Special Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Thursday 8 February 2024**
Time **9.30 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

Items which are open to the Press and Public
Members of the public can ask questions with the Chair's agreement, and if registered to speak.

1. Apologies for Absence
2. Substitute Members
3. Declarations of Interest, if any
4. Any Items from Co-opted Members or Interested Parties
5. Tees, Esk and Wear Valleys NHS Foundation Trust CQC Inspection and Improvement Action Plan - Presentation by Brent Kilmurray, Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust and Beverley Murphy, Chief Nurse, Tees, Esk and Wear Valleys NHS Foundation Trust (Pages 3 - 210)

   A copy of the full CQC Inspection Report is attached for members information
6. Tees, Esk and Wear Valleys NHS Foundation Trust Community Services Transformation Programme - Presentation by Jo Murray, Associate Director of Mental Health and Learning Disabilities Partnerships and Strategy for County Durham, Tees, Esk and Wear Valleys NHS Foundation Trust (Pages 211 - 224)

7. North East Ambulance Service NHS Foundation Trust Quality Account 2023/24 priorities and performance update - Presentation by Tracy Gilchrist, Deputy Director of Quality and Safety, North East Ambulance Service NHS Foundation Trust (Pages 225 - 236)
8. NHS Dentistry Services - Presentation by Sarah Burns, Joint Head of Integrated Strategic Commissioning, County Durham Care Partnership, Durham County Council and North East and North Cumbria Integrated Care Board (Pages 237 - 260)
9. Shotley Bridge Hospital Update - Presentation by Richard Morris, Associate Director of Operations, County Durham and Darlington NHS Foundation Trust (Presentation to follow)
10. Such other business as, in the opinion of the Chair of the meeting, is of sufficient urgency to warrant consideration

Helen Bradley
Head of Legal and Democratic Services

County Hall
Durham
31 January 2024

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee**

Councillor V Andrews (Chair)
Councillor M Johnson (Vice-Chair)

Councillors J Blakey, R Crute, K Earley, D Haney, K Hawley, J Higgins, L A Holmes, L Hovvels, J Howey, P Jopling, C Kay, C Lines, M McKeon, S Quinn, K Robson, A Savory, M Simmons, D Stoker and T Stubbs

Co-opted Members: Mrs R Gott and Ms A Stobbart

Co-opted Employees/Officers: Healthwatch County Durham

Contact: Paula Nicholson Tel: 03000 269710

Tees, Esk and Wear Valleys NHS Foundation Trust

Inspection report

West Park Hospital
Edward Pease Way
Darlington
DL2 2TS
Tel: 01325552000
www.tewv.nhs.uk

Date of inspection visit: 18 April 2023 to 2 June 2023
Date of publication: 25/10/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Tees, Esk and Wear Valleys NHS Foundation Trust provide mental health and learning disability services in County Durham and Darlington, Teesside, North Yorkshire, York and Selby. The trust have 167 services across 66 locations. The trust provide 10 core services:

- Specialist community mental health services for children and young people
- Community mental health services with learning disabilities or autism
- Community-based mental health services for older people
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Wards for people with a learning disability or autism
- Forensic inpatient or secure wards
- Long stay or rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Acute wards for adults of working age and psychiatric intensive care units

The trust also provide one specialist service.

We carried out unannounced inspections of 4 of the inpatient mental health services provided by this trust, and short notice (24 hours) announced inspections of 2 of the community services.

We also inspected the well-led key question for the trust overall.

Our findings

We inspected acute wards for adults and psychiatric intensive care units and community mental health services for adults of working age because we had concerns about the quality of care provided relating to serious incidents occurring in the services.

We inspected inpatient wards for people with a learning disability and or autism because at our last inspection in 2022 we rated the service as inadequate overall and needed to ensure the quality of care had improved.

We inspected inpatient forensic secure services because at our last inspection of this service in 2022, we rated this service requires improvement overall and inadequate in the safe key question and needed to ensure that the quality of care had improved.

We inspected wards for older people with mental health problems and community mental health services for people with a learning disability or autism because of the length of time since we last visited these services and due to the potential high-risk nature of these services.

We did not inspect long stay/rehabilitation mental health wards for working age adults, mental health crisis services and health-based places of safety, or community-based mental health services for older people because we have not been in receipt of information of concern since our last inspection of these services.

We did not inspect specialist community mental health services for children and young people because the services had not had time since our last inspection to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection.

We are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

Overall, we rated safe, responsive and well led as requires improvement and effective and caring as good.

Our rating of the trust stayed the same. We rated them as requires improvement because:

- At this inspection we rated 3 of the six services core services we inspected as requires improvement overall and 3 as good. In rating the trust, we took into account the current ratings of the four services we did not inspect this time.
- We rated 7 of the trust's 10 core services and one specialist service as good and 4 as requires improvement. We rated 9 core services as requires improvement in the safe key question and 5 as requires improvement in the responsive key question. We found effective leadership and management at local level in most services, however we found that some of the trust's systems and processes did not operate effectively at a senior level. This meant that whilst we rated well-led as good in most core services, we rated the trust as requires improvement for the overall well led key question.
- The trust did not always have enough suitably trained staff to deliver safe care in all services. This was due to high vacancy rates, high sickness rates and significant reliance on temporary staff in some services. There was low compliance with specific modules of mandatory training. This included modules directly related to patient safety such as moving and handling, positive and safe care (restraint) and resuscitation.
- Some areas of the trust's estate continued to present risks to quality and safety. Action plans to remove environmental ligature risks had not all been completed. Seclusion facilities were not always fit for purpose. Some wards had blind spots which had not been identified or mitigated, the trust acted on these at the time of the inspection.

Our findings

- The trust's reducing restrictive practice programme for 2022-23 had failed to reduce overall rates of restraint. The use of restraint had increased by 17% in the trust's services since the previous year. The trust continued to use prone and mechanical restraint without appropriate challenge and oversight by senior leaders. However, there had been a reduction in the use of prone and supine restraint, with an increase in less intensive forms of restraint.
- Staff did not always consistently take appropriate action to reduce risk to people using services. Some patients in acute mental health services were able to access leave from wards without appropriate risk assessment. Some patients' physical health was not always monitored appropriately in acute mental health, forensic and learning disability inpatient services. Risks were not always shared and handed over effectively between shifts on some wards.
- People continued to wait too long to access services. Waiting times for community mental health services had not improved since the last inspection. There were significant waiting times in child and adolescent mental health services and for neurodevelopmental assessments. The trust's locality model had introduced variation where some patients faced inequity of access to services because of where they lived. The trust needed to work with both integrated care boards to improve access to services.
- Staff did not always receive, or record that they had received regular supervision and appraisal. This meant that the trust did not have effective systems in place for oversight of whether staff received appropriate opportunities for support and development.
- The trust did not have effective systems to consistently collate, analyse and present information about quality and performance in a way that identified risks and challenges, or supported effective decision making. There were examples of early warning signs in frontline services which had been missed by the trust's risk management and audit processes.
- The trust had a backlog of 100 serious incidents requiring investigation. There were further backlogs in incidents requiring routine investigation and in incidents resulting in patient deaths requiring review through the trust's learning from deaths processes. The trust's backlogs delayed opportunities to learn lessons and make improvements to prevent incidents recurring. The trust had experienced several similar incidents where learning was not evident. The trust were receiving external support to manage the incident backlog.
- The trust had experienced several high-profile incidents. The impact of the incidents had resulted in lasting and persistent changes to the culture of the trust which included an over-cautious approach from senior leaders to recognise and celebrate improvement.
- Where there had been incidents or treatment which caused harm to patients, the trust's approach had not always ensured staff and leaders reached out to people who had been harmed by its practices. The trust missed opportunities and appeared reluctant to consistently engage with people who used services, staff and others who had negative experiences or had been involved in incidents.
- The trust did not always act in accordance with the requirements of the duty of candour by failing to make an apology without delay for incidents resulting in harm.

However:

- Forensic inpatient secure wards, wards for people with a learning disability or autism and wards for older people had all improved since our last inspection. The trust no longer had any services which were rated inadequate. The leadership and safety of community mental health services for working age adults had improved since our last inspection in December 2021 and ratings had improved to a rating of good overall.
- Leaders were experienced, visible and approachable. Leaders at all levels had ensured that improvements were made since our last inspection. The trust had made improvements to its fit and proper persons' process.

Our findings

- Executives and non-executives were passionate about the trust's delivery of safe, high-quality care and were aware most of the trust's challenges, risks, and issues.
- The trust had a clear vision and strategy, understood by all staff and driven by the chief executive. We were able to see progression towards the trust's achievement of its strategic goals. Staff demonstrated the trust's values in the care they provided.
- Staff felt supported and valued and had confidence in the trust's freedom to speak up process. The trust had undertaken work to understand the risks of closed cultures across the services it provided.
- The trust was making improvements to its information management systems which included a refreshed patient record system which had been co-created with staff, service users and carers and was clinically designed.
- There continued to be good and improved engagement with staff, stakeholders, and partners. The trust was ambitious about co-creation and had several programmes in place to enhance opportunities for involvement.
- The trust had implemented a recognised methodology with a clear and embedded approach to quality improvement which involved staff at all levels, we were able to see examples of where quality improvement approaches had been used to improve services and processes. However, we saw that the trust's approach to quality improvement was sometimes related more to problem solving than innovation.
- The trust had sought feedback on its governance processes and had made significant changes to governance arrangements which had made it easier for services to escalate risks to the board

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the trust. During the inspection visit, the inspection team:

- visited all 42 of the trust's forensic inpatient secure wards, acute wards and psychiatric intensive care units, wards for older people and wards for people with a learning disability and autism.
- visited two of the trust's learning disability respite units.
- visited 14 of the trust's community locations.
- spoke with 292 members of staff.
- spoke with 131 people using the trust's services.
- spoke with 31 carers or relatives of people using the trust's services.
- reviewed 217 care records including 115 medicines administration charts.
- carried out 6 short observational framework for inspection (SOFI2) observations.
- observed several meetings including multi-disciplinary team meetings and safety huddles.
- observed four sub-committees of the board as well as one board meeting.
- held three focus groups with staff and governors.
- spoke with 25 members of the trust's leadership team including members of the board, the chair and the chief executive.
- sought feedback from a range of stakeholders including health watch and the integrated care board.

Our findings

- reviewed the trust's process for fit and proper persons employed.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

In wards for older people with mental health problems.

Patients told us that staff were kind and considerate and that they were always around to support them whenever they needed. They said that staff managed very well at busy times, and they said that they dealt with difficult situations very well. Patients said they felt safe whilst they were being cared for on the wards. Patients told us that the wards were always kept clean and that they felt the facilities met their needs. They said that they valued the range of support available and sessions and activities that were taking place. They said that food and drinks were good quality and available at all times.

In forensic secure inpatient wards.

Patients talked positively about the activities they were involved in including cooking, drama, pet therapy and fitness. Patients told us staff were supportive and kind and that they felt safe on the wards. One patient talked about the comprehensive support they were receiving in their transition to their future placement. Another patient talked about the service meeting their cultural and faith needs and facilitating access to the Imam.

In wards for people with a learning disability or autism.

People told us staff were friendly and nice. They told us staff supported them to carry out activities that were of interest to them. People showed us their accommodation and described how they had personalised it. One person was happy to tell us about their future plans. Relatives and carers of people using the service told us that environments were clean and fit for purpose. They told us people usually had a stable staff team who knew and understood the person well. They told us they felt their relatives were safe using the service. One family member told us there had been a significant reduction in the number of incidents involving their relative. They told us people received high standards of person-centred care.

In acute wards for adults of working age and psychiatric intensive care units.

Patients were mostly positive about the care and treatment they received. Most patients told us that staff were very friendly, kind and supportive and were very complimentary about the quality of care they received. They told us that staff always treated them with dignity and respect. Most patients told us that staff were responsive to their needs and had regular 1:1s with nursing staff.

Most patients were very complimentary about the quality and choice of the food available.

Patients told us they had access to activities during weekdays.

Patients felt involved in their care and treatment and that staff involved their carers as appropriate.

In community services for people with a learning disability or autism.

Our findings

Patients told us they were actively involved in discussing and planning their care needs along with their social care needs. One patient told us their care was “really really good, I like my nurse and psychiatrist”. Other patients told us that the service “couldn’t be better” and was “great”. Carers and relatives told us that the service helped them identify what support was available for them and their relative and the team “moved heaven and earth for us”.

In community mental health services for adults of working age.

Patients who used the service told us they were actively involved in coproducing, writing, and planning their care and were involved in decisions about their care and treatment. One patient told us their care support worker was ‘better than therapy, or medicines’. Another patient told us ’I’m striving, not surviving and feel valued’. Other patients told us that the service “did what it said on the tin and exceeded my expectations’ and ‘the service saved my life’. Carers and relatives told us that the service supported them, and they had access to carer support champions and could attend carer support groups.

Trustwide

We reached out to the trust’s stakeholders to give feedback for the inspection and received it from Healthwatch York.

Healthwatch York noted that in children’s services more recently they had been hearing and receiving positive feedback on the service including improved communication with parents, improved information and signposting in the letters parents receive when their referral has been acknowledged.

Healthwatch York also shared that they had noted a recent willingness from the trust to help them understand more about their approach to service provision and a want to link Healthwatch York to people around the system. Healthwatch York had been invited to speak to the trust about their mental health crisis care work, including the invite to host conversations with the crisis team staff. They also noted that leadership within the trust had been open to conversations around needs for improvements and the challenges they were facing.

They shared some positive comments from patients and staff in relation to quick responses from the crisis team and improved access to the crisis team’s telephone in York.

However,

In community mental health services for adults of working age

Patients said getting through to teams in York and Middlesborough was difficult, because the phone lines were constantly busy.

Some patients told us that the trust’s approach to care did not feel person centred and inclusive.

In forensic secure inpatient services

We spoke with 41 patients. One patient told us that staff did not understand their needs, particularly unfamiliar staff and this meant that staff misinterpreted their communication. Eleven patients told us that the food was of poor quality. Seventeen patients told us the staffing levels were low, this impacted on them being able to pursue activities,

access leave and have the staff support that they required. Patients on Brambling ward told us that they couldn't use the safes in their rooms, either because they were broken, or staff had not helped them to set them up. A patient told us and records confirmed for another patient that they had not received a debrief following incidents. Four patients told us that some staff do not protect their privacy and dignity by entering their room without knocking.

In wards for people with a learning disability and autism

Two family members raised concerns about the number of agency staff working in the service. One family member said there weren't enough meaningful activities.

In acute wards for adults of working age and psychiatric intensive care units.

We spoke with 47 patients. Six patients told us that staff could be busy, they told us that sometimes nurse staffing levels caused delays in dealing with requests specifically those that needed the support of a registered nurse. 10 patients across all the sites told us they did not know who their named nurse was and/or they were not having proactive regular and meaningful 1:1 conversation with nursing staff to talk about their mental health, wellbeing and progress. They reported that this was due to nursing staff being too busy as the wards were short staffed. Patients did say if they asked to speak to a nurse themselves this was facilitated.

They told us that there was less to do in the evenings and at weekends. Some patients told us that there was too much focus on physical activities such as walking and going to the gym. Some patients were not aware of the activities available as there wasn't always an updated activities timetable.

One patient told us that staff had refused to follow a specific aspect of their care plan and that this had caused them distress, they also told us that they were not given a copy of their care plan and information about their rights.

Trustwide

Healthwatch York told us that in children's services there continued to be a need for improved communication around services available to help with 'waiting well' and prevention. Also, a need to address inefficient administration systems.

They told us that findings in March 2023 in relation to care of older people with mental health problems suggested; discrepancies in diagnostic wait times, discrepancies in experiences of health care and a lack of coordination between providers, concerns around how 'user friendly' accessing support can be, lack of formal information and guidance support. They said that the public and partners told them about 'blockages' at every stage of the diagnosis process.

Outstanding practice

We found the following outstanding practice:

In wards for older people with mental health problems:

Our findings

- Several wards were participating in a national pilot to enable them to develop better communication and connection with people who lived with dementia. The trust had been commended for this work and had been shortlisted for a national award by the Royal College of Psychiatrists. This nomination outlined that the staff had demonstrated effective leadership and good teamwork, improved engagement of patients and carers and that there was evidence of improvement resulting from the team's work.
- Staff across all wards demonstrated a commitment to Safewards which meant they were able to continually make improvements to both the environments and the way they interacted with patients. This had a positive impact on the experiences of patients that used the wards.

In community mental health services for people with a learning disability and autism.

- Staff were using electronic devices to aid communication with patients. All patient information was produced in easy read format.

In forensic inpatient secure wards.

- The dietitian service along with patients had created a healthy eating cookery book "Cook healthy, eat, repeat – 'A recipe for a healthier lifestyle'" which had won an award at the Positive Practice in Mental Health Awards 2022.
- On Mallard ward, they cared for older patients, with associated physical health needs. There had been patients at the end of their life who wished to die at the service, staff had received training in end of life care and could facilitate the patients wish. The ward worked closely with community health teams and chaplaincy services to provide the care at end of life and facilitate the patient's wishes after death.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 7 legal requirements. This action related to 5 services and the trust at well-led level.

Trustwide

- The trust must ensure that there is a reduction in the use of restraint and restrictive practices particularly prone restraint. The board must have improved oversight of the use and reduction of restrictive practices including mechanical restraint. Regulation 9 (1) (a) (b) person centred care.
- The trust must ensure that people can access care which meets their needs by reducing waiting times. Regulation 9 (1) (a) (b) person centred care.
- The trust must ensure that all staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in immediate life support as per national guidance and best practice. Regulation 12 (1) (2) (a) (b) (c) safe care and treatment.

