management team were proactive in monitoring the use of high risk treatments, such as high dose antipsychotic therapy and rapid tranquilisation, to help ensure prescribing was safe, and followed best practice, professional guidance and relevant mental health legislation.

Nursing staff carried out regular checks on ward medicine prescription and administration records to make sure that these were accurate and fully completed and to identify any medicines omissions. However, these checks were not fully embedded into routine practice across all trust locations. A trust audit of medicines omissions in September 2014 had identified that one third of the wards had a medicines omission rate above the trust target.

Outcomes for people using services

The trust speciality development groups set the audit agenda for the year. This is monitored and overseen by the clinical effectiveness group. Minutes of these meetings were available and demonstrated that this was the case.

The trust participated in national audit and local audits were also in place. These linked to NICE guidance, complaints, and trends identified through incident reporting and CQC mental health act monitoring visits and inspections. The trust also audited themselves against CQUIN targets.

The trust took part in a number of national audits. This included:

- National Audit of Schizophrenia 2013/14
- Prescribing Observatory for Mental Health (POMH-UK) (4 audits)
- National Audit of Psychological Therapies for adult mental health
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

We saw that following the audits, the trust developed action plans to improve the care and treatment and outcomes for patients. These were monitored through the clinical effectiveness group and directorate quality assurance groups to the trust wide quality assurance committee.

The trust also ran a number of local audits, 113 clinical audits were reviewed by the trust in 2013/14. We saw that information from completed audits was shared across the staff groups, the wards and governance teams. This meant that changes could be identified and actioned to improve outcomes for people.

There had been a total of 1359 readmissions within 90 days between1 March 2014 and 31 August 2014. The readmissions occurred across a total of 41 wards. Seventy seven percent of all readmissions occurred within four wards (Baysdale, Holly Unit, Aysgarth 1 and Bankfields Court Unit 2). However we were informed by the trust that these units are designated as respite units and readmissions would be expected. In the 2014 Mental Health Benchmarking report, the trusts rates of readmission were lower than other similar mental health trusts both in terms of adult admission and older people's services.

The psychiatric intensive care units were members of the National Association of PICU care which meant that staff had an opportunity to share good practice and improve outcomes for patients.

In the older people's service had incorporated the Excellence in Practice Accreditation accredited by Teesside University into their practice. This meant that the service could benchmark itself against best practice to improve care, treatment and outcomes for patients.

In the substance misuse services, progress of people was measured using Treatment Outcome Profiles (TOPS). These outcomes are measured as part of the National Drug Treatment Monitoring Service.

Good

Are services effective?

In the community based mental health services for older people a range of outcome measures were being used. This included Health of the Nation Outcome Scales (HONOS), Warwick Edinburgh Mental Well-being Scale (WEMWBS) and Model of Human Occupation Screening Tool (MOHOST).

In the community mental health services for people with a learning disability or autism, the mental health cluster tool was being used to monitor the people the service was seeing.

A number of the services participated in peer accreditation schemes.

The trust had a performance dashboard to monitor performance across the organisation. The medical director confirmed that individual teams have their own dashboard.

The trust participated in research and had a research governance group. The minutes of these meetings were available to staff and identified a number of research projects that the trust were leading on or participating in. The trust had a research and development strategy in place.

We concluded that the trust regularly collected and used information to monitor outcomes for people.

Staff skill

The 2014 NHS Staff survey involved 287 NHS organisations in England. Over 624,000 NHS Staff were invited to participate using a self-completion postal questionnaire survey or electronically via email. 255,000 responses were received from staff, a response rate of 42% compared to 49% in 2013. The trust had a response rate of 57% which is in the top 20% of mental health/learning disability trusts in England. A total of 457 staff took part.

Compared to other mental health trusts, the trust reported an increase in the number of staff receiving well-structured appraisals in the preceding 12 months, also better communication between staff and senior management.

In all wards and community teams, staff were appropriately qualified and had the right skills and knowledge to carry out their roles and responsibilities. In addition to the trust corporate induction programme, local induction checklists were in place.

Across the trust, with one exception, staff reported that appraisals took place. Records demonstrated that compliance levels in most wards and teams was over 80% with some exceptions as at December 2014.

These included

- Bankfields court Bungalow 3 recorded at 28%
- Stockton psychosis team recorded at 35%
- Stockton crisis resolution team recorded at 25%
- Bilsdale ward recorded at 30%
- Ripon community team recorded at 9%
- Harrogate community team recorded at 10%
- Elm ward recorded at 32%
- However in 367 Thornaby Road, the registered manager told us that staff did not have an appraisal. We reviewed one appraisal document dated May 2014, but appraisals before this date had been destroyed.

The trust had undertaken a mandatory training needs analysis, which included medical staff, which had been revised in September 2014. This identified the nature and purpose of the training, the groups of staff it was applicable to, how the initial training should be delivered, how further update training would be delivered, whether prior learning would be taken into account and the frequency of update training. This meant that all staff understood what mandatory training was applicable to them and the frequency that the training would take place.

Mental Health Act training and Mental Capacity Act training were not mandatory training. We saw that regular training opportunities were made available to staff from the mental health legislation team. Flyers for these sessions were available throughout the trust. Sessions covered key aspects of mental health legislation and ran at the main hospital locations and teams of the trust. The sessions ran from March 2015 to December 2015.

Ward managers and team leaders were responsible for ensuring staff completed mandatory training, supervision and appraisal. Staff told us and we were provided with evidence that staff could access training relevant to their role.

The learning disability and autism service had a steering group and champions for positive behaviour support. The role and purpose of the group and champions was to embed teaching and learning across the locations to ensure positive behaviour support was an effective tool to manage complex behaviours which challenged.

Good

Are services effective?

With the exception of 367 Thornaby Road, we saw evidence that staff were participating in clinical and management supervision.

Ward managers and team leaders were responsible for tackling poor performance. They provided us with examples of the actions they had taken to manage this, including management supervision, training and if required disciplinary action.