Our findings

- The trust must ensure that learning from incidents, deaths and complaints is effective and embedded and that the risk of repeat incidents is reduced. Regulation 12 (1) (2) (a) (b) safe care and treatment.
- The trust must ensure that it continues with work, at pace to improve and make safe the inpatient estate including the continuation of the removal of ligature anchor points and door replacement programmes. Regulation 15 (1) (b) (c) premises and equipment.
- The trust must ensure that engagement involves working with service users and their families to understand poor experiences and learn from episodes of harm. Regulation 17 (2) (e) Good Governance.
- The trust must ensure that governance systems and processes are established, embedded and operated effectively to assess, monitor and improve the quality and safety of the services. Using accurate and clear information to make improvements to the safety and quality of services. Regulation 17 (1) (2) (a) (b) good governance.
- The trust must improve governance systems and processes to identify and escalate risks including early warning signs in frontline services. Regulation 17 (1) (2)(a) (b) good governance.
- The trust must ensure that feedback from audits, complaints, incidents and executive and CQC visits to services are utilised and tracked to improve quality. Regulation 17 (1) (2) (a) (b) good governance.
- The trust must ensure that backlogs in the; serious incident review, mortality review, incident review and complaints are resolved with pace, and that actions are taken to prevent reoccurrence. Regulation 17 (1) (2) (a) (b) good governance.
- The trust must ensure there is a specific, measurable action plan in place to implement internal and external report recommendations. Regulation 17 (1) (2) (a) (b) good governance.
- The trust must ensure that all risks on the corporate risk register and board assurance framework are reviewed, mitigated and removed with enough pace to resolve key issues to patient safety, service quality and strategy in a timely manner. Regulation 17 (1) (2) (a) (b) good governance.
- The trust must ensure that there are safe levels of nursing and medical cover in place on all wards throughout the day and night to ensure that seclusion reviews are completed, and doctors can attend wards within 30 minutes of a psychiatric and in a medical emergency. Regulation 18 (1) staffing.
- The trust must ensure that staff receive and record appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a) staffing.
- The trust must ensure that it acts in accordance with the duty of candour regulation. Regulation 20 (1) (2) (a) (b)
- The trust must ensure that it has a strategy for physical healthcare. Regulation 17 (1) (2) (a).
- The trust must ensure that it has a clear policy relating the use of technology to monitor patients on inpatient wards and that this policy is accessible to patients and staff to understand the reasons for its use. Regulation 9 (1) (a) (b) person centred care.

In forensic inpatient services

- The trust must ensure that the seclusion facilities meet the needs of patients in the service and meet the requirements of the Mental Health Act Code of Practice. (Regulation 15)
- The trust must ensure there is a comprehensive handover for all patients which includes risk and how best to support patients. Information must be accessible for staff new to the ward, in a format that provides essential information in how best to support patients. (Regulation 12)

Our findings

- The trust must ensure that patients' health is appropriately monitored, including the side effects of high dose antipsychotic treatment, blood glucose and where appropriate bowel monitoring. (Regulation 12)
- The trust must ensure that blind spots on the wards are mitigated. (Regulation 12)
- The trust must ensure that there is a comprehensive oversight of the use of mechanical restraint and that the necessary safeguards are in place with records to support this. (Regulation 12)
- The trust must ensure that there are sufficient staff to provide consistent care to patients. (Regulation 18).

In wards for older people with mental health problems

- The trust must ensure that there are cogent recorded reasons for the use of prone restraint and that the reason for its use is recorded with a suitable rationale to ensure patients are protected from abuse and improper treatment. Regulation 13 (1) (2) Safeguarding.

In acute wards and psychiatric intensive care units

- The trust must ensure that there is adequate medical cover on all wards which ensures that medical staff can undertake timely reviews and attend within 30 minutes of a psychiatric emergency and in medical emergencies. (Regulation 18 1).
- The trust must ensure that staff manage and mitigate the risks to service users when they are detained and are permitted to go on section 17 leave. [Regulations 12(1) and 12(2) (b)].
- The trust must ensure that leaders operate effective systems to improve the quality and safety of the service and to mitigate the risks to the health safety and welfare of service users. [Regulations 17(1) and 12(2) (a) (b)].
- The trust must ensure that patients' health is effectively and safely monitored, following rapid tranquilisation, and physical health monitoring is completed in line with the regularity as stated in care plans where appropriate such as blood glucose and bowel monitoring. [Regulations 12(1) and 12(2) (b)].
- The trust must ensure that concerns about access and discharge to the service are managed appropriately including management of delayed discharges and the use of leave beds. (regulation 9, Person centred care)

In inpatient wards for people with a learning disability and autism

- The trust must ensure that care and treatment is provided in a safe way for service users by ensuring that staff carry out appropriate monitoring of patient's physical health. Regulation (12) (1).
- The trust must ensure that care and treatment is provided in a safe way for service users by ensuring that there is a continued reduction in the use of restraint particularly in the reduction of prone and supine restraint. Regulation (12) (1).
- The trust must ensure that seclusion reviews are undertaken in line with the Mental Health Code of Practice. Regulation 12 (1)
- The trust must ensure that care meets people's needs and reflects their preferences by ensuring all patients have a discharge plan and by continuing to make progress in supporting people to be safely discharged from the service into appropriate ongoing placements and reduces lengths of stay. Regulation 9 (a) (b) (c)
- The trust must ensure that governance processes are effective and embedded and ensure the service continues to improve. (Regulation 17)

- The trust must ensure that there are enough staff to provide safe and consistent care to people. Regulation 18 (Staffing)

In community mental health services for adults of working age

- The trust must ensure that waiting lists are reduced to ensure that patients receive timely access to services and support (regulation 9, person centred care).
- The trust must ensure that there are sufficient staff to provide timely, safe and consistent care. (Regulation 18, staffing)

In community services for people with a learning disability or autism

- The trust must ensure that there are sufficient staff to provide safe and consistent care to people. (regulation 18) Staffing

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider that the mental health legislation committee reviews data on the use of restraint and the use of force report.
- The trust should ensure that governors have clear lines of support and access to non-executive directors.
- The trust should ensure that disciplinary and grievances are completed within the trust's policy.
- The trust should ensure that data and intelligence provided to the board from the freedom to speak up guardian is utilised to its full extent including within its work on closed cultures.
- The trust should ensure that freedom to speak up guardian's report includes what action had been taken to resolve cases to assure the board and committee of the outcomes of speak up feedback.
- The trust should consider a review of the work and rest spaces for doctors.
- The trust should ensure that support offered to peer support workers is formally included in supervision policies.
- The trust should consider how actions and outcomes from executive visits to service is fed back to staff at service level.
- The trust should review how issues effecting more than one sub-committee of the board are reviewed and shared.
- The trust should review Mental Health Act policies to ensure that they are reviewed and in line with best practice and statutory frameworks.
- The trust should ensure that the quality of information provided in safeguarding referrals improves to ensure they wholly evidence 'think family' and always include information about what is in place to support management of immediate risk.
- The trust should ensure that the pharmacy workforce and succession plans are in place.
- The trust should ensure that the harm minimisation policy is fully embedded and reflected in staff practice.
- The trust should consider how audits include review and oversight of clinical decision making and clinical practice beyond the daily huddle structure.

In forensic inpatient services

Our findings

- The service should ensure that staff receive supervision.
- The trust should ensure that search records are accurate and reflect the search process and findings.
- The trust should ensure that patients and staff are offered a de brief following incidents.
- The trust should ensure that the blanket restrictions on Kestrel and Kite wards are individually assessed.
- The trust should ensure that rooms and facilities are accessible for patients with mobility needs, including access to emergency call alarms.
- The trust should ensure that appropriate food options are available for patients and food is stored in line with food safety requirements.
- The trust should ensure that staff complete all required training including mandatory training.
- The trust should ensure that information is shared consistently with ward based staff who cannot attend the team meetings.
- The trust should ensure that actions from community meetings are actioned, and the outcome and update shared with patients.
- The trust should ensure that care records are person centred, including individual reasons for the care plan for example choking. There should be evidence of patients' involvement in care plans and that the patient voice is clear. Multidisciplinary meeting minutes should be person centred with thorough updates from members of the team recorded and rationale for decision recorded.
- The trust should ensure that staff consider how they access the ward spaces and not use wards as a cut through.
- The trust should ensure that all equipment that required calibration is calibrated, including auroscopes.
- The trust should ensure there is support available for staff to attend reflective practice and other wellbeing opportunities.
- The trust should review how they plan and conduct the ward visits to ensure staff visit unannounced at different times to ensure balanced feedback is gathered.
- The trust should ensure that all lockable safes for patient use are in working order.
- The trust should develop their governance processes to ensure information is easily accessible.

In wards for older people with mental health problems

- The service should ensure that staff receive training and supervision.
- The trust should ensure that there is clear rationale for prescribing as required medicines including when multiple medicines are prescribed for the same indication and a direction is given for which is first or second line.
- The trust should ensure that the storage of gas cylinders is carried out in line with their own policy.
- The trust should ensure that each patient's identified risks are clearly mitigated within a risk management plan.
- The trust should continue to make improvements to ensure that the number of bathrooms is sufficient for the number of patients on each ward.
- The trust should continue to monitor and mitigate the risk of patient falls and take action to reduce the number of falls.

In acute wards and psychiatric intensive care units

Our findings

- The service should ensure that staff receive training and supervision.
- The trust should ensure that patients are afforded the necessary safeguards when they are secluded, including appropriate medical and nursing reviews. The trust should ensure that where it is not possible to meet the requirements for seclusion safeguards that cogent reasons are recorded for having to depart from national guidance.
- The trust should ensure there is clear rationale for prescribing as required medicines including when multiple medicines are prescribed for the same indication and a direction is given for which is first or second line.
- The trust should ensure that medicines authorisation paperwork is readily available at the time of prescribing and administering medicines.
- The trust should ensure that appropriate action is taken when medicine fridge temperatures are out of range and that oxygen is stored correctly.
- The trust should continue to maximise patients' privacy and dignity when patients on Cedar ward were required to be escorted to the seclusion room at the end of the male patients' bedroom corridor.
- The trust should ensure that where autistic patients are admitted to the acute wards, information about their individualised needs (positive behavioural support, communication, and sensory needs) are more clearly indicated in care planning and risk assessments records for all staff to see and consider.

In inpatient wards for people with a learning disability and autism

- The service should ensure that staff receive training.
- The service should ensure that the respite unit at Bankfields Court is well-maintained.
- The service should ensure that all of people's care records are holistic, thorough, and regularly updated.
- The service should ensure that governance processes are embedded to ensure audits are effective in making improvements to people's care records.
- The service should ensure that they continue to work within models of care that support people to leave long term segregation and seclusion.
- The service should ensure that the reasons for use of as required medication is consistently recorded.
- The trust should ensure that people's living spaces are conducive to recovery and feel welcoming.

In community mental health services for people with a learning disability or autism

- The service should ensure that staff receive training and supervision.
- The trust should ensure staff have access to integrated online systems.
- The trust should ensure that supervision systems allow accurate recording.

In community mental health services for adults of working age

- The service should ensure that staff receive training and supervision.
- The trust should ensure that patients are able to access services by telephone in York and Middlesborough.
- The trust should ensure that they continue to embed the harm minimisation policy.

Our findings

Is this organisation well-led?

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

Leadership

Leaders had the skills, knowledge, and experience to perform their role, they understood the trust's challenges to quality and sustainability and could identify the actions needed to address them.

Since our last inspection there had been a number of key personnel changes of both executive and non-executive members of the board which had strengthened the trust's leadership team.

Members of the board were supportive of the chief executive, they felt included and involved with the strategy and direction of the trust.

The trust leadership team had some knowledge of current priorities and challenges and took action to address them but risks in front line services were not always prioritised by the board.

Leaders were sighted on the key risks on the board assurance framework and corporate risk register. They were aware of their responsibilities to monitor and mitigate risks for defined actions.

Leaders were not always aware of all risks to patient and staff safety in front line services due to comprehensive information not always being available to the board or board committees for example in relation to serious incidents, mandatory training and the use of restrictive practice.

Leaders had ensured that the quality of front-line services had improved since our last inspection by providing support, guidance and oversight to services which were previously delivering poor care. Services provided in forensic inpatient services and learning disability inpatient wards had improved since our last inspections and staff were clear about the leadership support they had received to enable them to make changes.

There was a programme of board visits to services and staff fed back that leaders were approachable.

Staff told us that leaders were visible and approachable. Leaders undertook visits to services and had completed 9 visits to 54 teams (concurrently to different locations) between March 2022 and March 2023 to services including child and adolescent mental health services, community mental health services for older people, inpatient wards, crisis services, prison services and community mental health teams. Visits had been undertaken by leaders including the chair, chief executive, governors, and executive and non-executive directors.

The findings from leadership visits were reported to board by the director of corporate affairs and involvement. We found that the issues staff reported during the visits matched those identified by the leadership team, such as recruitment and demand. The trust said that individual lead directors took forward issues arising from visits. However, the trust did not maintain a record of actions agreed following visits. This meant that there was limited evidence that the board responded to feedback from staff during visits with action to make improvements.

All pharmacy and ward-based staff we spoke with knew who medicines leaders were. There were open lines of communication with senior pharmacy leaders who maintained visibility over the large geography of the trust.

Our findings

During a focus group, we spoke with staff side representatives. They told us that leaders were visible and approachable most of the time, but this was often dependent on the area in which staff worked as the large geography of the trust prevented visits to some services.

The trust had prioritised sustainable, compassionate, inclusive, and effective leadership.

The trust had 13 voting board members. The board was led by the chair and deputy chair with four other non-executive directors and one non-executive director who was also the senior independent director. Executive members of the board included the chief executive, chief nurse, medical director, director of finance information and estates, and the two care group managing directors. The director of corporate affairs and involvement, assistant chief executive, director of therapies and director for people and culture were non-voting members of the board.

The non-executive directors were from mixed professional and NHS backgrounds which allowed them to bring a range of experience and challenge to the board. Non-executives told us that they felt comfortable to bring respectful challenge and described a unitary board who had a shared vision for the trust and a belief in the achievement of the strategy.

Non-executive directors chaired the sub committees of the board and had clearly defined lines of responsibility.

The trust had a fit and proper persons policy and the process had improved since our last inspection. All of the directors' files we reviewed were compliant with the regulation.

The board did not entirely reflect the diversity of the population it served.

The board was not made up of people who reflected the communities it served. The 2021 census noted that 5.8% of people in the North East of England had ethnic backgrounds which were not White British.

The non-executive directors were made up of 4 (57%) females and 3 (43%) male and one non-executive director was from an ethnic minority group. The voting members of the board's executive team were made up of 3 males (50%) and 3 females (50%), one of the executive team were from an ethnic minority background.

During our inspection we held a focus group where we met with the trust's council of governors. Governors told us that they felt able to give feedback to the board but commented that there had been significant changes in leadership and governance which had impacted on their ability to know who they should be working with. They told us that when they asked questions of the board they were considered, and answers were followed up after meetings as required. A small number of current and former governors told us that they had concerns about the openness of the leadership team and that they did not always feel that the trust responded to patient safety concerns.

On the whole, governors felt supported and told us that the opportunity for pre-meetings were very helpful and there were other suggestions for support such as them buddying up. They found that the papers and reports they received were useful but not everyone received the correct information and sometimes it was high level and complex. Some governors were involved in recruitment, and they were involved in the appointment of the chair. They said they felt listened to when raising concerns about appointments. Governors received a regular newsletter which outlined progress to strategic goals and shared improvements from across the trust.

Governors were involved in leadership walkabouts.

Our findings

The trust asked governors to take part in specific pieces of work such as task and finish groups where appropriate and governors enjoyed taking part.

Governors were aware of key risks to the trust including recruitment and retention and waiting lists. They also told us that the trust needed to make improvements in sharing positive news stories about the things staff and services had achieved.

The trust reviewed leadership capacity and capability on an ongoing basis.

Since our last inspection, the trust had made significant changes to its organisational structures. The trust had undertaken this work to reduce the layers of reporting from ward to board and ensure clearer operational oversight following a review from an external partner in May 2021.

The trust had split into two care groups:

- Durham, Tees Valley and forensics
- North Yorkshire, York and Selby

Each care group had its own managing director and care group board. The care group boards included a lived experience director, a medical director, a group director of therapies and of nursing and quality, and a director of operations and transformation. General managers for each service line reported to a care group board member.

There were four service lines in North Yorkshire, York and Selby (adult mental health, older people's services, child and adolescent mental health services and learning disabilities). Durham, Tees Valley and forensics had six service lines which included the above and forensic services and health and justice services. Each service line was supported by general manager, who were supported by associate directors of medicine, therapies and nursing and quality.

The leadership team had established appropriate lead practitioners for learning disabilities, the Mental Capacity Act, the Mental Health Act and child and adolescent mental health. The trust had a named doctor for safeguarding children and adults professional safeguarding leads. The chief nurse was executive lead for safeguarding.

The chief pharmacist was experienced and qualified for their role and had clear lines of communication to board level. Medicines leaders were part of the trust's governance systems to ensure that medicines priorities were communicated effectively.

The trust was undertaking an ongoing programme of development at board and leadership level. This included a six-month induction programme for newer board members and an ongoing programme of development for which the trust had commissioned an external partner.

Vision and Strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

The trust had three values;

- respect: listening, inclusive, working in partnership.
- compassion: kind, supporting, recognising and celebrating.

- responsibility: honest, learning, ambitious.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care.

The trust launched their current strategy with their big conversation in 2020 with a vision of 'we want people to live their best lives'.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

The big conversation was a way in which the trust sought the opinions of all stakeholders which they used to shape their current strategy 'journey to change' in a collaborative way.

The journey to change was focussed on three strategic goals:

- to co-create a great experience for our patients, carers and families.
- to co-create a great experience for our colleagues
- to be a great partner

The strategy was underpinned by five strategic journeys which were the trust's priorities to ensure realisation of the strategy these were:

- clinical
- quality
- co-creation
- infrastructure
- people

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

The trust was making progress against delivery of the strategy. Executive and non-executive directors took the lead on the five priority areas and there were clear plans in place to make improvements to each area which were actioned via sub committees of the board and monitored via the board assurance framework. For example, the addition of lived experience directors within care group boards had strengthened the trust's approach to co-creation.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders.

The trust worked with two integrated care boards and understood that there was a need to align the strategy to the needs of two different populations in the wider health and social care economy. Having individual care group boards in place meant that the trust had a good understanding of the need to deliver flexibly, but overall, the strategy met the needs of the population they worked with as a set of standard goals and priorities to achieve.

Our findings

The board and executive team were proud of the strategy and told us that the chief executive's vision for the strategy was clear, and they felt they were unified in achieving it.

The medicines optimisation framework set out clear themes and priorities and was developed in line with the trust's strategic goals. Reviews of the framework were completed by the pharmacy senior leadership team. There was no pharmacy workforce plan or succession planning in place however this had been identified and would be actioned this financial year.

Staff knew and understood the trust's vision, values, and strategy and how achievement of these applied to the work of their team. The trust embedded its vision, values and strategy in corporate information received by staff.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Staff we spoke with in core services where able to explain the trust's journey to change strategy and information relating to it was visible in the services we visited.

The trust did not have a strategy for meeting the physical healthcare needs of patients.

The trust had a physical healthcare and wellbeing policy (2021) but had not developed a specific strategy for meeting the physical healthcare needs of patients. This was reflected in our core service inspections where we found that in 3 of 6 of the services we visited that people's physical healthcare needs were not being met as prescribed.

Culture

Leaders felt supported, respected and valued.

Executives and non-executive directors told us that they felt supported in their roles and that the culture of the board in terms of openness and transparency had improved in the last 18 months.

Staff felt supported, respected, and valued.

Staff including leaders told us that they felt positive and proud to work in the organisation. The trust had taken part in the 2022 NHS staff survey. There were some improvements to previous years. The trust was rated top in 'overall positive score change' for staff experience out of the 25 NHS mental health trusts that commissioned the same provider to undertake the survey for 2022.

The organisation's survey response rate was 44%, this was a decrease from the 2021 survey from 50%. The survey measures 9 key themes:

- we are compassionate and inclusive.
- we are recognised and rewarded.
- we have a voice that counts.
- we are safe and healthy.
- we work flexibly.
- we are a team.

- staff engagement.
- morale.

The trust's overall organisation score of 7.4 had remained the same from the previous year. Trust benchmark scores were above the median in all 9 areas but were not the highest in any category. The lowest scores were in relation to learning and morale with the highest in relation to being compassionate and inclusive.

Both care groups and corporate services had implemented an action plan in response to the survey, with a specific action plan for adult learning disability services in the Durham, Tees Valley and forensics care group. Action plans were detailed and included measurable outcomes to secure improvement in the areas identified as a concern in the survey.

The trust did not always take appropriate learning and action as a result of concerns raised.

The trust's reputation had been damaged by several high-profile incidents. The impact of the incidents had changed the culture of the trust which included an over-caution in leaders to celebrate the trust's successes.

There was a reluctance from the trust to engage with people who had been harmed by poor care. We spoke with people who had used the trust's services, staff who had been employed by the trust and relatives who had used trust services. Some people told us that the trust had not reached out to them following incidents of harm or distress. This was a missed opportunity to learn from incidents and improve the quality of care.

The trust's strategy, vision and values underpinned a culture which was patient centred.

The trust was working to reduce and mitigate risks of closed cultures developing within services. In February 2023 following a request from NHS England, the trust undertook a programme of work to identify closed cultures within the organisation, recognising that the services they provided to vulnerable people held several risk factors for the development of closed cultures.

The trust developed a cultural assessment tool which was used in all inpatient wards. The tool used six key risk factors; safety, patient experience, clinical effectiveness, healthy flourishing engaged teams, training and development and well led.

The trust undertook a desktop exercise using available intelligence to score each ward and risk rate for development of or existence of a closed culture. On-site visits were undertaken, and actions were identified for improvement, these were given to care groups for action with ongoing quarterly monitoring reports to be shared with the quality committee.

The trust worked appropriately with trade unions.

During the inspection we conducted focus groups. We spoke with staff side representatives. All attendees told us that they felt well supported by the trust despite significant organisational change, they told us that the trust was following the organisational change policy.

Representatives told us about improvements to communications, improvements in reasonable adjustments to working arrangements and improvements to leadership within teams. They also told us about how staff networks supported people. They told us that there were ongoing issues with information technology infrastructure in some areas and how they agreed that recruitment and retention should continue to be a focus for the trust.

Our findings

Governors told us that the trust was improving and changing the culture, and that the chief executive was open and honest with staff. Governors told us that they felt staff were well supported with several initiatives such as staff support groups.

Staffing continued to be a significant challenge for the trust. Staff in most of the services we visited told us that staffing issues created the most pressure in their working day and had the biggest impact on morale. Patients in some services told us that low staffing affected their care and recovery.

The trust did not have enough staff to provide safe high quality care in all services.

Safer staffing reports for April 2023 noted that of 53 wards the shift fill rate for registered nurses on day shifts dropped below 90% on 31 wards and dropped below 75% on 19 wards. For health care assistants this only dropped below 90% on six occasions and never below 75%. The trust often increased health care assistant staffing to above safe levels to account for the reduction in registered nurses.

There was an improved picture during night shifts which showed that staffing levels for registered nurses only dropped below 90% on six wards, four of these were below 75% staffing levels. There were only two wards where healthcare assistant staffing dropped below 90%.

Fill rates for allied health professionals were much lower. In April 2023, the trust reported that 18 wards had allocated registered allied health professionals, 15 of these wards reported staffing below 75%, the picture was the same for non-registered allied health professionals.

The trust's staffing data was complex and combined from several datasets and systems which meant it was difficult to accurately review the trust's sickness, vacancy and turnover data. The trust was not always able to obtain one version of the truth which made planning and actions difficult to undertake.

The trust employed 7818 whole time equivalent staff, with 4681 staff employed in the Durham and Tees Valley care group and 1781 staff employed in in the North Yorkshire, York and Selby care group.

The trust had 429 vacancies, 217 in the Durham, Tees Valley and forensics care group and 51 in the North Yorkshire, York and Selby care group, 77 in estates. Most vacant posts were for nurses (270 vacancies), there were 64 medical vacancies. This was a 5.4% vacancy rate.

Teams with higher rates of vacancies included three of the trust's secure inpatient wards which accounted for 71 vacancies.

Between 1 April 2022 and 31 March 2023 983 staff had left the trust and 1250 had joined. This gave an average turnover rate of 12%. Teams with the highest rates of staff leaving were in estates and facilities (25 staff).

The trust had an average full time equivalent sickness rate of 6% broken down as 4% long term sickness and 2% short term sickness. The rate had remained static across the last 12 months. This related to 752 absence occurrences in The Durham and Tees Valley care group and 379 in North Yorkshire, York and Selby care group.

The trust used bank and agency staff to support services to safe staffing levels. Between 1 March 2022 and 1 March 2023 the trust used 685,861 hours of bank staff and 429,238 hours of agency staff. There were several wards where agency use was particularly high as a percentage of overall staffing.

- Wold View - 37.15%
- Ramsey Talbot MDT - 33.94%
- Cedar Ward - 30.20%
- Bankfields Court - 28.69%
- Overdale Ward - 27.09%
- Ebor Ward - 22.05%
- Moor Croft - 20.86%
- Bedale Ward - 20.62%

The trust's staffing establishment review undertaken in February 2023 reported that temporary staffing accounted for 12% of the trust's total pay expenditure in that month. In secure inpatient services this rate was 20.5%.

In the last 12 months, staff had made incident reports relating to staffing on 562 occasions. Incident reports noted occasions when seclusion reviews could not be completed due to low staffing numbers, staff had reported that they felt vulnerable and unsafe and that there were not enough staff to respond to incidents. Staff also reported a high number of missed breaks (530 in March 2023).

The trust had undertaken an annual staffing establishment review which was presented to the board in April 2023, whilst this contained lots of information and was over 300 pages long; it did not provide summary detail to support the board to understand staffing challenges across wards.

The trust recognised that recruitment, retention, and staffing levels were one of the most significant risks faced by the organisation. Recruitment continued to be a risk on the board assurance framework, the risk description was that 'inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services'.

Since our last inspection, the trust had employed a new director of people and culture. They and their team were undertaking a revised approach to staffing with the support of their non-executive director. This included detailed work on understanding the vacancy and recruitment issues including hot spots for designations of staff and geographical areas which were hard to recruit to.

The director understood that retention was an area for improvement so were working on understanding why people were leaving the trust. They had developed groups focussing on people who were thinking of leaving the trust to divert people to other roles to support them and prevent them from leaving the trust. This included a monthly group provided by employee support and organisational development. They also provided a framework for anonymous feedback for anyone leaving or thinking of leaving and the opportunity to have a confidential one to one with an independent colleague. In addition, there is an internal transfer process to enable staff to move more easily to roles but stay in the Trust.

The trust also had daily controls in place to mitigate risks to patients of low staffing which included daily staffing report outs to ensure wards had the appropriate level of qualified, non-qualified and appropriately trained staff on each ward.

Pharmacy team staffing challenges had impacted on staff morale and staff had reported through the staff survey that they did not always feel valued. Senior leaders within the pharmacy team had taken steps to engage with staff regarding this and when we spoke with staff during the inspection they said they felt supported by the pharmacy leaders.

Our findings

Medicines leaders had reviewed how communication was received and had introduced new methods such as short videos as a method of communication so that all could be engaged.

The trust was aware that strong and effective leadership in services was a key factor in retaining their workforce. All leaders in the trust were undertaking a three-year development programme which alongside the use of 360 degree feedback they hoped would be supportive to improving leadership across the trust.

The trust was aware that their recruitment process had been too slow, for example in that in one recruitment campaign, 90 people were offered posts but due to the length of time taken to complete recruitment processes, 30 staff did not take up post. Staff also told us that recruitment campaigns were sometimes inaccurate which had led to a lack of candidates applying. The quality improvement team had worked with the team, and they had redesigned the processes which resulted in improvements, but they were not yet embedded.

The trust had a guardian of safe working hours who provided quarterly and annual reports to the board. Reports were thorough and gave a clear conclusion of the improvements required to retain and support junior doctors with good oversight of areas of concern. Reports included fines levied.

During the inspection we held a focus group with junior doctors who were largely satisfied with their employment with the trust. They described the trust as approachable for suggestions about change, but at times slow to enact it. Medics did share that working in Scarborough could be isolating, and our core service inspections also evidenced concerns about the on-call rota in this location.

Doctors spoke of their concerns about gaps in consultant staffing and how this impacted on their opportunities for learning and supervision and how much they enjoyed working with experienced consultant colleagues. They described good educational development and said that they felt this was a priority for the trust. They spoke of a strong wellbeing offer from the trust but commented that in some areas they lacked appropriate and safe spaces to work from and despite long hours sharing workspaces between 8 doctors with no air or natural light.

Managers addressed poor staff performance where needed.

The trust had disciplinary processes in place to address behaviour and performance that was inconsistent with its vision and values. The ‘managing concerns of potential conduct’ procedure was last updated in March 2022.

Between 1 March 2022 and 1 March 2023, there had been 59 disciplinary processes undertaken. Of these cases, 47 were in relation to staff within the Durham, Tees Valley and Forensic services and 11 in North Yorkshire, York and Selby services. The highest rates of disciplinary processes were undertaken in forensic inpatient services (18) adult mental health services (11) and learning disability services (9). The most common reasons for disciplinary action were maltreatment, negligence and inappropriate behaviour. Most disciplinary action was noted to have been undertaken with White British staff (85%). This was reflected in the 2022 Workforce Race Equality Standard data.

The trust aimed to reach a conclusion within each case within eight weeks and provide an outcome within 5 working days of a hearing. We reviewed 5 disciplinary cases during the inspection one of these cases met the deadline. We found that 2 cases took 6 months to complete, and 3 cases took 3 months to complete.

The trust had appointed a freedom to speak up guardian and provided them with sufficient resources and support to help staff to raise concerns.

Our findings

The trust had a good freedom to speak system in place, with a full-time guardian and officer in place which was an increased commitment since our last inspection. The guardian provided reports to the board every six months and into the people and culture committee. The guardian had worked into specific teams when themes and trends of concern had arisen.

The officer told us that they felt well supported by the board, and able to raise concerns. They also felt that they were able to remain impartial. The executive director of people and culture was the executive director with responsibility for the speak up process.

In February 2023 the trust reported an increase in people raising concerns via the guardian on the previous quarter from 33 in quarter 2 to 38 in quarter 3.

Patient Safety and quality was the most common reason for raising a concern (12 cases), followed by inappropriate behaviours (8), worker wellbeing (6), bullying and harassment (4) and demeaning treatment (4). 9 cases were classified as 'other'.

The guardian had analysed concerns and asked the board to consider the following themes from concerns:

- unmanageable workloads and unsympathetic managers, who either minimise concerns or at worse make the worker feel that they are not competent.
- staff often come to us because they feel that they had either not had a timely response, no response at all or any effective action plan.
- the importance of continued improvement plans and culture audits being undertaken.

The highest proportion of staff choosing to speak up within Quarter 3 were from the nursing profession and accounted for 37% of the cases received. Students, additional professional services, and estates accounted for 3% of cases which was the lowest representative profession choosing to speak up. 6 cases were received anonymously during this period.

The guardian followed up with each case requesting feedback, specifically as to whether the staff member had encountered any poor treatment because of speaking up. The February 2023 report noted that of 12 responses with feedback, 11 staff members said that they would be willing to use the process again.

However, the trust did not always use the feedback from the guardian as indicators of risk in services, for example feedback was not used in the closed culture review.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution.

In all services we visited and staff we spoke with, everyone told us that they felt able to raise concerns without fear of retribution.

The guardian also had a role in delivering training to managers about how to handle concerns. In February 2023, compliance across the trust with 'speak up, listen up' training was 80%.

There were mechanisms in place for providing all staff at every level with the development they needed, including appraisal and supervision.

Our findings

However, compliance was variable across teams and the trust's systems and processes for recording did not ensure they had data available to them to keep oversight of this.

The trust's supervision protocol was last updated in July 2021. It outlined that all staff involved in delivering direct patient care would receive at least 8 hours of clinical supervision each year with at least one hour every 3 months. This could be undertaken in form of 1:1 supervision, group/team supervision, live supervision with reflection and reflective review of video or taped sessions.

Staff we spoke with in services gave a varied view of supervision, with some saying they received it regularly and others reporting it did not always take place.

There had been an increase in compliance with clinical supervision for the trust overall. Compliance was 78% in quarter one of 22-23 which had increased to 84% by quarter four. However, there were 137 teams in quarter who had recorded less than 75% compliance with clinical supervision, 20 teams had reported 0% compliance and 48 teams reported 50% or less supervision compliance.

The trust's staff development policy outlined requirements for staff to receive quarterly managerial supervision. Rates of compliance with managerial supervision had increased from 79% in quarter one of 22-23 to 84% in Q4 of 22-23. Several individual teams were not compliant with 35 teams reporting 0% compliance, 105 teams reporting less than 50% compliance and 202 teams reporting less than 75% compliance. The teams with the lowest levels of compliance were adult mental health services.

The trust told us that they felt confident that staff were in receipt of regular live supervision including leadership support and staff's attendance at daily huddle meetings. The trust recognised that recording supervision was a concern and as such put a new system into place 'Power App' which was being embedded at the time of the inspection and due to be fully implemented by March 2024.

Appraisal compliance had increased from 79% compliance in April 2022 to 85% in March 2023. All localities reported appraisal compliance of above 80% and the trust board at 88%.

At a team level, compliance was highly variable, 28 teams reported 0% compliance, 18 teams reported less than 50% compliance and in total 69 teams reported less than 75% compliance with appraisals. The teams with lowest compliance were children and young people and child and adolescent mental health services.

The trust confirmed that they collated information about the supervision and appraisal of medical staff in different ways, they confirmed that 176 of 205 (88%) of medical staff had a job plan meeting in the last 12 months which confirmed they had been in receipt of supervision and appraisal. Junior doctors we met with at a focus group during the inspection told us that they felt the supervision process was regular and supportive and that monthly forums were also a chance for support and supervision.

Staff had access to support for their own physical and emotional health needs through occupational health.

There was a strong emphasis on the safety and wellbeing of staff. Leaders were aware that to improve staff retention, they needed to enhance the well-being support offered to staff.

Our findings

The trust had an extensive wellbeing offer for staff which included access to free therapy, coaching and mindfulness, and employment benefits such as free car parking and gym access. The trust also had a range of support groups provided by the employee psychology service which included burnout group, bereavement support group and an understanding self at work group.

The trust's equality, diversity and inclusion lead monitored all incidents which had led to the harm of staff members. They told us that the trust knew that they had further work to do on the impact on staff of racism in their workplace. The trust was in the process of embedding a violence strategy and there was a defined process in place to support staff who experienced abuse at work from patients and members of the public.

The trust had not ensured that staff were in receipt of all the training required for their role.

This meant that the trust was not ensuring staff were protected from harm and delivering care in line with best practice. The trust told us that they had difficulty in sourcing trainers and training venues, staff told us that they struggled to book training and that training often took place long distances from the North Yorkshire, York and Selby bases. At the time of the inspection, the trust told us that they had recently been able to source a new training venue in York which would support improvements in mandatory training compliance.