Multi-disciplinary working

Across the trust we saw good and effective multi – disciplinary team working. Multi –disciplinary teams were made up of consultant psychiatrists, nursing staff, social workers, psychologists, pharmacists, occupational therapists and other health and social care professionals depending on the services being received. For example, speech and language therapists in the learning disability in patient and community teams, teachers in the child and adolescent mental health services and dieticians and physiotherapists as each individual patients needs were determined.

In some of the community teams, health and social care teams were integrated. In other teams this was not the case but we saw that without exception good working relationships had been developed to ensure that effective care and treatment was delivered to the patient.

Staff told us and we observed staff working together to assess and plan care in a co-ordinated and timely way. Health and social care professionals would attend relevant meetings at the point of admission and discharge planning. They also attended Care Programme Approach (CPA) meetings. Positive transition planning took place when patients moved between services. In an audit carried out by the trust, only 79% of children and young people had a transition plan in place at the age of 17 and a half. We saw that an action plan had been developed in August 2014 to address the issues raised. Staff shared relevant information about care and treatment and changing needs. Records we reviewed confirmed this.

In most cases, patients attended and were actively involved in the multi-disciplinary meetings. At times, patients chose not to attend or were too unwell to attend these meetings. In these instances, members of the MDT would meet with the patient following the meeting to discuss what had taken place and what decisions were made about the individual patients care and treatment.

Staff handovers took place at least twice a day in both the wards and community teams. The handovers were effective and staff were updated about patient risk on a regular basis. In the hospital locations, 'a report out' meeting took place each morning on a daily basis. This allowed staff to discuss patients' progress, any changes in presentation and needs and to determine if other professionals could be included or better placed to support care and treatment needs.

Within the CMHTs and substance misuse services, teams had developed good, effective working relationships with the police, GP's and a range of third sector providers.

Information and Records Systems

Staff had access to the information they needed in order to deliver effective care and treatment. Electronic patient notes allowed trust staff to have access to updated information in a timely and accessible way. In North Yorkshire, the teams were moving from one set of electronic patient notes to those used throughout the trust, but staff were able to access original records and archived information. There had also been the development of new administration teams which had impacted on the North Yorkshire services. All administration had been located at one centre, Windsor House. All paper documents from all community teams and inpatient teams in North Yorkshire are sent there for filing. There were some concerns about the new arrangements raised by the administrators' focus group in North Yorkshire. They were concerned that the 'paper records,' that are not able to be scanned onto the electronic patient records, were not being filed in a timely manner. Examples given were, blood results, drug charts, letters from doctors. They were also concerned that there is no proper 'tracking system' of the paper records/notes in North Yorkshire. This may lead to important information not being available about a patients care and treatment.

In the community based services for adults of working age, local authority staff had to input information into their own recording systems and also the trust electronic patient notes system. This meant there was duplication of notes and time as systems were not linked.

There was an information strategy in place and we saw an information strategy domain roadmap dated August 2014. This identified the current position with the electronic

patient notes system and the trust plans to develop the system further to include information sharing with other systems, digital transfer of information and redesign to align with clinical processes.

Consent to care and treatment

There was a trust Deprivation of Liberty policy dated 10 September 2014 and an associated procedure for staff to follow. The policy took into account the most recent supreme court judgements following the Cheshire West case.

Most staff had received training related to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Most staff understood the issues relating to mental capacity and consent, with the exception of staff on Earlston House and older people's wards.

- On Earlston House, staff gave conflicting information relating to two female patients and their ability to give informed consent to having their bedrooms located on a male corridor. Our review of records and discussions with the patients identified they did not have mental capacity to make this decision. We could find no evidence to show that a mental capacity assessment had taken place in line with trust policy and the Mental Capacity Act. We raised this with the trust who immediately reviewed the capacity of these patients.
- In the older people's wards, some staff told us they were not aware of how the Mental Capacity Act and Deprivation of Liberty Safeguards would apply to their work. They did tell us if they needed to they would contact the trust's safeguarding team for advice.

We saw some good examples of facilitation of capacity assessments that ensured patients were supported to make specific decisions. There were excellent examples of some crisis teams encouraging advance directives to help people determine their future crisis care needs

- However in the forensic services there was no standardised tool available to record assessment of capacity which could lead to inconsistent recording.

We saw that the trust had good governance systems in place for meeting its responsibilities under the Mental Capacity Act and adhering to the relevant Code of Practice. A well-resourced and well-functioning administration service was available to staff to facilitate the discharge of their responsibilities, through the use of appropriate advice, prompts and checklists, and the provision of bespoke training. However Mental Capacity Act and Deprivation of Liberty Safeguards training were not mandatory.

The trust had not submitted any Deprivation of Liberty Safeguards notifications to CQC. However the trust reported that they had submitted nine Deprivation of Liberty Safeguarding applications to the local authority in the six months prior to our inspection.

Assessment and treatment in line with Mental Health Act

We found that where the Mental Health Act 1983 was used, people were detained with a full set of corresponding legal paperwork. In most instances a copy of the report prepared by the approved mental health practitioner (AMHP) was also present. We were told that the trust was reviewing its use of blanket restrictive practices and while we found that some wards had reduced the blanket restrictions they placed on patients, we saw on other wards that patients were being subjected to significant blanket restrictions including the routine searching of themselves and their rooms. We also found that the trust had provided two information leaflets to patients which contained contradictory information on searching, one of which was not consistent with the Code of Practice. We were told that the use of face down restraint had reduced considerably, but was still used and remained part of the trust's training on restraint. These issues served to undermine the trust's otherwise general adherence to the code.

We carried out Mental Health Act monitoring visits on a selection of the wards at locations where detained patients were being treated. We saw that where people in the community were subject to a Community Treatment Order (CTO) the proper processes had been followed.

In almost all the care records reviewed, relating to the detention, care and treatment of detained patients, we saw that the principles of the Act had been followed and the Code of Practice adhered to. There were rare minor lapses in adherence to the MHA Code of Practice on individual files.

We saw that attempts were made to inform people of their rights on admission and when they were placed on a CTO.

Good

Are services effective?

Staff were proactive to help patients to understand their rights for example by referring people to specialist advocates. On some wards patients who lacked capacity were automatically referred to advocacy for support.

We saw that documentation relating to the authorisation of Section 17 leave was well completed and in order, and we found that patients had a good understanding of their leave entitlement. However on a number of wards we found that authorised leave was often cancelled or postponed due to shortages of staff to act as escorts.

We found that robust processes were in place to record the discussion between doctors and their patients about their capacity to consent to treatment at the point medication was first administered, and then at important milestones in care provision. This was also the case for patients on CTOs.

We saw that the trust had good systems in place for meeting its responsibilities under the Mental Health Act and adhering to the relevant Code of Practice. A well-resourced and well-functioning administration service was available to staff to facilitate the discharge of their responsibilities, through the use of appropriate advice, prompts and checklists, and the provision of bespoke training. However Mental Health Act training was not mandatory.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Feedback from patients who use the service, relatives and carers was positive about the way staff treat people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Patients' privacy and dignity was maintained with the exception of Ward 15 and Cedar ward.
- Patients told us and we observed that they were involved in all aspects of their care and treatment. Patients actively contributed to the running of wards and changes to the services.
- The trust are members of the 'Triangle of Care' project. Wards used triangle of care self-assessments alongside carer surveys to improve the partnership arrangements with carers. There were a number of carers groups and carer support groups throughout the trust.

Across the services, with the exception of 367 Thornaby Road, there was information visible and available about local advocacy services or Independent Mental Health Advocacy for detained patients.

Our findings

Dignity, respect and compassion

We saw many examples of positive interactions between patients and staff throughout the inspection visit.

Staff we spoke to understood and respected patients' needs including their cultural, social and religious needs. These were taken into account when planning care and treatment.

Patients told us, and we observed, staff treated patients with respect, kindness and were caring and compassionate. Patients told us they were treated as people and staff were flexible to be able to support the patients wherever possible.

We observed that staff maintained confidentiality at all times.

The Patient-Led Assessment of the Care Environment (PLACE), England 2014 identified that the trust scored 91% for the privacy, dignity and well-being element of the assessment against an England average of 88%. With the exception of Ward 15 and Cedar ward, which were located in acute general hospitals, we saw that patients' privacy and dignity was maintained.

We received positive feedback from patients and carers throughout the inspection.

Involvement of people using services

Patients told us and we observed that they were involved in all aspects of their care and treatment. We also saw that patients actively contributed to the running of wards and changes to the services. Staff actively sought the views of patients that they were providing care and treatment for both in the wards and community mental health teams.

The trust are members of the 'Triangle of Care' project. It is a 'therapeutic alliance between patient, staff and carer that promotes safety, supports recovery and sustains wellbeing'. Wards completed and we saw evidence of completed Triangle of Care self-assessment tools. Wards used this information alongside career surveys to improve the partnership arrangements with carers. It identified that there are carers' leaflets on the wards that advise them about carers' assessments. Results of carers' surveys were displayed on the wards.

Patients and people living in care homes were encouraged and supported to maintain relationships with families and friends.

There were a number of carers groups and carer support groups throughout the trust.

Patients and carers could access information at ward level and via the trust website, about medicines used in mental health settings and services available to help them make informed decisions about medicines and the service they could receive.

Good

Are services caring?

The forensic learning disability wards had a reference group called 'For Us'. It met regularly and discussed the issues across the site for patients. They had also actively taken part in the recruitment of staff.

On some of the forensic wards, patients chaired their own CPA meetings. Patients also attended meetings of the quality assurance groups. Training to staff was also provided by patients. Patients were involved in a number of different initiatives across the hospital site at Roseberry Park including clinical governance meetings, events planning, training and research activities.

Community meetings were held regularly on the majority of the wards so that patients had a say in the running of the wards. We saw the minutes of the community meetings and there were action plans in place to make changes suggested by patients. Some of the wards had 'You said – We did' boards that described actions that had been taken in response to feedback.

Children and young people had been involved in making a film during their school holidays. This video would inform future patients about the children and adolescent mental health services. The video was located on the trust website.

In the wards for older people service, specifically on Springwood and Rowan Lea, they were using specialist computer programmes to enable staff to interact with people with memory problems in a positive way.

Where patients needed additional support to help them understand and be involved in services, it was available. However we did see that some of the information within the learning disabilities services was not always available in an easy read format.

Emotional support for people

Across the services, with the exception of 367 Thornaby Road, there was information visible and available about local advocacy services or Independent Mental Health Advocacy for detained patients.

The rehabilitation wards had booklets for patients and carers which were ward specific detailing the information they would need when admitted to the wards.

Across the wards there was information available to patients and carers that included contact details of external organisations, support forums, patient advisory liaison service (PALS), spiritual support and a range of health promotion leaflets.

The community mental health team for working age adults in Chester le Street had collated an information pack for patients. This provided them with relevant information about the service, their care and treatment and contact numbers in an emergency or crisis.

We met with carers from across the localities prior to the inspection. Carers felt patients dealt with by compassionate caring staff. Carers would appreciate it if staff could spend some time with them explaining and reassuring them through a traumatic experience. Carers recognise that time is limited but would welcome more support on admission.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because:

- Feedback from commissioners of services, clinical commissioning groups, local authorities and NHS England told us that the trust was very willing to engage in future strategy regarding planning and delivery of services.
- Commissioners told us that there was an opportunity for patients and commissioners to feedback on service planning and delivery of services each year for learning disability services.
- In the specialist community teams for children and adolescent, a gap had been identified in the provision of crisis services for children and young people. In response, the trust had developed a crisis service that was open seven days a week 8am to 10pm.
- The hours some of the children and adolescent mental health services open made them more accessible to young people out of school hours.
- We saw that services were planned in consultation with other health and social care partners to deliver services effectively.
- Staff had access to interpreting services. Services we visited had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived.
- Information about raising concerns and complaints was available to all patients in the wards, health based places of safety and community mental health services with one exception. At 367 Thornaby Road, there was no visible information on how to make a complaint for the people living there or their carers. There were no records of complaints being made at the service.
- Lessons from complaints were discussed at 'report out' meetings, team meetings or clinical supervision. Feedback on lessons learned were shared with patients via the 'you said….we did' boards located in all the ward environments.
- However in the learning disability services some patients had been in hospital between 9 and 14 years. We looked at the discharge plans and saw the minutes of recent 'Care and Treatment' reviews stating they were ready for discharge. There was no written discharge plans in place and commissioners still had not identified any placements in the community for patients.