In March 2023 the trust's integrated performance report stated that 85% of training courses were completed in February 2023. Our findings from all core service inspections showed that this was not the case at service level where significantly low numbers of staff were trained in key patient safety courses such as moving and handling, positive and safe (the trust's approach to restraint) and basic and intermediate life support.

For example, in forensic inpatient secure services basic life support training (level one) had 67% compliance, positive and safe level 1 had 41% compliance, positive and safe level 2 had 64% compliance, rapid tranquilisation had 50% compliance and resuscitation had 60% compliance.

The trust had not ensured that staff were trained in immediate life support which met the standards of the resuscitation council. The trust told us that what the trust referred to as basic life support met the standards of immediate life support. Staff did not always know what training level they had received, and the trust could not evidence effective oversight of training levels.

The number of staff who felt that equality and diversity were promoted in their day-to-day work was improving but remained variable.

The trust promoted equality and diversity in the organisation and worked to ensure that all staff, including those with protected characteristics under the Equality Act, felt they are treated equitably. The trust was aware that senior leaders in the organisation were not representative of the staff employed and communities they served.

The trust had met good levels of compliance with staff who self-reported their ethnicity (99%), although fewer staff had self-reported a disability (84%). However, this issue was not specific to the trust, as disability declaration rates were lower than expected nationally across the NHS.

The trust provided workforce race equality standard (WRES) data. 5% of the trust's workforce as at 31 March 2022 were from ethnic minority groups. NHS providers are expected to show progress against several indicators of workforce race equality. For 2021-2022 the trust reported good progress against most indicators.

Our findings

Of 9 indicators, 2 had remained at similar levels to previous years. This included that staff from ethnic minority groups were less likely to enter the formal disciplinary process than White staff. There had been good progress with this indicator. White staff were 1.1% more likely to access non-mandatory training and continuing professional development compared to staff from ethnic minority groups which had improved since the previous year.

5 indicators had improved since the previous year. There was an increase in the percentage of staff from ethnic minority groups within the trust from 4.7% (359 staff members) in 2021 to 5.1% (387 staff members) in 2022. There had been a decrease in the likelihood of White staff being appointed for shortlisting compared to staff from ethnic minority groups. The percentage gap of staff who believed that the trust acted fairly regarding career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age had increased. The percentage of staff from ethnic minority groups reporting discrimination at work from managers/team leaders or other colleagues had decreased.

However, of the 9 indicators, 2 had deteriorated on the previous year. There had been an increase in the percentage of staff from ethnic minority groups reporting that they had experienced harassment, bullying, bullying or abuse from patients, relatives, or the public.

The percentage difference between the trust's boards voting membership and its overall workforce was + 11% (voting) + 10% (exec). This meant that the trust's board was not wholly reflective of its workforce and the population it served.

The trust also provided workforce disability equality standard data (WDES). As of 31 March 2022, data indicated that 6.6% of the total workforce were disabled staff. There had been mixed progress against the indicators for this standard.

The trust reported good progress against 4 of the 10 standards. These were that the percentage difference between the organisation's boards voting membership and its overall workforce had improved on previous years and was + 2.5% and the percentage difference between organisations board executive membership and its overall workforce was - 6.6% and had also improved on previous years.

The percentage of staff saying that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties had reduced which was an improvement.

There had been a decrease in the likelihood of a non-disabled staff member being appointed compared to a disabled staff member. There had been an increase in staff recording if they had a disability this year.

Indicators remaining relatively the same as previous years included, the percentage of staff experiencing harassment/ bullying and the relative likelihood of staff entering the formal capability process.

However, 4 indicators had declined from the previous year which included;

- the percentage of staff disabled staff who believed that the trust provided equal opportunities for career progression or promotion.
- the percentage of disabled staff who were satisfied with the extent to which their organisation valued their work.
- the percentage of staff who said that their employer had made adequate adjustment(s) to enable them to carry out their work.

- the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

The trust had put in place several actions to continue its progress. The 2022-2023 data set was due for collection shortly after our inspection and the trust noted that they expected some areas of improvement.

The trust's current equality strategy was due to be reviewed in 2023. The trust had published their equality objectives for 2023-2027, most of which were in place at the time of the inspection and were reflective of the actions required to improve progress with the workforce race and disability equality standards.

The trust employed a full-time equality, diversity and inclusion lead. They told us that the trust was committed to equality, diversity and inclusion, there was an executive sponsor for the work, and staff told us that the chief executive often attended network meetings to engage with and listen to staff, and a budget was in place to hold learning sessions and events. The equality diversity and inclusion lead held lunch and learn sessions to which all staff were invited, and sessions included topics such as; deaf awareness, pride month, asylum seeker awareness, Black history month and transgender awareness week.

Some staff networks were in place promoting the diversity of staff.

Staff networks included; a network for staff with long term health conditions, the rainbow network, the BAME network, working carers, the neurodiverse network, the armed forces network and the menopause group. During the inspection we met with network leads at a focus group. They told us that the trust had given networks opportunities to implement changes. For example the trust now had a specific access to work team who had supported staff to obtain the assistance they needed in their roles. They told us that they felt the trust had made real improvements in terms of meeting reasonable adjustments.

Staff involved with the ethnic minority groups network told us that the trust was well engaged with the group, and this had resulted in improvement in the workforce race equality standard.

The trust had a reverse mentoring programme in place where staff from within the networks were able to mentor a senior leader to help them to develop understanding of how it feels to work for the trust with a disability.

All the trust's strategic goals centred around co-creation with staff, communities and partners. Network leads and governors told us about the trust's commitment to co-creation and how that had included the employment of 28 peer support workers across the trust. Staff told us how they felt this evidenced the trust's commitment to the value of lived experience.

We found that peer support workers were well supported by the trust. On induction with the trust, peer workers received a 5 week period of intentional trauma informed peer support worker training before they undertook face to face work with service users. Peer support workers also undertook the same mandatory and statutory training as all other trust employees.

Peer support workers were supported via 3 monthly supervision sessions, monthly reflection sessions and the opportunity to attend continual professional development sessions. Peer workers could access the same employee psychology service as all trust employees and the workforce were managed within the portfolio of the director of therapies to ensure they were appropriately supported.

Our findings

The trust recognised that this support was not formally included in the supervision policies and had plans in place to rectify this.

The handling of concerns raised by staff did not always meet with best practice.

The trust had grievance procedure to allow staff to raise informal and formal concerns. In relation to pay and working conditions, terms of employment and workplace rules or disagreements.

Between 1 March 2022 and 1 March 2023 staff had raised 16 grievances. The highest number were raised in the North Yorkshire, York and Selby care group (9), there were 5 raised in Durham, Tees Valley and forensic services, 1 in corporate services and 1 in medical services. Of these grievances the highest number related to adult mental health services. The majority of grievances were raised in relation to human resources issues such as re-grading of job roles, processes, working conditions and pay scales.

Data provided by the trust did not detail the ethnicity of all staff who lodged grievances, 10 were made by staff who were White British, the remaining 6 did not include this information. This was a missed opportunity to monitor whether White staff were being treated differently from staff from ethnic minority groups.

We reviewed 5 grievances during the inspection. We found that all 5 had been acknowledged within 5 working days as per trust policy and all hearings had the correct attendees. However, in 4 out of 5 cases the process took longer than the 21 days outlined by the policy. When we spoke with staff side representatives, they told us that they felt the internal procedures for raising concerns were flawed and unfair towards temporary (bank) staff and told us that investigations took too long.

Governance

The trust had structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. They had continually and regularly reviewed these. However, they had been recently changed but were not embedded.

There had been improvements in governance since our last inspection of the trust. The trust had commissioned a governance review in 2021 and a further review in 2023 which was supporting the board to review, improve and embed changes in governance.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. However, information was not always clear and did not always provide analysis to support effective decision making.

Board papers had improved, however they were often lengthy and did not always focus on the risks, recommendations and decisions required by senior leaders. Data was often presented at the highest level which limited the board's ability to see issues and hotspot areas of quality issues and poor performance. There was limited evidence of sub-committees utilising deep dives to investigate and escalate areas for improvement to the board.

There was a framework which set out the structure of ward/service team, care group and senior trust meetings. Meetings were used to share essential information such as learning from incidents and complaints and to take action as needed.

Our findings

The trust's governance review and the associated changes had ensured that layers of governance had reduced so there were less steps to reaching the board to highlight risks to senior leaders.

The trust's governance structure identified responsibilities for individual groups and committees to maintain oversight of operational delivery of both care groups. The structure also identified to which sub groups of the executive directors group each care group was required to provide assurance of their quality. The executive directors group then provided assurance to the trust board sub committees.

The trust board had implemented a structure which established each care group as independent functions within the trust with their own quality assurance and improvement group, people, culture and diversity group, resource and business development group and a risk group.

The clinical leaders group brought together leaders from the five clinical networks: learning disabilities and autism, adults, older people, child and adolescent mental health services and forensic services.

Non-executive and executive directors were clear about their areas of responsibility.

We observed sub-committees of the board during our inspection and reviewed papers. Sub-committees were allocated responsibility for individual risks relevant to their remit on the board assurance framework. Each committee chair worked closely with a member of the executive team and gave appropriate challenge to the executive team.

The trust did not have a process to effectively share risks impacting on the remits of more than one sub-committee. Committee chairs told us that they had begun to meet to discuss cross cutting issues but there was further work to do to embed these processes and ensure key issues were being managed in one, not multiple places.

Medicines governance systems were in place to ensure patients had access to the medicines they needed in a timely manner. Some medicines systems required further embedding and oversight to ensure that actions occurred when deviations were identified. In the services we visited we found that patients physical health needs were not always reviewed in accordance with their care plan.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. Governance was not entirely effective to ensure the Mental Health Legislation committee was effective and had oversight of all relative risks.

At the time of the inspection the committee chair was new and had made amendments to the way in which the committee would be managed, including that the terms of reference had been reviewed, lived experience directors would begin to attend the committee and discussions were ongoing as to whether the hospital manager's report would return to the committee after being stood down due to Covid-19. The committee were also planning a board development session which related to changes to Mental Health Act and Mental Capacity Act changes. A service user representative attended the committee.

The agenda was aligned with the board assurance framework, and the committee discussed relevant and high-risk topics via an annual reporting programme. However, in the committee we observed and the papers we reviewed, we found that data and intelligence was not provided which gave enough detail to allow assurance and analysis and summary of the information presented was not sufficient. In May 2023 data relating to detention rates was presented to

the committee but no analysis was provided. Data reported concerning trends which were not addressed or summarised in the report with actions for improvement. For example, the trust's rates of detention per 100,000 population for White patients was higher in the trust than the national average, and Black / Black British patients were more than twice as likely to be detained than White patients.

The Use of Force report was not overseen by the committee, but by the Quality Assurance Committee along with 6 monthly updates from Positive and Safe group. Oversight of this data by the committee would increase the trust's specialist oversight of the use of restrictive interventions.

The trust had good oversight of themes raised from CQC's Mental Health Act monitoring visits but did not always take timely enough action to resolve them. Quarterly thematic reports from visits were provided to the mental health legislation committee and weekly updates regarding the status of provider action statements and findings of monitoring visits were provided to the executive director's group. Overall oversight of the trust's action plans in response to visits was managed by the quality governance team. However, issues were not resolved in a timely manner and actions did not always result in improvement.

Since 1st August 2021 CQC had completed and issued 37 Mental Health Act monitoring reports to the trust. Our visits continued to have repeated themes of concern which the trust had been unable to make sustainable improvements to as an outcome of the visit action planning, these included:

- care planning (17 visits)
- patient involvement (13 visits)
- therapeutic environment (11 visits)
- discharge planning (11 visits)
- blanket restrictions (11 visits)
- staffing levels (11 visits)
- documentation (11 visits)

The trust's policies in relation to the Mental Health Act were largely compliant with the Code of Practice. There were some related policies which were overdue for review:

- the blanket restrictions policy (February 2023)
- patient search policy (March 2021)
- mobile technology policy for patients and visitors (2017)

The associate hospital manager policy did not sufficiently address 38.10 of the Code of Practice that "Hospital managers should ensure that they and the hospital managers' panel understand equality issues and that there are sufficient numbers of panel members with a specialised understanding of the specific needs of particular groups including those listed below, and that panel members can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with learning disabilities and/or autistic spectrum disorders"

Our findings

The policy stated that people appointed to be on hospital managers panels should 'understand equality issues' and receive 'equality and diversity training'.

Management of risk, issues and performance

Leaders used performance systems to identify, understand, monitor and reduce or eliminate risks, however systems did not always provide an accurate picture of all factors directly impacting on patient safety to allow early intervention and targeted improvement at service level.

Each month, the trust's quality and learning report was presented to the quality assurance committee. The report used statistical process control charts to determine whether there were underlying causes for concern.

The report covered; serious incidents, patient safety incidents, reducing restrictive practices, medication safety, inpatient falls, safe staffing, shifts greater than 13 hours, mortality and learning from deaths, quality assurance and improvement programme, friends and family test, learning from complaints (formal and informal) and compliments and CQC insight.

In each heading, the report gave an analysis (so what), actions being taken (now what), key learning points and improvement actions.

The trust did not have an effective process to consistently escalate concerns affecting quality and safety from the quality assurance committee to the board. The quality and learning report presented to the quality assurance committee had better identification of key risks and action taken than the integrated performance report presented to the board. This meant there was an inconsistency in the level of information provided to the full board, with board members who were members of the quality committee having better understanding and oversight of risks affecting the quality and safety of services than board members who were not.

The trust's integrated performance report used statistical process control charts to determine whether there were underlying causes for concern. The report contained a performance and controls assurance overview which outlined a performance assurance rating of 'substantial', 'good' 'reasonable' or 'limited'. The performance assurance rating did not correspond to the findings of inspections which identified concerns in services, for example in oversight of restrictive interventions, which were classified as having 'good assurance' in the integrated performance report.

The report focussed on 30 indicators divided into four measures focussed on quality, people, activity and finance. There were some key indicators of risk which were not included in both reports including waiting times, seclusion, long term segregation, complaints, compliments, supervision rates and cultural indicators such as whistleblowing or freedom to speak up concerns raised.

The data in the integrated performance report was presented at the highest level, usually by care group. By presenting only the highest-level breakdown of quality metrics, the board were prevented from seeing the detail within the data and limited opportunities for the board to question and challenge hotspot areas of poor performance. For example, the March 2023 integrated performance report stated that 85% of courses were completed in February 2023 and the analysis highlighted the need to improve information governance training. This report did not highlight to the board that some services within the trust were running on significantly low numbers of staff trained in key patient safety course such as moving and handling, restraint, and resuscitation.

Our findings

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts. The systems were not effective, reviewed and did not ensure that improvements could be made.

The trust did not have an effective process in place to manage complaints and learn from them to make improvements.

The trust had processes in place to manage complaints and a complaints policy in place which was last updated in 2021.

All complaints to the trust were received via multiple routes including letter, email, verbally and by the patient advice and liaison service (pals). The service was managed by the head of patient experience. The trust had 3 whole time equivalent complaint managers responsible for leading on all complaint investigations, and 4 whole time equivalent officers who were responsible for lower-level complaints received by the patient advice and liaison service.

There was a defined governance process for the management of complaints which included;

- a weekly activity report was provided to the patient safety and learning group.
- a monthly pals, complaints and patient and carer experience report was reported through to the executive quality improvement subgroup detailing themes from complaints.
- an integrated quality and learning report was reported into the quality committee monthly and detailed learning from complaints.
- 6 monthly and annual reports were presented to the executive quality improvement subgroup detailing themes from complaints and compliance with KPI's.

The trust had received 341 formal complaints in the last 12 months. The trust had not met targets in responding to complaints. 100% of all complaints had been acknowledged in 3 working days but less than 15% of complaints had been completed within 60 working days, 82% of complaints had been completed within 6 months.

The trust was aware of the issues with the management of complaints and at the time of the inspection were undertaking a review of their complaints handling service in line with the NHS complaint standards. The trust told us that the redesign of their processes would ensure that they have a quicker, simpler, and more streamlined complaint handling service with a strong focus on early resolution. The review was to be carried out using quality improvement methodologies and co-created with service users and carers.

The trust planned to move to a new system for complaints management which would also capture themes and trends for learning and monitor action plans.

The most common reasons for making a complaint were categorised as;

- care and treatment
- inadequate or incorrect information
- care planning
- assessment

Our findings

Most complaints were not upheld (149), 55 were partially upheld, 15 were fully upheld, 11 were withdrawn and 112 complaints had no outcome recorded in the data provided by the trust.

There were 7 complaints referred to the public health service ombudsman, with the most recent being referred in 2021.

The trust had received 2676 informal complaints via their patient advice and liaison service in the last 12 months. Adult mental health community services were raised as a concern in 874 of these complaints, adult mental health inpatient services in 210 and child and adolescent mental health services in 211. The trust responded to 79% of these informal complaints within 15 days as per their policy.

The most common reasons for making an informal complaint were categorised as:

- care and treatment
- assessment
- inadequate information
- negative comments about staff

The trust had received 138 concerns raised by MPs, 137 of which related to care and treatment.

During the inspection we reviewed ten complaints which had been submitted to the trust. The complaints had been fully and thoroughly investigated, taken seriously and the complainant received a compassionate response.

There had been a slight improvement in the rate of Mental Health Act complaints and whistleblowing concerns being raised with CQC.

Between April 2021 and March 2022 CQC had received 100 Mental Health Act complaints and 34 whistleblowing concerns.

Between 1 April 2022 and 31 March 2023 CQC received 94 Mental Health Act complaints and 27 whistleblowing concerns from the trust's staff. Themes included: staffing levels, staff assaults and incidents and working environments.