Our findings

Planning and delivery of services

The trusts services are primarily based on a locality basis:

- Durham and Darlington
- Tees
- North Yorkshire

As a result the trust work alongside eight clinical commissioning groups, seven local authorities and NHS England.

Admissions into the acute beds were gate kept by the trust's crisis teams. Staff in the crisis teams told us that they sometimes had problems accessing a bed in the locality the patient lived in. On occasions an 'out of locality' placement would be made, which meant that patients were treated in a different part of the trust. However we saw that as soon as a bed was available in the patient's own locality, arrangements for transfer were made where clinically appropriate. In the trust's quality account 2013/14, they had recognised that 22% of patients did not receive care at their 'local' inpatient unit. They had therefore, with local stakeholder involvement, agreed that a priority for 2014/15 would be to further manage the pressures on acute beds through three key actions:

Good

Are services responsive to people's needs?

- Reduce the percentage of people on community team caseloads that are admitted to inpatient care by quarter 4 2014/15.
- Reduce the readmission rates to inpatient care following discharge by quarter 4 2014/15.
- Continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care by quarter 4 2014/15.

During our inspection we identified that the trust were working to achieve these actions with clear action plans in place within the speciality development groups.

We held focus groups with commissioners of services, clinical commissioning groups, local authorities and NHS England. They told us that the trust was very willing to engage in discussions about future strategy regarding planning and delivery of services. They listened to local opinions and one example of this was the decision to keep open the acute and older persons ward located at Sandwell Park hospital. The meant that people who lived in that locality continued to be able to access local services.

Commissioners told us that there was an opportunity for patients and commissioners to feedback on service planning and delivery of services each year for learning disability services.

The development of health based places of safety and joint working with the police forces reduced the numbers of assessments taking place in police cells. This was particularly of note in the North Yorkshire area. The delivery of the street triage system meant that people were seen very quickly during the day.

The rehabilitation services accepted referrals from a range of sources. Some wards had a single point of access, Lustrum Vale, Park House and Primrose Lodge. They also had a liaison nurse who visited the acute wards on a regular basis to identify patients who may be suitable for the rehabilitation services.

In the specialist community teams for children and adolescent, a gap had been identified in the provision of crisis services for children and young people. In response, the trust had developed a crisis service that was open seven days a week 8am to 10pm. This had resulted in a reduction in admissions to hospital by 50%.

The hours that some of the children and adolescent mental health services open made them more accessible to young people out of school hours. For example, Stockton opened till 8 pm twice a week and would open at weekends to alleviate waiting lists. South Durham reported opening 8 am to 8 pm and home visits from 7 am when requested.

Minutes of the clinical leaders/operational directors meetings showed that the trust were reviewing where patients needs were not being met and were using this information to inform and plan how services are planned and developed. We saw that business planning and commissioner relations were also discussed prior to executive management team meeting in the operational managers meetings. One example of this was that the development of a full review of the functional bed use in mental health services for older people was required. This was agreed following discussion in executive management team and linked in to the commissioner intentions in the North Yorkshire locality.

Executive team members told us that planning and delivery of services are part of the trust's quality improvement system. Patients either current or past would be part of the team or the trust would utilise a patient consultation scheme.

We saw that services were planned in consultation with other health and social care partners. The older people's community mental health teams provided support to acute and community hospital staff to help them identify potential mental health issues and to support them to manage them in line with current guidance. They provided training and support to staff in these areas to develop their knowledge and skills.

We found some good examples of how the teams had developed good working relationships with partner organisations both internal and external of the trust. This included the use of volunteers through a voluntary agency to support patients and good links with community mental health teams, housing organisations and the trust wide recovery college.

Diversity of needs

Staff had access to interpreting services. These provided face to face and telephone services. We were given a number of examples across the services of where this had been used to support people whose first language was not English.

Patients with specific dietary needs were catered for.

Good

Are services responsive to people's needs?

Wards for older people had been designed in line with NICE Guidance and Sterling design standards for people with dementia. This meant the environments were light, airy and had pictorial prompts for people to orientate them within the building. In particular we saw on Rowan Lea and Springwood that patients accessed a computer system designed to assist with memory problems and enable patients to take part in reminiscence. Staff stated that they found this equipment easy to use and it helped them to involve patients in developing their life stories and understanding their interests.

Within the community mental health services for people with a learning disability or autism, the teams had developed leaflets in accessible formats. Some consultant psychiatrists' letters were produced in a pictorial format where appropriate.

Services we visited had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived.

Across the trust, we saw that support was given to patients with protected characteristics. For example patients were signposted to lesbian, gay, bisexual and transgender support groups. We met with some transgender patients. They indicated and we observed that staff were sensitive to their needs and supported patients to attend external appointments.

There were several multi faith rooms across the trust that patients could access. When possible, staff tried to get people out into the community to maintain spiritual and religious needs. Local faith representatives visited wards and could be contacted to request a visit if needed. We saw that in the Northdale Centre, the direction of Mecca was indicated in the seclusion room.

Right care at the right time

Bed occupancy was highest in those beds defined as 'mental illness'. At the end of December 2014, this was recorded as 87%. Bed occupancy had fallen overall at the trust. However it had increased in those beds defined as 'Learning Disabilities' which was reported as 82% at the end of December. The mean percentage bed occupancy over the six months 01 March – 31 August 2014 ranged from 39% to 108% (across 82 wards). We requested the occupied bed days, including leave beds, for the period 1 September 2014 - 30 November 2014. This showed that it ranged from 30% to 109% (across 82 wards) giving an average bed occupancy for those three months of 88%.