There had been a slight increase in none Mental Health Act related complaints to CQC about the trust from 159 in 2021-2022 to 168 in 2022-2023. Of these 168 complaints, 80 of these concerns related to the trust's community services and 89 to the trust's inpatient services. Themes from complaints about community services included: people not feeling included and listened to, cancelled appointments, crisis responses, staff behaviour and discharge processes. Themes from complaints about inpatient services included: communication, staffing, discharge, and leave.

The trust had good processes in place in relation to safeguarding adults and children.

Between 1 March 2022 and 1 March 2023, there were 3096 safeguarding adults concerns raised with most concerns raised in Middlesborough and in relation to people in receipt of adult mental health services. There were 4728 safeguarding children concerns raised with most concerns in relation to parental mental health and parental substance misuse and the most common place being in Durham and Tees Valley.

Our findings

We reviewed safeguarding referrals during the inspection and found that they were appropriate and showed sound evidence of staff exploring risk relating to capacity, consent and self-neglect in adults. The quality of information provided in referrals could improve as they did not always wholly evidence 'think family' and referrals did not always include information about what was in place to support management of immediate risk.

Staff received a range of safeguarding training which was targeted to their role within the trust from levels 1 to 4 accordingly and including prevent training.

The trust's strategic plan for 22/23 for safeguarding was in the form of a workplan for the safeguarding team. It had 11 key objectives which included; domestic abuse, training, safeguarding assurance, impact of parental mental health, including fathers/partners (under 18's services), self-neglect, safeguarding presence in clinical areas, named doctor for safeguarding adults, multi-agency public protection arrangements and safeguarding adult supervision.

Each objective had a named lead with actions to be updated each quarter, and red/amber/green rated updates provided for monitoring actions and progress.

The trust had processes for safeguarding reporting to board which included bi annual reports to the quality assurance committee, and reporting to the executive quality assurance group. The trust also had a safeguarding and public protection group which monitored the work plan.

The safeguarding team supported the two care groups with two named professionals for safeguarding adults and two named professionals for safeguarding children. The named professionals spent time in services to ensure they were visible and approachable for staff. This supported bringing safeguarding knowledge and learning into clinical services. The safeguarding team consisted of 20 staff and 3 administrators.

The safeguarding leaders had formed strong working relationships with local authorities to enable them to work in partnership, and they attended safeguarding boards for adults and children across the trust's localities.

The team joined the daily patient safety huddles to provide support and advice and incidents were notified to them for review via the incident reporting system.

The trust had a process in place for staff to receive safeguarding supervision. There was a mandatory requirement for 3 monthly safeguarding children supervision for staff working with children subject to a child protection plan or working with parents or carers caring for a child subject to a child protection plan.

"Between April 2022 and March 2023 specialist safeguarding children supervision had taken place in the Durham and Tees care group on 328 occasions and on 82 occasions in the North Yorkshire, York and Selby care group."

Between April 2022 and March 2023 specialist safeguarding adult supervision had taken place in the Durham and Tees care group on 363 occasions and on 53 occasions in the North Yorkshire, York and Selby care group. Of the 416 trust wide cases 200 were completed, 168 were missed or stood down and 38 were outstanding at the time of the inspection.

There were no mandatory requirements for specialist safeguarding adult supervision however it is good practice this takes place.

Our findings

Between April 2022 and March 2023 specialist safeguarding adult supervision had taken place in the Durham and Tees Valley care group on 328 occasions and on 82 occasions in the North Yorkshire, York and Selby care group. Because this was not mandatory for staff the trust did not record the cases requiring supervision in the same detail as for children's safeguarding supervision.

The trust had participated in several safeguarding reviews in 2022-2023 this included child safeguarding practice reviews, safeguarding adult reviews, domestic homicide reviews and learning reviews. They participated in 12 reviews involving children and 28 involving adults.

The trust had failed to achieve its target to reduce the use of restrictive interventions.

The trust's positive and safe annual report of June 2023 reported on incidents of restrictive intervention between February 2022 and February 2023 and showed a significant increased over the last 12 months. The number of restrictive intervention incidents had increased by 17%, from 6423 in 2021-2022 to 7530 in 2022-2023.

The trust had not made enough progress in the reduction of the use of restrictive interventions. The trust presented annual and bi-annual positive and safe reports, and restrictive intervention usage and progression of the trust's positive and safe plan was reviewed bi-monthly via the quality assurance committee.

Data provided by the trust for this inspection for 1 April 2022 and 1 April 2023 staff had undertaken 7931 restrictive interventions. Of these, 126 were undertaken in the prone position.

Prone restraint is a type of physical restraint holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone and being placed prone onto any surface. Due to the high-risk nature of this restraint, the 2015 Mental Health Act Code of Practice states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position". NICE guideline NG10: Violence and aggression also recommends avoiding prone restraint, and only using it for the shortest possible time if needed.

We found in one ward for older people with mental health problems, prone restraint had been used to deliver PRN (as required) medication and staff had not recorded reasons for not using other methods of least restrictive actions on three occasions.

In the same period, there were 2619 episodes of supine restraint, this is where a patient is restrained laid down, on their back. There were also 1311 episodes of rapid tranquilisation, 930 episodes of seclusion and 100 episodes of long-term segregation.

There had also been 39 uses of mechanical restraint, some but not all incidents had been in secure services with care planning from the Ministry of Justice, some had involved mechanical restraint by the police. However not all incidents were reported and recorded in line with trust policy and the Mental Health Act Code of Practice. We fed this back to the trust during the inspection and the chief nurse immediately put actions in place including a new protocol to ensure that the chief nurse and medical director were involved in the multi-disciplinary decision-making process relating to the trust's use of mechanical restraint.

Our findings

The trust's integrated performance report noted that one patient who had been involved in a significant number of restraints would soon be discharged from the trust's care. This was presented in the report as a factor for the trust to consider, which may reduce the numbers of restraint in future. This did not take into account possible systemic factors in the trust's inpatient services including risk assessment and management, staffing levels, staff training and team culture which contribute to how staff manage incidents of violence and aggression resulting in restraint.

High levels of use of restrictive interventions, particularly where it is known that staff are not engaged in safe training levels may be an indicator of a closed culture, of high acuity and of potential injury to patients and staff. The trust's reducing restrictive intervention programme was not effective in using the data available to support the reduction of levels of restrictive intervention and therefore reducing risks to patients and staff. The board had not taken enough action to monitor progression of the plan and take timely action. However, the use of restrictive interventions had reduced in wards for people with a learning disability and autism, where the trust had worked with staff and external providers to reduce the use of restrictive interventions.

The trust did not ensure that they were able to learn from incidents of patient harm to manage risks, issues and performance.

Between 1 April 2022 and 31 March 2023, the trust reported 19,207 incidents to the national reporting and learning system. 13755 were reported as 'no harm', 4498 as low harm, 796 as moderate, 46 as severe and 112 deaths. There had been an increase in reporting incidents from April 2021 to March 2022 where 14778 incidents had been reported.

The most common incident related to self-harming behaviour (9,205 incidents), disruptive behaviour (1921), patient slips, trips and falls (1614), treatment / procedure (1196), infrastructure including staffing (866).

Leaders did not review and close incidents within a reasonable timeframe.

Staff reported incidents via the reporting system which were allocated to leaders and the patient safety team to review. The June 2023 quality and learning report noted that there were 1210 incidents awaiting approval at the time of reporting, including 675 from April 2023. 89.3% of the incidents awaiting approval had an initial rating of 'low' or 'no harm'. The patient safety team prioritised review of any incidents reported as moderate harm and above. The delay in review of incidents meant there was a reduced opportunity for rapid learning and improvement from incidents.

The trust did not have a robust and effective process to learn from serious incidents, mitigate risks and prevent reoccurrence.

Between 1 February 2021 and 30 April 2023. The trust had reported 327 incidents to the strategic executive information system (STEIS). Of these incidents 58 were categorised as internal comprehensive, 2 as internal concise and 260 were to be confirmed. The trust had closed 109 incidents.

Of these the most common incident type was actual suspected self-inflicted harm (173 incidents) followed by falls (14) and disruptive/aggressive behaviour (7). There were 4 incidents pending review which had not been categorised.

There had been no reported never events.

The trust had a significant backlog of 100 serious incidents requiring investigation. The trust told us that several factors had influenced the backlog position which included capacity in their own patient safety team and awaiting feedback on incidents and their closure from clinical commissioning groups.

Our findings

The trust had processes in place to address the backlog. The trust's newly appointed chief nurse was monitoring progress and had introduced refreshed analysis of each incident in the backlog with weekly meetings to monitor progress. They were also writing to all patients and families involved in the incidents to make apologies for the delay in investigations. Although this process had now begun, it was not done in a timely manner, and we reviewed one complaint during the inspection which highlighted the distress caused to a family from the delays in the serious incident investigation including the fact that this had caused a delay to the coroner's inquest.

We found that prior to this work being undertaken by the Chief Nurse, the trust's data and information in relation to the backlog was unclear. CQC were provided with different data for the number of ongoing investigations and the data provided by the trust did not correlate with the information within the strategic executive information system.

All incidents awaiting to be allocated to a reviewer had been placed into 2 cohorts.

- cohort 1; all unallocated serious incidents reported up to 31st January 2023 (47)
- cohort 2; all unallocated Serious incidents reported from 1st February 2023 onwards (53).

The trust had employed a patient safety programme lead to manage cohort 1 incidents via an external agency and they had also appointed a number of external SI reviewers.

The trust was not carrying out investigations in line with the NHS serious incident framework because investigations were not; open and transparent, preventative, objective, timely and responsive, systems based, proportionate and collaborative because investigations had not been undertaken in all cases beyond an early learning (72 hour) review. The trust told us that they were assured that despite detailed investigations not being completed for serious incidents, they conducted thorough 72-hour reviews into every incident to ensure that immediate actions were taken and to reduce the risk of repeated incidents.

Following a thematic review of a cohort of serious incidents in July 2022, the trust was able to identify seven key themes across serious incidents and programmes of work were put into place to improve quality and safety in these areas:

1. risk assessment and management
2. multi-agency working.
3. care planning
4. record keeping
5. safeguarding
6. involvement with patients and carers
7. medication

In July 2022 the trust launched an improvement plan to mitigate the risk of reoccurrence against these common themes. This included:

- a refreshed electronic patient record system to improve recording and support improved care planning and risk assessment.
- an increased number of suicide awareness trainers.

- a suicide and self-harm minimisation group.
- revised clinical guidance.
- learning and development enhancements and an improved training matrix.
- medical emergencies training
- enhanced learning opportunities including the organisational learning group, safety bulletins, patient safety clinical huddles and patient safety rapid (72 hour) reviews.

The trust had also undertaken some thematic work in specific teams where there had been serious incidents in a short time.

The trust had also used the learning from identifying these key themes to refresh their quality assurance programme from January 2023. The trust's quality assurance programme included targeted audits and reviews including:

- self-declaration
- modern matron quality reviews
- practice development reviews
- community quality reviews
- peer reviews
- director visits.

The trust had continued to provide updates to commissioners on these themed areas monthly. However, there was insufficient improvement in these key areas, for example.

- from July 2022 to May 2023 there had been a further 90 serious incidents related to self-inflicted harm. This was an increase in incidents from 81 in the same period the previous year.
- during our service level inspections, we found that Clozapine management remained poor (theme 7).
- staff did not have immediate life support training in line with national standards (theme 7 and theme 4).
- the organisational learning group did not take place on a regular basis, it had taken place in October and November 2022, January 2023 and April 2023.

We could not see evidence that when audits were undertaken, they also reviewed clinical decision making alongside records to ensure that care provided to patients was safe, high quality and in line with best practice guidance.

The trust had undertaken a review of seven service users who died in their care between 27 December 2022 and 4 March 2023. The trust's early learning analysis from these incidents noted several factors (differing in each case) that had not been consistently addressed by the work on the seven common themes including multi-agency working, lack of safeguarding referrals, poor evidence of carer contact, lack of formulation, difficulties with resuscitation in one case and a lack of updates to safety summaries (risk assessments).

During the inspection we reviewed 5 completed serious incident reports for incidents occurring between March and July 2022. Two of these incidents had been reviewed by trust practitioners, and three by externally commissioned reviewers.

Our findings

All investigators had involved the relatives of the patient, provided appropriate support and included their questions in the terms of reference. They included action plans for improvement which were monitored at care group level.

The themes from these incidents mirrored those present in other cases and included, risk assessment(s) and record keeping. Practitioners not completing face to face assessments with patients was mentioned as a factor in some cases.

None of the incidents we reviewed had been completed within the trust's 60-day timescale.

The trust had followed the duty of candour legislation in two of these incidents, but this had not been conducted in three incidents. In the two where it was followed this was not done in a timely manner.

In cases where incidents had involved other organisations, there was no evidence in the reports that system wide learning had taken place.

There was a positive culture in the review of medicines incidents which allowed continual learning and development. There were systems were in place to ensure learning was shared.

The trust's mortality review process was in line with national guidance, but the trust was not acting in accordance with the process to ensure timely investigation and learn from unanticipated deaths.

Learning from deaths is an essential part of quality improvement work for organisations. Since September 2017, all Trusts in England have been required to have a process in place for mortality reviews, following the publication of the CQC review in December 2016, 'learning, candour and accountability: a review of the way Trusts review and investigate the deaths of patients in England' and the national guidance on learning from deaths published by the national quality board.

The trust's mortality review process was in line with national guidance.

The trust had established a mortality review group which met at least twice every three months.

The trust had implemented systems to identify and learn from unanticipated deaths although these systems did not ensure all deaths were reviewed in a timely manner.

The trust had a 'learning from deaths policy: the right thing to do (incorporating the protocol for reporting learning disability deaths to the learning disabilities mortality review (LeDeR) programme)' which was in date and was not due for review until December 2024.

Initial or more detailed reviews of death were determined by criteria set within this policy. Initial or more detailed reviews were to be carried out for all deaths involving people using the trust's inpatient services, people discharged from inpatient services within the month before their death, people with a learning disability, and people under the age of 64 using the trust's community services. The trust required 20% of community deaths to be reviewed for people 65-75 years old and 10% of deaths to be reviewed for people over 75 years old. The trust's policy allowed incidents to be exempted from the mortality review process if they were instead declared as serious incidents.

In May 2023, the trust had 57 deaths which required a more detailed (structured judgement) review and a backlog of 43 deaths still requiring initial assessment.

Our findings

The trust did not apply duty of candour correctly.

The trust had a duty of candour policy in place. The policy outlined that immediately, or as soon as reasonably practicable after a notifiable safety incident the appropriate person must:

- notify the relevant person, say you are sorry, give an account of what has happened, an apology, offer a written notification and provide reasonable support.

The trust told us that its failure to act in accordance with the duty of candour in all cases was due in part to the serious incident backlog was preventing investigation prior to using the duty of candour. This is not in line with the requirements of the regulation which requires providers to act in accordance with the duty of candour without delay.

The trust's governance team told us that they were aware of this long-standing issue and felt that the issue was related to the quality of staff recording their compliance with the duty of candour. The trust had commissioned external partners to conduct listening reviews to analyse the understanding of duty of candour in services. This work suggested an internal review of compliance with the duty of candour policy.

The trust did not meet access and waiting time standards.

Several of the trust's services had waiting lists due to increasing demand for services. Leaders were sighted on risks and various programmes of work were in place to make improvements and reduce risk to people waiting for services.

The trust banded waiting times into:

- wait for first contact; wait for a first successful direct contact from journey start to assessment.
- wait for second contact; wait for a second successful direct contact from journey start to treatment.

NHS England currently publishes access and waiting time metrics for three mental health pathways:

- NHS talking therapies, for anxiety and depression. By March 2016, 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.
- children and young people with an eating disorder. Treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.
- early intervention in psychosis. 60% of people experiencing first episode psychosis should commence a package of care within two weeks of referral.

The trust had 4727 people waiting for first contact with community services with 140 people waiting more than one year, 908 people waiting 3-6 months, 362 people waiting 6-9 months and 146 people waiting 9-12 months.

There were long waits for first contact with child and adolescent mental health services (CAMHS). 2257 children and young people were awaiting first contact, 5 of these people were waiting for eating disorder services. 625 young people were awaiting a service from another CAMHS services. However, there was no one waiting for the CAMHS crisis service there were only 8 people waiting for more than 3 months.

Our findings

1627 young people were awaiting first contact with one of the thrust's three neurodevelopmental assessment teams and 136 of these young people had waited longer than 12 months for first contact. The trust told us that there had been a 300% increase in referrals to this service. There had been two system-wide meetings in May 2023 to draft an options appraisal to agree what steps were most appropriate to reduce the waits with options presented at the delivery impact and assurance group by the integrated care board on 08 June 2023.

1535 people were waiting for support from community mental health services for older people, with four people waiting longer than a year for the Harrogate memory team which had 377 people waiting for first contact.

There was not always a joined up whole trust approach to community services. The trust's locality model introduced inequity in service provision which meant some patients had better access to services than others depending on where they lived. The Harrogate memory team had a waiting list of 377 people whilst the Hambleton and Richmond team had 137 people waiting.

Waiting lists for second contact were more significant with 7017 people waiting for their second contact. 1314 people had been waiting for more than one year with 2864 people waiting for child and adolescent mental health services.

- The trust told us that several actions were in place to improve access to services and reduce waiting lists. These included enhanced monitoring and challenge of performance in relation to waiting times, regular contact with people waiting to access services and pilot programmes in specific services aimed at reducing waits for services with increased demand.

The trust had not managed and mitigated all environmental estates risks.

The trust's inpatient estate continued to present environmental challenges which were a risk to quality and safety. During our core service inspections, we found a number of estates related issues which included:

- the mixed sex accommodation psychiatric intensive care unit at West Park hospital was not conducive to ensuring the privacy and dignity of patients.
- some wards had blind spots which made staff observation difficult and reduced patient safety.
- a number of seclusion rooms were closed during our visits due to the need for refurbishment.
- some inpatient wards continued to have ligature points awaiting removal or rectification.

The trust had ongoing estates plans in place to reduce and mitigate risk which included a door replacement programme and a programme of renovation at Roseberry Park Hospital.

The trust had an infection prevention and control lead in post and the draft infection prevention and control board assurance framework was last reviewed in March 2023. The framework reported that the trust was compliant with 43 key lines of enquiry, partially compliant with 8 and non-compliant in 2 areas. Actions were overseen by the infection prevention and control committee.

Following the sad deaths of three young people (aged 17-18 years) whilst in the care of the trust's inpatient services between June 2019 and August 2020, NHS England commissioned an independent investigation which was carried out by an independent investigator.

Our findings

The reports into the three individual deaths have been published, with a fourth report into the governance arrangements at the trust at the time of these incidents published in March 2023.

The reports made ten recommendations and the trust had published actions against each recommendation.

The trust had not formulated an action plan in response to the recommendations, with action owners or timescales for actions. Whilst there was some progress against the ten recommendations, there was more to do to fully embed and sustain improvements. Areas identified during the inspection as requiring further action included management of risk, compliance with the duty of candour, management of complaints and risk escalation to the board through the integrated performance report. The trust had successfully implemented improvements to safeguarding processes, organisational structures and governance in frontline services.

The trusts had a west lane programme board which met in August 2022, October 2022 and March 2023. We reviewed the minutes of the most recent board meeting and found that the trust planned to close the programme board.

The trust had processes in place to monitor the number of delayed transfers of care and to work with partners to reduce these.

Between 1 April 2022 and 31 March 2023 218 patients had delayed transfers of care. Patients most effected by delayed discharges were using; wards for older people (Springwood, Wold View and Moor Croft), acute wards (Tunstall, Ebor, Willow and Maple) wards for people with a learning disability and autism (Bankfields Court).

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams did not always act on results to make improvements where needed.

There was systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.

The trust had a clinical audit programme, quality assurance programme and infection prevention and control audit programme in place with planned dates for audits throughout the year. Infection prevention and control audits included inpatient wards, community settings and prisons.

Clinical audits were both national and trust wide audits and included but were not limited to:

- national clinical audit of psychosis (NCAP) early intervention and prevention 23/24 re-audit.
- clinical audit of medical emergencies in eating disorders.
- clinical audit of GP communication – discharge letters.
- positive and safe audit.
- clinical re-audit of manual handling of people.
- clinical audit of emergency equipment.
- clinical re-audit of venous thromboembolism (VTE).
- improving physical healthcare to reduce premature mortality in people with severe mental illness: cardio metabolic assessment and treatment.

Our findings

- POMH Topic 22a: use of anticholinergic (antimuscarinic) medicines in old age mental health services.

Audits were conducted and reports overseen by the audit and risk committee in conjunction with the agreed audit cycle. All other committees saw audits relevant to their work. The chair of the audit committee told us that audit was an iterative process in the trust and the programme was flexible to undertake audits in line with new risks and priorities.

Quality assurance programme audits did not always show improvements and themes from audits were repeated in ongoing incidents.

In July 2022's thematic review of incidents, the trust recorded that only 61% of patient records indicated that a patient had a mental health state examination prior to leave from the ward. Only 80% of records evidenced what actions should be taken if a patient failed to return to the ward following leave. In early 2023, a serious incident was declared, and immediate learning was that the patient's leave was not appropriately managed, and risk assessed. During our inspection of acute wards and psychiatric intensive care units, we found ongoing issues with the safe management of leave. This evidenced that the trust's processes for learning and improvement was not consistently resulting in robust, embedded and sustained improvement.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. There were arrangements for identifying, recording and managing risks, issues and mitigating actions. However, the trust's risk management processes had missed potential early warning signs of poor-quality care in frontline services.

In September 2022, the trust's revised organisational risk management was published. The trust was in the process of aligning and embedding the revised risk management framework.

The trust had a board assurance framework which was reviewed and assessed regularly at board meetings and by committees. It was in line with national standards.

The trust had 14 risks entered onto its board assurance framework, 11 were noted as high and 3 as moderate risks as follows:

- recruitment (high). Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality / safe services.
- demand (high). Demand for our services, particularly due to the post covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements.
- involvement and engagement (moderate). A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience.
- experience (high). We might not always provide a good enough experience for those who use services.
- staff retention (high). Multiple factors contribute to staff leaving the trust, undermining the provision of safe and sustainable services.
- safety (high). Failure to effectively undertaken and embed learning could result in repeated serious incidents.
- infrastructure (moderate). Poor quality physical or digital infrastructure could impede ability to co-create a great experience.
- cyber security (high). A successful cyber attack could compromise patient safety.

- regulatory action (high). Further regulatory action could result in loss of confidence and affect reputation.
- influence (moderate). Changes in the external environment, and insufficient capacity to respond to or align with our objectives with those of partners might lead to loss of strategic influence and reputation.
- governance and assurance (high). The absence of a clear line of sight from ward to board, due to ineffective governance and assurance processes could result in the inconsistent quality of services and increased risk to patients.
- Roseberry park (high). The necessary programme of works and Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing.
- West Lane (high). The outcome of the independent enquiry, coroner's investigations and civil legal actions could affect our reputational and regulatory standing if the Trust is not able to demonstrate the necessary improvements and approach.
- CITO (high). Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff.

The board assurance framework outlined controls in place for each risk, to mitigate and reduce them with clear actions to be undertaken and ownership by committees and the executive team.

The trust had an organisational risk management policy. Risk escalation and review followed a clear governance process with all new risks being reviewed at the local service improvement and development groups and care group risk groups, prior to inclusion in care group board papers, and prior to any 15+ risks being reviewed at the trust wide executive risk group prior to entry onto the corporate risk register. We were able to follow the process of a new risk raised at service level through the governance process and into addition onto the corporate risk register.

The trust's corporate risk register detailed risks with scores higher than 15 and which had a wider trust impact or a direct impact on an objective. Local risks which were being adequately managed and actioned or risks which were an associated risk to a wider risk, already included on the corporate risk register, were not included.

As of 1 April 2023, the trust had 19 risks on the corporate risk register, risks included:

- estates concerns; risk of harm to patients by ligature, mixed sex accommodation
- recruitment in North Yorkshire for consultants
- digital infrastructure and cyber security
- bank and agency usage in ALD services
- waits for crisis line in York and North Yorkshire
- incident review backlogs
- national shortage of LD beds
- compliance with clinical supervision
- access to MHSOP beds in North Yorkshire and York
- documentation in secure services
- the commence of the trust's contract in HMP Hull and Humber
- liaison services in tees

Our findings

- waits for neurodevelopmental assessment
- waits in Durham and Tees Valley children's services
- compliance with positive and safe training
- reduced capacity in the pharmacy leadership team
- medical devices monitoring

All risks were linked to the board assurance framework and were aligned to committees with an executive lead. Risks had appropriate controls in place to reduce or mitigate them.

There were several risks which had remained on the corporate risk register for long lengths of time. For example, long waits for calls to the crisis service in York and North Yorkshire was entered onto the risk register in July 2021 and the concern relating to bank and agency usage in learning disability services was entered in June 2021 with the risk relating to the recruitment of consultants entered in October 2020. This meant that we were not assured that risks were being mitigated and removed with enough pace in resolving key issues.

We saw that the risk registers and key risk issues matched those that staff told us when we inspected core services.

The pharmacy risk register was reviewed by the senior leadership team within the pharmacy. The chief pharmacist knew who to escalate risks to and told us that clear lines of escalation would be in place once governance meetings were embedded following the trust review.

The trust's risk management processes had missed potential early warning signs in frontline services which meant not all risks identified by the inspection had been identified through the trust's internal processes. These included:

- restraint and mechanical restraint and prone restraint
- absent from leave / use of leave plans
- learning from serious incidents, seven key themes
- services in business continuity

NHSE undertook a financial assessment as part of our inspection and reported that:

- the trust met its financial plan for 2022/23 and was planning to breakeven in 2023/24. Achievement of these targets was indicative of effective processes for managing risks and delivering target performance. NHSE told us that the organisational structure supported delivery of plans as demonstrated by the financial overperformance in 2022/23 and plan for 2023/24.
- Senior leaders were experienced and qualified to manage the trust's finances. The executive director of finance was appointed in October 2020 and had held senior finance roles in the NHS with over 30 years' NHS experience across commissioning, community and mental health provider organisations. The Trust Chair was a qualified accountant and auditor with 36 years of experience in NHS and local government. The Board had responsibility for overseeing and assuring financial performance at monthly Board meetings. The Strategy and Resources Committee, on behalf of the Board, oversees the stewardship of the Trust's finances and investments.
- In 2022/23 the Trust delivered a surplus of £1.208m, which was marginally ahead of the planned £1.160m surplus. For 2023/24, the Trust had submitted a financial plan to breakeven. Initially the 2023/24 plan was a deficit of £12.7m, but the Trust have worked closely with the ICB and the wider system to reduce this to breakeven.

Our findings

- The trust had operated at a surplus historically. However, the underlying financial position of the Trust had shown deterioration and has moved from a planned underlying deficit of £24.4m in 2022/23 to £39.7m in 2023/24.
- The trust's financial risks included a significant increase in the need for agency staffing between 2020/21 (£8.4m) and 2022/23 (£20.7m). Spend in 2022/23 represented 5.2% of the total staffing bill. There are plans for this to reduce marginally in 2023/24 to £19.6m, however the continued reliance on agency staffing is a key concern.
- Financial information was provided to NHSE regularly and on time. The Trust openly communicated with NHSE on financial issues.
- The trust meets regularly with the NHSE Head of Locality Finance and flags any emerging issues or queries as and when they arise.
- NHSE is not aware of any concerns regarding the validity of reported financial data.
- The trust is engaged with peers in providing support to the local system (ICS) across a variety of areas where improvement is required: financial, operational and quality.
- The trust attends regional network improvement events and other leadership and financial events, such as those held by the Healthcare for Financial Management Association (HFMA) and any NHSE specific events

The trust ensured that potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.

When considering developments to services or efficiency changes, the trust monitored and assessed the impact on quality and sustainability.

A key challenge for the Trust in 2023/24 was to fully deliver the cost improvement programme which requires £20.8m of efficiencies to be delivered. The trust met the cost improvement programme for 2022/23, however this was at a value of £13.7m and an under delivery of recurrent cost improvement programme of £2.3m was offset by an over achievement of non-recurrent cost improvement programme.

Quality impact assessments required sign-off by the medical director and director of nursing for all cost improvement schemes. This was to assess the impact they would have on clinical performance and patient care.

Information Management

The trust did not have effective systems to consistently collate, analyse and present information about quality and performance in a way that identified risks and challenges, or supported effective decision making. However, the trust was making significant improvements to patient records in frontline services.

The trust had a range of quantitative and qualitative data and information to monitor and measure quality and performance. However, it was not always possible to obtain one clear version of data and/or information.

Information came from a variety of sources and was delivered to a variety of different groups and committees, and it was difficult to understand the narrative. For example it was difficult to obtain a clear picture of staffing, mandatory training and serious incident data for the inspection.

Information technology systems were being improved systems and staff had access to the IT equipment and systems needed to do their work.

Our findings

Staff told us that they had sufficient access to information, some staff told us of issues with connectivity.

The trust was bringing a refreshed electronic patient record system into services in 2023. The transition was well planned with an appropriate programme board and support for staff with emergency preparedness plans in place. The refreshed system would allow better recording processes and more seamless management of information and data.

The system was co-created with clinical staff to ensure it had the appropriate functionality and was clinically focused, service users and carers had also been involved in user testing to ensure the system was patient, not service centred.

To ensure safe implementation of the new system, the trust had rotas in place to manage the service desk as close to 24 hours per day as possible, with floorwalkers in place to support clinical staff and one person in each team as a nominated champion or lead, there was also a strategic and clinical implementation cell in place.

The trust had an experienced chief information officer who was also the deputy senior information risk owner. The chief information officer chaired the digital performance group which was a sub group of the executive group and its terms of reference included monitoring digital key performance indicators such as service times and digital service desk responsiveness, they also monitored and mitigated risks and fed into the digital programme board.

The trust's digital challenges related to implementation of the new system, cyber security risks and the costs of enhanced cyber security. The trust was also challenged by community information technology infrastructure because teams worked with two integrated care systems, to mitigate risks they worked closely with partner organisations and met regularly with colleagues from NHSE.

The trust was working with the integrated care board on the Great North Care record which they hoped would lead to integrated electronic patient record systems in the longer term and had plans to build upon relationships with partners in primary care to improve digital integration between care providers.

The trust had implemented infra-red systems on some wards following serious incidents to enhance the oversight of staff when observing patients. The system had been designed specifically for mental health care and included a regulated medical device which operated with an infrared-sensitive camera. It helped staff visually confirm a patient is safe and measured their pulse and breathing rate without disturbing their sleep. The Trust had worked with patients to develop patient information on this technology and had a standard operating protocol in place however, the Trusts website did not contain any information about the use of this technology for patients and relatives and there was not a policy in place.

The trust had a team in place to begin the implementation of electronic prescribing and medicines administration systems. This was the start of a programme of digital advances for the trust which were supported by the pharmacy team.

There were effective arrangements in place to ensure that data or notifications were submitted to external bodies as required.

Information governance systems were in place including confidentiality of patient records.

The executive director of finance, information and estates was the senior information risk owner (siro) the executive board member with allocated lead responsibility for the organisations information risks and provides the focus for the management of information risk at board level.

Our findings

The executive medical director was the caldicott guardian. The trust had appropriate procedures in place for the management of general data protection regulations which included the use of data protection impact assessments to identify and reduce risk.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives

The trust ensured that people's views and experiences were gathered and acted on to shape and improve the services and culture.

The trust was committed to engagement with partners and stakeholders and co-creation was a key part of the trust's 'our journey to change' strategy. There were several ways in which the trust was engaging with its communities including establishing co-creation boards across both care groups. The trust described these as; made up of service users and carers and staff, who will work alongside the care group boards. The trust had a patient experience and involvement lead in post who was delivering on a variety of co-creation projects.

The Trust's friends and family test information showed that in March 2023, 91% of patients and 97% and carers responding to the test, reported their experience as very good or good. There had been improvements in the total number of responses the trust received across the two care groups. The Trust regularly scored between 91-94% which exceeding national targets of 87%.

The trust did not always ensure they reached out appropriately to build and repair relationships with service users and carers and staff who had been in receipt of poor care or treatment.

The trust had written to all families and service users impacted by the delay in serious incident investigations in June 2023, but this should have occurred much sooner. The trust's duty of candour process was not effective, and complaints, disciplinary and grievance responses and actions were not always completed within a reasonable timescale. We spoke with service users and carers who told us that the trust had not engaged well with them following a poor experience.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.

There were mainly positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.

The trust engaged well with stakeholders and partners. The trust was a partner in several system wide groups included but not limited to the Teesside mental health alliance and County Durham and Darlington partnership board. In North Yorkshire they were a partner in the mental health learning disability and autism partnership board.

There was transparency and openness with all stakeholders about performance.

Our findings

NHS England's system oversight framework placed the trust in segment 3. This meant that NHS England and NHS Improvement regional teams worked collaboratively with the trust to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved. Through this, they aimed to better understand their support needs and agree improvement actions. The trust was open and transparent in this process and attended regular quality board meetings with NHSE, CQC and other stakeholders to support their improvement journey.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects.

Leaders and staff strived for continuous learning, improvement, and innovation this included participating in and leading research projects and were part of recognised accreditation schemes.

The trust had received 7 accreditations across 10 of its services:

- association of family therapy and systemic practice; trust wide.
- memory services national accreditation programme; Harrogate and District and Hambleton and Richmond memory services.
- electro-convulsive therapy accreditation service; Ryedale suite ,Roseberry Park Hospital and Needham suite Foss Park Hospital.
- home treatment accreditation scheme: York and Scarborough crisis and home based treatment team.
- accreditation programme for psychological therapies services; Durham talking changes service.
- perinatal quality network; Tees perinatal mental health team
- forensic quality network; Ridgeway

The trust was actively participating in clinical research studies.

The trust had a research and development plan in place for 2021-2026 which had been developed in collaboration with stakeholders and staff and in line with the trust's strategic objectives.

In 2022-2023 the trust had recruited a total of 757 participants to 32 research studies. Nationally, out of 46 mental health Trusts, the trust place 13th for number of recruits and 11th for number of studies. Through a combination of grant funding, income from the National Institute for Health and Care Research clinical research network and direct study payments, 92% of the Trust's research and development income was externally generated.

The trust acted as research site and as a participation identification centre and sponsored research into three grant funded national institute for health and care research multi-centre studies:

- community-based behavioural activation training for depression in adolescents (COMBAT).
- multiple conditions in older adults (MODS WP3&4).
- screening for depression in patients aged 65 years and older, who are living in the community (Cascade).

As part of this role, the trust's research and development team were actively engaged in activities such as site set-up and green light activation, risk review and monitoring, recruitment tracking and trial management group attendance.

The trust had a research leader for each speciality who regularly presented updates about research studies. This included adult mental health, mental health services for older people, parkinsons disease, forensics, children and young people, learning disabilities, people and culture, commercial studies and workforce development. The research leads also disseminated information via the trust's 96 'research champions'. The research champions helped encourage and facilitate staff member/department engagement in research opportunities.

The trust had a research governance group which met quarterly to oversee research activity including safety and performance and reported twice per year to the quality assurance committee.