It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Crisis teams were the gatekeepers to the acute admission beds. The national threshold is to gate keep 95% of all admissions to psychiatric inpatient wards. The trust was performing above this threshold between April and June 2014 when it was achieving 99%.

The acute admission wards followed the principles of the purposeful inpatient admission process (PIPA) which is an evidence based approach to ensure all admissions had a clear reason, development of a clear formulation and goals to be achieved to facilitate discharge. During our inspection, acute admission wards were operating within safe bed numbers.

When admission to a psychiatric intensive care unit (PICU) from an acute ward was required, there was a clear admission process in place to ensure it was appropriate, timely and arrangements were in place to transfer back to the acute unit when necessary. We saw that there was an admission flow chart based on the 'PICU pyramid.' This approach engaged patients in the management of their behaviours to prevent PICU admission. If a PICU admission was required, it was seen as a last resort.

Forensics and Crisis Services met their targets for days waited from referral to initial assessment, however 'Children', 'Adults', 'Older People' and Learning Disabilities' services all failed to meet the trust's target of 98% of external referrals seen within four weeks between 1 April 2014 and 31 August 2014.

Staff on both Holly and Baysdale wards (CAMHS wards) liaised with the community services to provide the most appropriate services needed at the time for the patients and families. Staff worked flexibly to enable this to happen.

Referrals into community mental health teams for working age adults were either accepted by a duty team or by a single point of access. Some teams had waiting lists whilst others did not. Urgent referrals would usually always be seen within 72 hours and routine referrals within 28 days. Where there were waiting lists, routine referrals could wait

Good

Are services responsive to people's needs?

six – eight weeks before being assessed. Patients who did not attend (DNA) were followed up by community teams. The trust monitored DNA patients as well as cancelled appointments.

At the time of our inspection, community mental health teams for people with learning disabilities or autism that we visited were meeting the trust's target for seeing external referrals within four weeks.

Waiting times set by the trust for specialist community mental health services for children and young people were below the national target of eight weeks. The only exception to this was the Darlington and Durham primary mental health team which sometimes were outside of the national target for waiting times.

In the learning disability services, we saw clear examples of when patients were refused admission to hospital because they did not require hospital care. We also saw examples where staff supported transfers to residential community settings by transferring with the patient and supporting the staff in the new service. However we did see that discharge planning needed improvement. On some of the assessment and treatment wards, some patients had been in the hospital between two and 14 years. The 'care and treatment' reviews identified that these individuals were ready for discharge. There were no discharge plans in place for these patients. Discussions with executive members of the trust identified this was due to a lack of placements in the local area for patients to be supported in. Each individual patient would require a bespoke package of care to manage them safely in the community and further engagement was needed with the local authorities and external agencies to ensure this was in place. We concluded that partner agencies and commissioners had not undertaken proper steps to ensure patients who do not require treatment in hospital were discharged.

The Department of Health publishes monthly data relating to Delayed Transfers of Care across 242 acute and non-acute NHS trusts, including both the number of delayed days and the number of patients who experienced a delayed transfer of care each month. In August 2014 the trust faced its highest number of delayed days (643). The number of patients with a delayed transfer of care has steadily increased since February 2014 peaking in July 2014. The trust reported that between November 2013 and October 2013 some of the reasons for delays were due to:

- Public Funding – 28%
- Awaiting Residential Home Placement or Availability – 13%
- Awaiting Nursing Home Placement or Availability - 28%
- Awaiting Care Package in Own Home – 12%

This shows that cuts to public spending may now potentially be impacting on patient transfers of care.

The proportion of patients on the Care Programme Approach who were followed up within seven days of discharge from psychiatric inpatient care remained above the England average from April 2013 to September 2014. The England average was 97% whilst the trust were performing at 99%.

Learning from concerns and complaints

The total number of complaints received by the trust in 2013/14 has decreased in the last year. The proportion of complaints upheld by the trust had also decreased from 57% to 56%. One hundred and seventy one formal complaints were made in the last 12 months between 1 September 2013- 31 August 2014. Ninety five of these complaints were upheld.

Of the 171 complaints received, 5 had been referred to the Parliamentary and Health Service Ombudsman (PHSO) and as of September 2014, they were all awaiting decision.

A majority of complaints received and upheld were with regards to 'all aspects of clinical treatment' and 'attitudes of staff'.

Information about raising concerns and complaints was available to all patients in the wards, health based places of safety and community mental health services with one exception.

- At 367 Thornaby Road, there was no visible information on how to make a complaint for the people living there or their carers. There were no records of complaints being made at the service.

The trust informed all patients about the patient advice and liaison service (PALS) which also offered support to patients who wished to raise a concern, complaint or a compliment.

Patients we spoke to were able to tell us how they would make a complaint and most patients felt that they could raise concerns and staff would listen to them.

Good

Are services responsive to people's needs?

Lessons from complaints were discussed at 'report out' meetings, team meetings or clinical supervision. Lessons learnt formed part of the reporting mechanisms at speciality development groups, quality assurance groups and locality management and governance groups. Action plans were developed and monitored to ensure that changes required due to lessons learnt were embedded into practice on the wards and in the community mental health teams.

Feedback on lessons learned were shared with patients via the 'you said….we did' boards located in all the ward environments.

Outstanding ☆

Are services well-led?

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.

Summary of findings

We rated well-led as outstanding because:

- The trust had a clear vision, mission and quality strategy, supported by clear values. All staff in the trust understood these and had translated the visions and values into their own work.
- There was clear ownership of the vision and values throughout the organisation.
- There was a clear governance structure that ran through the organisation and was understood by all.
- Staff knew that there was a whistle blowing policy in the organisation and felt confident that if they needed to raise concerns, they could do so without fear of victimisation.
- Staff within the organisation were able to tell us who the senior leaders were and said they were visible and approachable.
- Staff feel engaged in the planning, delivery and continuous improvement of services. They told us that they were motivated and proud to work within the organisation.
- The trust had developed a quality improvement system which all staff routinely use. The trust use the quality improvement tools and methods to drive up quality, eradicate waste and improve services. We found that it was embedded at every level across the organisation.
- The trust also participated in external peer review and accreditation and the majority of services that participated were accredited as excellent.
- The trust had achieved the 'Gold Standard' in Investors in People award.