The trust worked in partnership with primary care services and other NHS trusts to provide a regional approach to enable research access for research participants.

Staff in the research team worked with clinical teams to identify people eligible for research studies. This was through direct referrals from clinicians or by screening electronic health records. Patients and carers were approached directly to discuss research opportunities, and this was outlined in the trust's privacy notice.

The trust told us that they were working to further embed research into clinical pathways. For example, with dementia clinicians discussing research as an option with patients and providing information about how to sign up to the 'join dementia research register'.

Posters and leaflets were in clinical areas to provide further information for people attending appointments. The trust had also built research into the new patient record system to enable prompts to routinely ask patients about their interest in participating in research.

There were organisational systems to support improvement and innovation work. Staff had training in improvement methodologies and used standard tools and methods.

The trust had a strong and effective approach to quality improvement. A strategic lead for quality improvement was in post and leading 12 quality improvement team members supported by an associate director and two managers who linked directly into each care group with two administrative staff. The team focussed on supporting teams across the trust in quality improvement projects and delivering training in the trust's quality improvement approach.

The trust's priority for quality improvement was building capacity and capability into the organisation with an effective quality improvement learning and development programme. The trust had a stepped approach to training in quality improvement for all staff which included key performance indicators to drive learning and development.

Quality improvement leaders attended committees and sub-groups and told us that 70% of their projects came from those direct links and conversations into care groups to problem solve using the quality improvement methodology.

The quality improvement team had led on a number of areas of work in 2021-2023 which included;

- the trust vaccination centre
- review of governance framework in the Durham and Tees Valley care group
- physical health monitoring for adult learning disability service users in North Yorkshire and York
- lateral flow kit distribution – planning and deployment using a QI Approach

- purposeful inpatient admissions

The team were embedded in all aspects of improvement, this included working on the implementation of the revised patient safety incident framework and supporting the review of the human resources and complaints processes.

The strategic lead told us that the board and chief executive were strong advocates for quality improvement and had attended training to strengthen their own development.

The trust continued with their work on their community transformation programme in line with NHS England's Community Mental Health Framework which describes how the Long-Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. The trust had programmes in place in three geographical areas; North Yorkshire and York, County Durham and Tees Valley.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Oct 2023	Good ➔➔ Oct 2023	Good ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Oct 2023	Good ➔➔ Oct 2023	Good ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
367 Thornaby Road	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022
Jubilee House	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Overall trust	Requires Improvement ➔➔ Oct 2023	Good ➔➔ Oct 2023	Good ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023	Requires Improvement ➔➔ Oct 2023

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

Rating for 367 Thornaby Road

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022

Rating for Jubilee House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement → ← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023
Wards for older people with mental health problems	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

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

Wards for older people with mental health problems

Good ↑

Is the service safe?

Requires Improvement →←

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose apart from two wards where we had concerns about the layout.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. This assessment was carried out routinely and the results were displayed for staff to read. Each ward was also monitored throughout each day to ensure that areas were safe.

Staff could observe patients in all parts of most wards. On one ward we noted that there were blind spots where staff could not easily observe patients. We pointed this out to staff during our visit and a plan was put in place to ensure that this was rectified.

The ward complied with guidance on mixed sex accommodation. The majority of the wards were set up to accommodate a mix of male and female patients. Where this was the case, all wards had designated areas for male and female patients to sleep. Rooms were en-suite or setup in a way where male patients didn't have to pass female bedrooms to access bathrooms. There were designated female lounges and staff managed the flow of patients well to ensure that they remained safe. For example, staff had set up observation stations at points in the wards that had been assessed as potentially higher risk.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Each ward had an accessible ligature assessment available for staff and displayed simple maps for staff to be able to locate the most common ligature anchor points.

Staff had easy access to alarms and patients had easy access to nurse call systems. During our visits we observed patients and staff make use of alarms to alert staff and saw staff quickly responding where needed.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. However, we had concerns about the number of bathrooms that were available on one of the wards. On Roseberry ward, there were only 2 bathrooms for patients to use, 1 male bathroom with a bath and a shower and 1 female bathroom with a bath and a shower. Four of the female bedrooms did have their own toilet and basin but no bathing area. At the time of inspection 7 males shared the male bathroom and 7 females shared the female bathroom. Two of the bedrooms on the ward could be changed to female bedrooms and if this was done, there would be 9 females sharing one bathroom. National guidance states that there should be at least one bathroom for every three patients. We spoke to the trust about this and they explained that this issue would be addressed as part of future service redevelopments and that currently patients appeared to be satisfied with the availability of toilets. None of the patients we spoke to said that this was a problem.

Staff made sure cleaning records were up-to-date and the premises were clean. It was clear that staff took pride in keeping the environment cleaned to a high standard.

Staff followed infection control policy, including handwashing. Those that wanted to, could wear masks and they were available for all staff and visitors should they be required. There were sufficient supplies of hand sanitiser throughout the wards.

Seclusion room

None of the wards for older people had a seclusion room, patients on these wards were never secluded. The elimination of the use of seclusion addressed the previous must-do action.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. There was a range of equipment available to support patients with mobility issues and other physical health difficulties.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the patients, however they had not received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staff and patients gave positive feedback about the amounts of staff that were on the wards, they said they could always get the support they required when they needed it. The service employed 299 staff and between 1 April 2022 and 31 March 2023, there had been 23 staff leavers giving an average staff turnover of 8%.

The service had variable vacancy rates. Data showed that the trust employed more than their budgeted number of nursing staff by 8 staff across the service. However there remained 4 vacancies in Westerdale North and 14 in Westerdale South and 4 at Wold view.

The service had low rates of bank and agency nursing staff. When they used agency staff, they were usually well known to the wards they were working on, and managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The ward operated on established staffing levels and sometimes used bank and agency staff to ensure that increased levels of patient's observations could be maintained.

Levels of sickness varied across all the wards from between 4% to 16%. Sickness rates were highest at Wold View and Westerdale North. Managers supported staff who needed time off for ill health. Staff gave us examples of ways in which they were supported by their managers when they were not well.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers could easily deploy more staff where they were required, if necessary, at short notice.

Patients had regular one- to-one sessions with their named nurse. Those patients that required this input were well engaged with their staff team and stated that they could speak to their named nurse on a regular basis, and this was included as part of the regular multi-disciplinary team meetings and input into the development of their care plans.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. On the rare times that leave or activities were cancelled an alternative was always offered or rearranged as soon as it could be.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. We examined several handover documents, and they showed a useful exchange of information was taking place between shifts. Staff that we spoke to knew patients well and could tell us about each patients risks and how to manage them.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had an on-call system in place and staff told us that this system was effective for them to receive support where it was needed.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had not completed and kept up-to-date with all of their mandatory training.

The mandatory training programme was comprehensive but because of the availability of places on specific courses it did not meet the needs of patients and staff. Across all wards 58% of staff that required it had completed manual handling training, 77% had completed managing violence and aggression training and 74% had completed basic life support training.

As part of the inspection, we asked for the trust to assure us that the impact of low compliance was mitigated and they were able to show us that they could provide suitable numbers of staff on each shift for them to operate safely.

Managers monitored mandatory training and alerted staff when they needed to update their training, but they told us that the availability of training was poor and that it was sometimes cancelled. This meant that there was a backlog in staff accessing the necessary training requirements.

Assessing and managing risk to patients and staff

We looked at 31 care records across all wards. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. There was evidence that of the 31 records we reviewed, 2 specific risk assessments did not

fully reflect the patients' identified risks, but care and treatment was being delivered in a safe way for these patients. All other risk assessments were detailed and thorough and included specific sections relevant to each patient. Where a risk such as falls, self-harm, absconding or aggression was identified it was clear that these had been explored in more detail and where necessary specialist support was requested to develop risk management plans.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Risk management plans were completed where necessary and information on how to support patients was readily available for staff. Although the electronic records could be difficult to navigate, staff knew how to find all relevant information and paper copies of summaries were available for staff.

It was clear from talking to staff and patients that staff knew each patients risks and strategies to support them well. There were several well attended meetings across the working week to ensure that the necessary information was shared across teams, these included regular handovers, regular multi-disciplinary meetings and ward based reflective practice sessions.

It was clear that staff communicated well with each other to ensure that they all had the correct information to support each patient effectively.

Staff identified and responded to any changes in risks to, or posed by, patients. There was an electronic system that was used to report incidents and we were able to see where incidents had led to alterations in the way in which patients were supported, for example in the level of observation by staff of a patient may be increased. Handovers were also utilised to make sure that staff were informed of immediate changes to risks.

Staff followed procedures to minimise risks where they could not easily observe patients. Ward areas were routinely assessed to ensure that they were appropriate to the current level of acuity, for example areas could be either left open or locked depending on the levels of risk that patients posed. There were enough staff to supervise patients if they needed to use a space that would otherwise be unsafe to use alone.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Where this was necessary it was decided by the whole multi-disciplinary team.

Use of restrictive interventions

Levels of restrictive interventions were low, apart from on Oak ward.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards but not all staff had carried out the necessary refresher to ensure that their training was up to date. However, managers ensured that there were enough staff available at any one time to carry out any necessary restraints.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff displayed and described a good understanding of a least restrictive approach to supporting patients and the different ways in which different patients could be supported to facilitate this. However, on Oak ward there was a high use of rapid tranquilisation reported and on 3 occasions staff had used a prone restraint to administer this and had not recorded a satisfactory rationale for doing so.

Across the wards there had been one use of mechanical restraint. As a result of this incident being reviewed it had been highlighted as a lesson learnt and steps were taken to ensure that this practice was not repeated.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training, 94% were up to date.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records which were both paper-based and electronic.

Patient notes were comprehensive and all staff could access them effectively. A small number of staff told us that the electronic system used to store care records was slow and that the internet connection sometimes failed. However, staff had printed paper copies of the latest records to mitigate this risk.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records. The whole organisation used the same system so records could easily be shared and there were useful relationships with other organisations to ensure smooth transition of information when patients were transferred out of the organisation.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. There were systems in place for staff to obtain medicines prescribed including if these were needed in an emergency or out of hours. Staff stored and managed medicines and prescribing documents securely however on two sites we found that oxygen cylinders were not always stored in line with policy.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff were visible on wards and attended multidisciplinary meetings. Patients and families could speak with pharmacy staff regarding their medicines, and we saw examples of when this had been utilised. Where people were prescribed medicines to be administered covertly (hidden in food or drink) we saw that plans were in place to aid staff to administer these medicines safely and these were reviewed to ensure they were up to date.

Staff completed medicines records accurately and kept them up to date. All administration charts we looked at were signed and dated in line with policy. Controlled drugs were audited regularly, and registers were accurate. Temperature monitoring records were completed daily and were within range, where deviation had occurred actions had been taken. Checks of emergency equipment had been completed regularly.

NHS primary care prescriptions (FP10) were available and there was a process to review their use, however, we saw on one ward that an audit had not been completed that was required to check compliance with the policy. This was actioned during the inspection.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation was completed in a timely manner. On one of the sites we visited, the pharmacy service had initiated a discharge medicines process, this ensured that when patients were discharged the GP and community mental health teams were contacted by pharmacy to discuss the patients ongoing medicines needs.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Regular pharmacy led reviews were documented on the medicine's charts however on some wards there was a lack of clear guidance for staff to support them in offering an alternative if a patients refused their first choice of medication.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We found that for patients prescribed medicines that required monitoring, for example diabetes, clozapine or lithium, regular reviews were carried out and monitoring was documented.

Track record on safety

The service did not have a good recent track record on safety. They had reported 13 serious incidents over the last 12 months.

There had been two serious incidents in the service which occurred in February and March 2023. One of these incidents related to a patient who was able to tie a ligature. Staff we spoke with were aware of the incident and told us about the support they had received since this sad incident and learning taking place across the service relating to the measurement of risk.

The trust had also made some rapid improvements since this incident which included a review of the resuscitation response. The trust were continuing to roll out the installation of door sensors and Oxehealth equipment to further reduce and mitigate risk.

A further unexpected death had occurred of an informal patient on time away from the ward to their own home from Moorcroft ward in York. We were concerned that during this patient's first episode of home leave for the weekend, staff had not made direct contact with them. This incident was still under investigation by the trust at the time of the inspection. However, we did not identify further concerns about the management of leave during the inspection and found that patients had leave plans, including section 17 leave, located in their records.

Wards for older people with mental health problems

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff had access to an electronic system which they used to report, track and learn from incidents. Staff were able to talk confidently about what types of things they would be expected to report and knew how to do so.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. Staff told us that the way in which incidents were reviewed had been much improved recently. A local manager was now giving staff feedback once they submitted an incident, this meant that it happened more quickly and was carried out by someone that knew the staff members involved and could therefore tailor feedback to make it more useful.

Staff told us about the communication and bulletins that they received from the trust in relation to incidents that occur throughout their services. There was clearly effort being made to ensure that learning was disseminated as widely as it could be.

There was evidence that changes had been made as a result of feedback. We saw several examples of care plans and risk management plans that had altered as a result of feedback from incidents, showing that staff were altering their approach as a result of learning that had taken place following incidents. For example, through learning from incidents, wards had implemented new zonal observation stations at strategic locations on each ward to help ensure that staff are in the right places to deal with potential incidents. Staff are also using these observation stations to engage patients in activities and tasks to keep them occupied and stimulated.

Staff held a range of different meetings throughout the week which gave different disciplines and grades of staff the opportunity to come together. We observed a number of these meetings, and we were impressed by the quality of the discussions that were taking place. It was clear that there was an open and transparent approach to patient care and that each team member played an important role in that process.

The service had reported 13 serious incidents over the last 12 months, 7 of these incidents were patient falls.

The trust provided data which showed that between 1 April 2022 and 21 April 2023 886 falls had occurred on the wards. 596 were no harm incidents, 244 were low harm incidents, 37 were moderate harm and 9 were severe harm incidents. Most falls had taken on Wold View ward at Foss Park Hospital (212).

Staff were taking steps to ensure that falls were minimised and that when they did occur that staff handled them effectively. They were gathering and analysing data to help them ensure that all necessary steps were being taken to mitigate the risk of people falling. Through this work it had been identified that several incidents had occurred in a similar part of one ward. This gave staff the opportunity to look at how they managed this space and as a result they implemented a new observation point and made some changes to the ward décor to encourage other areas to be used and to ensure that suitable supervision was provided where it was needed.

Wards for older people with mental health problems

Managers debriefed and supported staff after any serious incident. Staff told us that they were well supported by their managers when serious incidents occurred. They told us that there was always the opportunity to take part in debriefs and reviews of incidents.

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Care records showed that staff had access to a useful amount of information to enable them to form initial assessments and risk management plans to ensure patients were treated safely and effectively.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff had access to a range of experts to support this process which included physical health nurses, dieticians, and doctors. Supporting patients to improve their physical health was seen as an important part of each patient's recovery.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. In most of the care plans that we looked at there was helpful detail to support each patient's recovery journey that was clearly linked to their individual and assessed needs. However, a small number of care plans we looked at contained only a limited amount of information. Staff told us that this was because the work that should be carried out on the ward was detailed within a booklet that each patient received, and more detailed plans would be developed as patients moved on to different wards or as they were required.

Staff regularly reviewed and updated care plans when patients' needs changed. There was evidence that care plans had been reviewed routinely and where significant changes had occurred. For example, as patients' treatment journeys moved towards their discharge there was evidence that this work became the focus of their care plans.

Care plans were personalised, holistic and recovery orientated. It was clear that the patient voice was captured within care plans and that they were written in collaboration with the patient and with the involvement of the wider multi-disciplinary team. Care plans covered a wide range of different areas of work, and this included how each patient would be ready for the next stage of their treatment, or discharge, where appropriate.

Best practice in treatment and care

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

Wards for older people with mental health problems

Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. Patients had access to a range of resources and specialist equipment such as gyms, walking aids, hoists, accessible baths and adjustable beds. The wards had a range of areas that patients could access to take part in activities, including arts and crafts, cooking, exercise and self-care and well-maintained outdoor spaces where patients could get involved in gardening if they wanted to.

All wards made use of Safewards the aim of this model was to minimise the number of situations in which conflict arises between healthcare workers and patients that lead to the use of coercive interventions such as restriction and/or containment. Safewards 10 core interventions were a key part of the Trusts overall strategy for reducing restrictive interventions. Staff that we spoke to were able to describe what the model was and how it impacted positively on the work they carried out. It was clear to the inspection team that the use of this model was having a positive impact on the experiences of patients.

Several of the wards were involved in a national pilot that had introduced an innovative therapeutic approach to the way in which they supported patients with dementia. This work involved staff tailoring some of the spaces they used to ensure that they met the sensory, emotional and spiritual needs of the patients that required it. Staff told us and we observed that this was helping them communicate and connect to patients that were finding it difficult to communicate with words. These wards had been shortlisted for a national award for this innovative work.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw the inclusion of dietitians and speech and language therapists where this input was required, and we observed staff following instructions and ensuring that patients' needs were being met. There was a range of alternative options available at mealtimes and there was a range of snacks available throughout the day which included healthy options.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff made use of display boards and information leaflets to give patients the opportunity to make informed choices on topics such as healthy eating, smoking, exercise and other activities which could help them live healthier lives.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the national early warning score to monitor if patients' health was deteriorating and they took necessary action when it was required.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Wards undertook monthly audits which looked at documentation and risk in general and used the results of these audits to improve the quality of their work. We were told about a piece of work that looked at how staff monitored those people waiting for treatment and how they used good practice from a different part of the trust to improve their own practice.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. These included mental health and physical health nurses, psychiatrists, physiotherapists, psychologists, dietitians, speech and language therapists, occupational therapists, activity coordinators, health care assistants and domestic staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. We spoke to a number of new staff and they told us that they were given a useful induction when they started work on the wards and they said that managers and staff worked hard to ensure they were well supported before taking on tasks. The trust had also developed a checklist that they could use to ensure that agency staff were given a clear induction before they were expected to work on a ward.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff from a range of different disciplines were given the time and space to come together as a team in several different ways. There were regular patient focussed meetings on each ward where staff could share information about how they supported each patient. Staff told us that they had the opportunity to attend regular staff meetings and that minutes from these meetings were stored and circulated amongst those that couldn't attend. We also saw examples of bulletins that were circulated to staff to ensure that they received necessary updates, such as any emerging risks or developments within the wider organisation.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Despite some of the mandatory training compliance being low, staff were given the opportunity to take part in a range of training sessions that were specific to their roles. For example, different elements of dementia care, end of life care, preventing and managing falls, dealing with challenging behaviour, nutrition support and tissue viability.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a number of these meetings across several different wards during our inspection and we found that the depth and quality of discussion to be of a high standard. We saw staff from all disciplines making contributions and we felt that the voice of the patient was always held in high regard.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We looked at examples of handover meeting notes and they were detailed, thorough and helped staff gain a good understanding of the current needs of each patient.