Our findings

Vision and strategy

The trust had a clear vision and mission, supported by five strategic goals.

The trust had developed a quality strategy to enable them to achieve their vision. In addition the trust had developed four quality goals as detailed below:

- Goal 1: Everyone who uses our services has a positive experience and feeds back that they were listened to, engaged in their care and treated with compassion, respect and dignity.
- Goal 2: We reduce to a minimum the harm that people who use our service suffer
- Goal 3: We will deliver excellent outcomes as reported by patients and clinicians.
- Goal 4: Our staff feel positively engaged with the trust

The trust had underpinned this with the trust values of

- Teamwork
- Quality
- Respect
- Wellbeing
- Involvement

The trust had developed a 'Staff Compact'. The staff compact was 'the gives and gets' between the trust and its staff.

The trust quality strategy 2014-19 describes how the trust will deliver the strategy through three frameworks:

- Patient Experience Framework
- Patient Safety Framework
- Clinical Effectiveness Framework

and through the trust's Workforce Strategy. The trust underpins the delivery of this strategy with its Clinical Assurance Framework and Frameworks for the Management, Assurance and Escalation of Risk.

The trust support the delivery of this strategy with the TEWV Quality Improvement System and implementation of a range of trust strategies.

We saw that the leadership team regularly reviewed and monitored progress on the strategy.

Outstanding ☆

Are services well-led?

In the majority of wards and teams that we visited that the trust's vision, values and strategic goals were on display. They were also on the ward/team computers home screens.

Staff at all levels across the organisation understood the vision, values and strategic goals of the trust. This included the staff in North Yorkshire who had only been a part of the trust since 2011. We saw that staff translated the visions and values into their respective teams and that there was ownership of the vision and values throughout the organisation. Staff could describe the staff compact and that they valued this approach.

Governance

The trust board of directors were accountable for the running of the trust. They provided the overall strategic leadership to the trust.

There was also a Council of Governors who provided a link between the local communities and the board of directors. They hold the board to account and providing assurance to members, stakeholder organisations and the public on compliance with the provider licence, the delivery of the strategic direction and the quality of services.

We held a focus group with governors who were extremely positive about the trust, specifically its openness and commitment to patient care and service provision. They raised some areas where they felt services could improve, but were clear that the trust were aware of these.

There was a clear governance structure in place that included a number of committees that fed directly into the board. There were six committees/groups which were; an audit committee, an investment committee, a mental health legislation committee, a nomination and remuneration committee, executive management team and the quality assurance committee.

The quality assurance committee was the principal provider of assurance to the board and council of governors. Assurance was delivered through the locality management and quality boards.

The trust had oversight and assurance of clinical effectiveness and clinical assurance through the thematic quality assurance committees and groups that fed directly into the quality assurance committee. These groups included the patient safety group, the patient experience group, clinical effectiveness group, drug and therapeutics committee, infection prevention and control committee and the research governance group in addition to a number of other groups/committees.

The trust clinical assurance framework was based on clinical governance systems that ensures quality is monitored, from 'ward to board' –the trust described this as their 'clinical governance house '.

Staff at all levels could describe the trust's governance framework. Wards and teams had access to minutes of the governance meetings and team meeting agendas were on a standard template that enabled two way information flows. There were systems in place to allow ward managers and team leaders to monitor and manage as well as provide information to the senior managers of the trust. One example of this would be the trust's electronic staff record. This monitored the training that staff undertook. The system alerted staff and their managers when training needed to take place.

Staff on the wards had lead responsibilities for clinical audits and checks and contributed to the governance and quality agenda by active participation. Issues identified were fed back at team meetings and escalated to locality management and governance boards. Matrons and service managers attended these meetings. Minutes of the meetings that we reviewed confirmed this.

Matrons in the trust met monthly to monitor and review clinical quality issues. This meant that learning could be shared across the trust.

Ward managers and team leaders had the authority to escalate issues of concern to the clinical directorate quality assurance groups.

There was a clear meeting structure within the trust and staff could escalate issues and receive feedback on those issues via the meetings and the minutes that were available on the shared drive.

Wards and teams held their own risk registers and had the ability to put issues forward for inclusion onto the trust risk register so that the matter was escalated to the board.

We held focus groups with commissioners and stakeholders as part of the inspection. Commissioners and stakeholders told us that the trust had developed positive

working relationships across the board. They ensured senior level attendance at most meetings and were proactive in raising issues. Stakeholders said the trust was open and transparent in their dealings.

We were told the trust actively engage the councils, scrutiny committees through offering to take items rather than waiting for it to be raised as an issue. It was described as going beyond expectations. They understand the health and social care environment.

We were also told that they have worked in partnership with the most local mental health NHS Foundation Trust. This was most apparent in offender healthcare and there was clarity and collaboration around boundaries.

The relationship with the local acute trusts was described as healthy, specifically around emergency care and liaison psychiatry.

The only significant area of concern raised was around the engagement of families when reviewing serious untoward incidents.

Commissioners stated that the trust was open and transparent. There were clear lines of communication. The trust were consistent and come out to talk to commissioners and service users. They are seen as very accessible year after year and an outward looking organisation. Commissioners found the trust to be pragmatic and fair in their working relationships. They were willing to engage in discussions about future strategy and were seen as a very patient focussed organisation. The trust were keen to provide services that are not commissioned in order to provide the best service to patients.

The chair of the quality assurance committee described the quality impact assessment process for scrutinising cost improvement plans. He informed us that whole board reviews took place about these and gave examples from October 2014 and January 2015. He also informed us that the quality assurance committee would receive a paper in February on the quality impact assessments of all 2014/15 and 2015/16 cost improvement plans.

Service managers were able to talk confidently about the cost improvement programmes. They described the development process. The board sets the scene; directorates generate ideas which go to locality management and governance board and back to board. A three year plan is drawn up with the first year very detailed. Clinical leads sign off at locality management and governance board. Clinical directorate sign off the scheme and the director of nursing and medical director sign off the quality impact assessment. Service managers could not identify a time when a scheme had been refused through quality impact assessment. The chief executive explained that the trust works in an area of the country where some commissioners have higher levels of funding than some other areas in the country. He acknowledged that the financial situation for 2015/16 would be fine, however may see issues re cost improvement plans for 2016/17 and 2017/18.

Leadership and culture

We attended both the public and private board meeting that took place during our inspection. We saw that the public part of the meeting was conducted efficiently, and largely without challenge. The private board meeting was well attended with varied and good contributions from members. The contributions were noted to be well informed, relevant, succinct and respectful.

The chief executive led the items effectively. Board members were noted to challenge robustly and effectively. It was clear that the executive team and non-executives had a good grasp of the key issues facing the trust. We saw that the risk register was reviewed and amended as part of the board meeting. The chair was able to draw people in effectively and keep to time. The board came across as a cohesive and collaborative group.

The governor's focus group identified that the trusts openness was a major strength, if something is wrong, the trust own up to it and what to learn what they can do to improve. The perception of the governors is that the trust is financially sound and has excellent financial management.

Governors told us they had been on the 'Governwell' training which had been beneficial. They also identified some had been involved in a task and finish group looking at how the non-executive directors would carry out their roles. Governors felt that they could raise issues with the non-executive directors and are treated with respect. They felt very strongly that the board responds well to challenge or questions from patients and carers. Governors found the amount of training and development available for staff was amazing.

Outstanding ☆

Are services well-led?

Staff within the organisation were able to tell us who the senior leaders were and said they were visible and approachable. All the staff we spoke with knew the chief executive and many told us that he had visited their service.

Staff we spoke to knew that there was a whistle blowing policy in the organisation and felt confident that if they needed to raise concerns, they could do so without fear of victimisation.

Staff and staff side also told us about a new initiative that the chief executive had introduced. Managing concerns is a system that people can report and raise anonymously on any issue that is 'concerning' them. An example given was that staff find it annoying that the generator tests take place between 1 and 3pm at Roseberry Park Hospital. Responses are put directly into the trust e-bulletin so that all staff can see the outcome of issues raised.

We saw that through the TEWV quality improvement system, staff feel engaged in the planning, delivery and continuous improvement of services. They told us that they are motivated and proud to work within the organisation. They described that through the quality improvement system, they feel valued.

Morale across all staff groups within the core services we inspected was high. In the governor's focus group, it was identified that people were particularly struck by the enthusiasm of staff at all levels of the organisation.

In the 2014 staff survey, in relation to the overall indicator of staff engagement the trust score of 3.89 was in the highest (best) 20% when compared with trusts of a similar type.

In relation to percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months the trust scored 14% which compared favourably against the national average of 21%.

Percentage of staff agreeing that their role makes a difference to patients was 93% compared to trusts of a similar type who scored 89%.

Between July and September 2014 the average sickness absence rate for the NHS in England was 4.07 per cent, an increase from the same period in 2013.

We saw that in relation to staff sickness, trust sickness rates have been consistently above the national average over the past 12 months. For example in July the figure was 4.7%, in August 5% and in September 2015 it was 5.1%

Turnover, sickness and vacancy rates vary by location and core service at the trust. The trust overall has a turnover rate of 10.3%. There are 14 locations with a vacancy rate of 100%. There are eight locations with a sickness rate of 30% or over but all of these have a whole time equivalent staffing establishment of 2 or less.

We saw that the trust had a leadership and management training prospectus. This document outlined the leadership and development programmes available for staff. We saw that this approach covered a wide range of staff, from those beginning their leadership or management development to staff who were working towards very senior management posts. Some of the training was internal, some accredited through university or via national leadership programmes. We also saw that it included a clinical leadership development programme. Staff we spoke to confirmed that attendance on these courses was supported by the trust and they had valued to opportunities to attend.

The trust are considering development of a talent management programme and we saw an action plan updated until March 2015.

Fit and Proper Person Requirement

This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We saw that the trust meets the requirements of the fit and proper person requirements. It was already part of the trust's approach to conduct a check with any and all relevant professional bodies (for example, medical, financial and legal) and undertake due diligence checks for senior appointments.

Engagement with people and staff

We saw during the inspection that staff make every effort to engage patients in all aspects of their care and treatment. The trust also engage with carers and make sure there is information leaflets available to carers. We met with carers from across the localities prior to the inspection. The majority of the feedback was positive

- Carers groups available
- Street triage gives on spot assessment and access to 136 suite seems to be working well

Outstanding ☆

Are services well-led?

- Treatment “Second to none”
- People are treated with respect
- CPN was very responsive – support was fantastic
- Support worker for my son was very good.
- One carer had done a leadership course sponsored by the trust at Teesside University
- PPI meetings once a month except August anyone welcome
- Involvement leaflets once a month
- Want people to be involved in Governance

but there were some issues raised regarding:

- Carers have had to ask for care plans/copies of letters from professionals and support letters
- “It’s like being in a car crash you don’t know who anyone is” We could do with a spider diagram explaining who everyone is and what their roles are.
- CPN was always late or didn’t turn up and didn’t let the patient know until 5 minutes before. This has now been resolved as the patient complained to PALS who dealt with it straight away.

The trust gathers the views of patients and carers – on the wards they use the ‘patient experience tracker’. This is a tablet (computer) that collected real time feedback from staff, patients and carers. Not all staff felt that the questions were relevant or that changes always occurred as a result of the findings.

The street triage team captured people’s feedback instantly through using tablet devices.

Continuous Improvement

At the centre of the vision and mission statement was the premise of ‘service users at the centre of all we do’.

In order to support this, the trust had developed a quality improvement system which all staff routinely use. This was based on the Virginia Mason Production System from the Virginia Mason Medical Centre, Seattle and is based on the Toyota Production System (Lean) methodology.

The trust use the quality improvement tools and methods to drive up quality, eradicate waste and improve services. We found that it was embedded at every level across the organisation.

To support this improvement work, the trust have a dedicated Kaizen promotion office. The teams’ purpose is to provide training and facilitate improvement workshops. They monitor progress and ensure learning is shared.

Teams hold rapid process improvement workshops (RPIW). We were informed that these week long events empower staff to bring about change, eliminate waste and make improvements to services. The staff also described other improvement (Kaizen) events such as 3P (production, preparation and process) events to bring about radical, rather than incremental, change; and rapid pathway development workshops (RPDWs).

We saw during our inspection, the Model Lines programme and the impact this had had in community teams. A model line is a way to standardise the approach to care and converting it to the "model" for other teams in the same environment to follow and continually improve.

We saw and heard how the programme had resulted in better outcomes for patients. It had taken time to roll out the programme because the trust needed to be certain that the ‘team’ could manage the change and sustain the changes in working practices.

The Model Line programme was developed to support community teams to become recovery focused. It used the Quality Improvement System philosophy and tools to maximise the time staff have available to work with patients, their families and carers. The benefits for the trust were to enable them to deliver high quality services and manage financial pressures.

Middlesbrough older peoples’ CMHT showed us information on the recovery support groups which had been developed by the psychologists and run by a qualified nurse with a support worker. The CMHT set up the first recovery group in Middlesbrough and all recovery groups were linked to the trust’s recovery college, ‘cognitive stimulation therapy pathway’. This was available for dementia patients and developed by a student nurse on a placement. All student nurses’ were now required to produce a service improvement project as part of their placement.

The trust also participated in external peer review and accreditation. This included:

The Quality Network for Inpatient CAMHS (QNIC) and Quality Network for Eating Disorders (QED)

Outstanding ☆

Are services well-led?

- The Evergreen Centre – accredited as excellent (QNIC) and QED accredited
- The Newberry Centre – accredited as excellent (QNIC)
- The Westwood Centre – not yet accredited

Accreditation for Inpatient Services (AIMS) Working Age adult

- Farnham – accredited as excellent
- Tunstall – accredited as excellent
- Danby – accredited as excellent
- Esk – accredited as excellent
- Overdale – accredited as excellent
- Stockdale – accredited as excellent
- Bilsdale – accredited as excellent
- Bransdale – accredited as excellent
- Lincoln – accredited as excellent
- Maple – accredited as excellent

Accreditation for Inpatient Services (AIMS) Psychiatric Intensive Care Unit

- Bedale Unit – accredited
- Cedar Ward – accredited as excellent

Accreditation for Inpatient Services (AIMS) Rehabilitation

- Primrose Lodge – accredited as excellent
- Willow ward - accredited as excellent

ECT Accreditation Scheme (ECTAS)

- Bishop Auckland (Darlington) – accredited as excellent
- Ryedale Suite (Middlesbrough) – accredited as excellent

Memory Services National Accreditation Programme (MSNAP)

- Hambleton and Richmondshire Memory Services (Northallerton) – accredited as excellent
- Harrogate and District Memory Service – accredited as excellent

There were a number of other wards and a crisis/home treatment team starting to go through the accreditation process or review cycle.

The trust were involved with Safer Wards and Productive Wards initiatives.

The trust had been awarded the 'Gold Standard' by Investors in People. This put the trust in the top 7% of Investors in People accredited organisations. Investors in People is a nationally recognised people management standard which assesses how well organisations manage and develop their staff. It considers all aspects of an organisation's employment practice from recruitment through to reward, involvement, development and management.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the registered person had not protected people against the risk of having their privacy and dignity needs met. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At Earlston House, we found breaches in compliance with the Department of Health guidance on same sex accommodation (SSA) which could compromise the dignity and privacy of patients. At the time of our visit, two female patients' bedrooms were located on a male corridor. Regulation 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of having their medication administered as prescribed. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At Ceddesfeld and Hamsterley medication was covertly administered without reference to the pharmacist or through a best interest meeting.

This section is primarily information for the provider

Requirement notices

On Hamsterley Ward we found that medication records were not been signed when the medication was given

At 367 Thornaby Road, there was no documentation of medicine stock levels. Staff did not record daily temperatures to make sure medicines were stored correctly. Audits were not carried out to make sure medicines were administered or stored appropriately.

Regulation 12(f)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that the registered person had not protected people against the risk of not meeting their safety needs on ward 15. We found the registered person did not always ensure the discharge plan was person-centred within the learning disability services. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: On Ward 15 we found risk associated with patients and no intervention plans in place related to these risks. This included risk of ligature and self harm. The combination of the environment with multiple ligature points and the increased use of bank and agency staff on the ward who require access to information about risk made this a significant risk. The provider had not worked effectively with partner agencies to ensure patients had comprehensive, person-centred, holistic discharge plans to minimise the risk of patients remaining in hospital longer than was necessary. Partner agencies and commissioners had not undertaken proper steps to ensure patients who do not require treatment in hospital are discharged.

This section is primarily information for the provider

Requirement notices

Regulation 9(3)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of not meeting their health, safety and welfare needs. This was in breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: On Ward 15 in the seclusion room there were blind spots identified where patients could remain out of sight of the observing staff. The trust had taken the appropriate action to identify and escalate this environmental concern however this had not been responded to by the estates department from the host trust. Regulation 12(2)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints We found that the registered person was failing to act on complaints made. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At 367 Thornaby Road, there was no information on how to make a complaint in any format displayed around the service. The service had no record of any complaints. Regulation 16 (2)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person was not assessing, monitoring and improving the quality and safety of the services provided in the carrying on of the regulated activity. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At 367 Thornaby Road, there were no effective systems in place to monitor and improve the quality of the service provided. The only audit we saw was for infection prevention and control. Regulation 17(2)(a)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not made sure that staff received appropriate support through appraisal and supervision. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At 367 Thornaby Road, staff did not receive supervisions. We saw no appraisals prior to May 2014 as these had been destroyed. Regulation 18(2)(a)