Ward teams had effective working relationships with other teams in the organisation. Staff were able to utilise the skills and work of other teams to ensure a better-quality service for the patients that they were supporting. Staff displayed a good understanding of the work of the rest of the organisation and how and when they might utilise them.

Wards for older people with mental health problems

Ward teams had effective working relationships with external teams and organisations. We observed records of good communication taking place with external service providers to support the process of discharging patients onto new placements. Although there were a small number of patients that had their discharge delayed because of the availability of suitable alternatives, there was good communication taking place to try to resolve these issues as effectively as possible. We also observed one of the wards holding an open day for external providers which staff hoped would help strengthen this work.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. 90% of staff had completed training in this area.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. These staff carried out routine work to ensure that the care patients were given was in line with the Mental Health Act and the Code of Practice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. All wards had clear posters detailing who to contact and how to contact their advocates.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff and patients told us that on the rare occasion that leave could not be facilitated that an alternative was offered, or it was rearranged to a suitable time.

Staff were also making use of an extended period of section 17 leave prior to discharge to prepare patients and assess and identify any additional needs which would ensure the process was successful. The service employed a discharge coordinator who worked across the service to keep in touch with patients who were identified as suitable for the scheme. Staff ensure that detailed care plans, positive behaviour support plans and other necessary documents were provided as part of the discharge process.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Wards for older people with mental health problems

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. 89% of staff had completed training in this area.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff documented this clearly and frequently revisited decisions to recheck capacity. Staff displayed a good understanding of this process and made every effort to implement processes for the betterment of the patients journeys and experiences.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Where necessary and appropriate they included a family member, carer or advocate in this process.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

During this inspection we spoke to 12 patients, 7 carers and carried out 4 Short Observational Framework for Inspector observations and carried out other informal observations of care being delivered throughout the day.

Staff were discreet, respectful, and responsive when caring for patients. During our observations we noted a genuine and caring attitude towards patients from staff, it was clear that staff knew patients well and that they were working hard to ensure everybody's needs were met.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients that were able to be were engaged in conversations about their treatment and in the development of care plans and working towards discharge.

All patients said that staff treated them well and behaved kindly towards them. Patients told us that staff were often busy carrying out their duties, but that staff always had time to respond if they needed further support. Patients told us that staff made them feel safe and they were confident in the way in which staff would deal with difficult situations. Patients told us that it was very rare that staff would have to carry out physical interventions.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. We observed a strong culture of openness and support for staff by both managers and other staff. Staff told us that their managers were very approachable and spent time working on the wards.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff had developed a helpful admission pack which we saw them making use of during the inspection. The pack included a range of useful information to help a patient settle in to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. It was clear from records that patients that could contribute had been consulted in the development of care plans and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. There were some easy read displays, posters and leaflets available for patients to look at.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff gathered feedback from patients during their stay and at the point of discharge. Staff held regular meetings with patients where they could offer feedback and suggest changes. Staff told us that patients often gave feedback about food choices and that they used this feedback to develop the menu.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Families and carers told us that staff were very helpful and that they were pleased with the standard of care that was being offered to patients. They said that they were informed and involved when they needed to be and that staff could not do more to keep them updated.

Wards for older people with mental health problems

Staff helped families to give feedback on the service. Families and carers said that there was always the opportunity to speak to a member of staff to give feedback if they needed to. They said that they felt listened to and that their opinions were taken on board.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good  

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. We saw evidence within care records that discharge was an early consideration in a patient's treatment journey, as from the point of admission staff were looking at how to ensure the length of stay was as appropriate as it could be. Over the past 6 months, bed occupancy was 88% across all the wards.

The service had no out-of-area placements. The geographical footprint of the trust was large and this meant that sometimes patients were admitted far from their homes. The wards also offered different specifications, and this made the process of admission and discharge more complex. Staff were making effort to ensure that patients were moved closer to their homes whenever possible.

Managers and staff worked to make sure they did not discharge patients before they were ready. There was detailed discussion about readiness for discharge as part of the regular multi-disciplinary team meetings and care plans made it clear what steps needed to be achieved for discharge or transfer to be considered.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient and part of a defined pathway.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

The service employed a discharge coordinator to keep in touch with patients who were identified as suitable for the scheme. Staff ensured that detailed care plans, positive behaviour support plans other necessary documents were provided as part of the discharge process.

On one site the pharmacy service had initiated a discharge medicines process, this ensured that when patients were discharged the GP and community mental health teams were contacted by pharmacy to discuss the patients ongoing medicines needs.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. On all but one ward, each patient had an ensuite within their bedroom. There were quiet areas for privacy. The food was of good quality and patients could make or access hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Many patients had personalised their bedrooms with their own belongings such as photos.

Patients had a secure place to store personal possessions. Each bedroom had a safe or patients had access to a secure space.

Staff used a full range of rooms and equipment to support treatment and care. Bedrooms had a range of different facilities to support patients in different ways, for example, some had lifts and hoists so those that needed them could be accommodated safely. Shared bathrooms were equipped with accessible baths and there was enough space to ensure equipment could be used safely.

Each ward had a range of rooms to suit the needs of the patients that they admitted. These included one to one space, female only lounges, gyms and physiotherapy aids, relaxation rooms and arts and crafts. Staff had made efforts to create spaces that reflected places that people might visit in the community, such as a café and library.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private in their own rooms or using one of the quiet spaces. Those that did not have access to their own phone could use the ward phone to make calls.

The service had an outside space that patients could access easily. Each ward had access to a number of outside spaces which were extremely well looked after. These spaces were designed to make them easily observed so that patients could make use of them whenever they liked and if necessary to enjoy some time in the open air by themselves.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work where it was appropriate, and they supported patients into the community where it was needed. Sessions and activities on the wards were designed to keep patients stimulated and build and maintain their daily living skills.

Staff helped patients to stay in contact with families and carers. Those patients that needed it received support from staff to ensure that they kept in touch with families and carers. Staff took time to make phone calls on the behalf of patients and they made families and carers feel welcomed when they visited the wards.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards were dementia friendly and supported disabled patients. Several wards had also specifically been designed to ensure that they were dementia friendly, corridors were built as loops so that patients avoided walking down dead ends and potentially becoming distressed.

Staff had made sure that displays were dementia friendly colours where this was necessary, this followed national guidance.

All the wards had clear easy read signage to help people find their way around. Patients' bedrooms were identified by their own personal identification markers that they had chosen, for example with pictures or symbols of family members, hobbies or pets. Staff had also decorated the wards in a way which made different areas distinguishable from other areas, to avoid confusion. They had done this by using a range of different colours, murals and displays.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community if they were needed. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All the patients we spoke to said that they enjoyed the food and that there was a good choice. We saw a range of snacks and drinks available which included some healthy options. Access to hot drinks was mainly managed by staff due to the nature of many of the patients on the wards and the risks that this posed. However, where it was possible patients could make hot drinks for themselves.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and in receptions areas so that those visiting could see them.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. For example, we saw changes that had been made to the way meal times were arranged as a result of feedback from patients.

Wards for older people with mental health problems

Staff protected patients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care. We saw thank you cards that had been received from patients, families and carers and they were displayed for staff to see.

Is the service well-led?

Good  

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff we spoke to said that they valued their managers and said they spent time supporting them on the wards. The leaders that we spoke to clearly knew their staff and patient group well and had a good understanding of the work of their teams.

Staff also told us that they often saw and engaged with more senior leaders as they visited wards on a regular basis.

At our previous inspection of these services, we identified 9 breaches of regulation, all these breaches have been resolved and although we identified 2 new breaches of regulation it was clear that there had been considerable improvements made across all areas of work.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. Information about the trusts vision and values was displayed on notice boards.

Staff could describe how the work they carried out fitted in to the vision and values of the trust and it was clear to us that the vision and values meant had a positive impact on staff and the work they carried out. Managers set a good example and were open and committed to learning and continuous improvement.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

All the staff that we spoke to said they felt respected and valued by their managers and said they felt happy coming to work. They said they felt part of a team and the work that they carried out was important to them.

Staff could raise any concerns without fear, and they knew how to do so. Staff knew about the trust's whistleblowing policy and knew how to access the trust's freedom to speak up guardian.

Wards for older people with mental health problems

There was a positive culture amongst staff and managers, staff said that they appreciated the feedback that managers gave them and there were many opportunities for teams to come together to discuss practice, challenge each other and learn.

The trust had taken part in the 2022 NHS staff survey, each care group had an action plan in place to make improvements.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

We found that compliance on some areas of mandatory training was low, and a small number of prone restraints had been carried out without recording a suitable rational. However, there were effective systems and processes in place to assess and monitor work and to help make improvements where they were necessary.

Staff completed a variety of weekly and monthly audits that were reviewed by the managers and results from this work was shared across the wards and wider organisation to feed into an overall plan.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Risks to patients, staff and others were well managed within the teams. Managers regularly reviewed risk. Incidents were appropriately reported and investigated. The service had an up to date and detailed business continuity plan which fed into a trust wide plan.

Daily ward safety reviews were carried out to review known risks, identify any new risks and put appropriate control measures in place. Where it was necessary, managers were able to escalate risks to a register which led to increased scrutiny and monitoring.

Managers had regular meetings with each other to enable them to share information, discuss lessons learnt, good practice and to make decisions about what should be escalated to more senior staff within the organisation. There was evidence of a useful flow of information across the organisation,

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Patient information was stored on a secure electronic record system, which all staff could access. This system was used throughout the trust. However, some staff told us that this system was sometime slow or difficult to access. Where this was the case staff had made sure paper records were available.

Information governance and data security awareness were included in staff mandatory training. Compliance with information governance and data security training across the wards was 91.3%.

Wards for older people with mental health problems

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the population which it served.

Family members and carers told us managers and staff kept them up to date and communication was good.

Managers and staff engaged well with other healthcare professionals and had good links with partner agencies. These included social care, safeguarding and services that provided alternative placements for those that were seeking them.

Learning, continuous improvement and innovation

Staff and managers displayed a commitment to learning and continuous improvement. They made good use of their incident reporting system and data gathered was clearly being distributed across teams to ensure learning took place.

Several wards were participating in a national pilot to enable them to develop better communication and connection with people who lived with dementia. The trust had been commended for this work and had been shortlisted for a national award by the Royal College of Psychiatrists. This nomination outlined that the staff had demonstrated effective leadership and good teamwork, improved engagement of patients and carers and that there was evidence of improvement resulting from the team's work.

Staff were making use of an extended period of section 17 leave prior to discharge to prepare patients and assess and identify any additional needs which would ensure the process was successful. The service employed a discharge coordinator to keep in touch with patients who were identified as suitable for the scheme. Staff ensured that detailed care plans, positive behaviour support plans other necessary documents were provided as part of the discharge process.

Staff were also involved in a collaboration with several different institutions from across Europe. This enables them to share best practice and learn from the work being undertaken by the other organisations. Staff from the service had visited other countries to facilitate this process. Staff told us that this initiative was helping to motivate colleagues, build enthusiasm and develop their culture of continuous improvement.

Community mental health services for people with a learning disability or autism

Good ➔➔

Is the service safe?

Requires Improvement ➔

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

Safe and clean environment

All clinical premises where people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Environmental risk assessments were reviewed monthly, any environmental issues were raised with the estates team.

Staff had access to either personal alarms or alarms located within interview rooms. There were staff available on site to respond to alarms. Staff explained that they would be aware of any risks before appointments and would make the site team aware that support may be required.

All consultation rooms had the necessary equipment for people to have physical examinations. Sites also had a grab bag for conducting physical examinations off site. Staff told us that they regularly referred to the people GP for physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose.

Safe staffing

The service did not always have enough staff, who knew the people and received basic training to keep them safe from avoidable harm. The number of people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service did not always have enough nursing staff in all teams to keep people safe.

Managers used a recognised tool to calculate safe staffing levels. The number and grade of staff matched the provider's staffing plan. Service managers felt that the number of staff allocated to the team was enough for the work they were delivering.

The service employed 294 staff. Between 1 April 2022 and 31 March 2023, there had been 40 staff leavers, this was a turnover rate of 14%. There were 35 vacant posts, 6 were for allied health professionals and 20 were for nursing staff and 4 were for healthcare assistants. This was a vacancy rate of 12%.

The York team had recently had low staffing numbers, managers told us these vacancies were filled by members of other teams providing support.

Community mental health services for people with a learning disability or autism

Managers supported staff who needed time off for ill health. Service mangers informed us that sickness levels were low. Managers made arrangements to cover staff sickness and absence. Each team would support each other by providing cover in other teams when required. Sickness levels were variable across the service and were highest in

- South Tees community team (13%)
- Darlington community nursing (9%) additional clinical services (13%), allied health professionals (13%)
- Middlesborough day services nursing (14%) and additional clinical services (9%)

Service managers informed us that they did not use bank and agency staff to fill staffing vacancies.

Medical staff

The service had enough medical staff.

Each location had a dedicated psychiatrist and out of hours cover was provided by the local teams and the trusts on-call system.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

The service could get support from a psychiatrist quickly when they needed to. This included psychiatrists from different teams providing cover when necessary.

Mandatory training

Staff and managers believed compliance with mandatory training was above their target percentage. Staff, service manager and clinical leads told us about issues getting access to certain training modules. This was due to the number of courses available, and a number of courses being cancelled.

We requested the training data from the trust, they supplied training data for all adult learning disabilities services, the data includes inpatient data. Some modules fell significantly below the trust target of 90% these included.

For North Yorkshire, York and Selby

- Positive and Safe Care Level 1 Update (55.00%)
- Resuscitation - Level 2 - Adult Basic Life Support - 1 Year (40.00%)
- Face to Face Medication Assessment (62.50%)
- Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year (60.00%)
- Observation & Engagement (60.00%)
- Manual Handling People Part 1 (58.33%)
- Positive and Safe Care Level 2 (33.33%)
- Positive and Safe Care Level 2 Update (33.33%)

For Durham, Darlington and Tees

- Listen Up (50.46%)

- Positive and Safe Care Level 2 Update (59.64%)
- Positive and Safe Care Level 1 Update (42.62%)
- Resuscitation - Level 2 - Adult Basic Life Support - 1 Year (67.77%)
- Manual Handling People Part 1 Update (47.73%)
- Manual Handling People Part 2 Update (47.73%)
- Resuscitation - Level 1 - 1 Year (67.61%)

Staff told us that training sessions were taking place far away from where they were based. Managers had completed train the trainer training, so they were able to sign off certain modules.

The mandatory training programme was comprehensive and met the needs of people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Services kept local spreadsheets on the staff compliance and notified staff when their training was due.

Assessing and managing risk to people and staff

Staff assessed and managed risks to people and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with people and their families and carers to develop crisis plans. Staff monitored people on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident. Each patient had a safety plan and a safety summary in place, which was updated according to risk and changes in care. The 29 records we reviewed had an up-to-date safety plan and safety summary, with 3 having care act assessments. The Durham team, who were integrated with the local county council, used a different risk assessment tool called a care act assessment.

Management of patient risk

Staff continually monitored people on waiting lists for changes in their level of risk and responded when risk increased. Waiting lists were reviewed and discussed daily at the staff huddle. Staff had regular calls with people, and their carers if appropriate, on waiting lists to assess their level of risk had not changed.

All referrals had initial triage assessments with the appropriate clinician. Dependent upon the outcome of assessments, people triaged as routine would then aim to be seen within 28 days or within 48 hours for urgent referrals.

Staff attended daily huddles at each site where areas of risk were discussed including inpatient, people at risk of admission and people who did not attend appointments. Daily huddles also included reviews of initial assessments, new referrals, waiting lists, duty cover, open safeguarding, datix incidents, safety notices and items to raise to the trust wide quality meetings. These meetings also covered key messages from the trust, information for sharing and staff wellbeing check ins.

Staff followed clear personal safety protocols, including for lone working. All staff were aware of the lone working policy and could provide information on how the system worked.

Community mental health services for people with a learning disability or autism

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had access to Level 3 safeguarding children and safeguarding adults training. Eighty percent (80%) of staff in North Yorkshire, York and Selby had completed Level 3 Safeguarding training, in comparison to 84% of staff within Durham, Darlington and Tees.

The Trust had an up-to-date safeguarding policy in place, that staff could access via the intranet.

All staff we spoke with were able to give examples of safeguarding incidents and demonstrated a detailed knowledge of what constituted a safeguarding referral.

All current safeguarding referrals were discussed at the daily huddle meetings.

Staff were able to access guidance around safeguarding through the Trusts' safeguarding team. This team supported staff and provided feedback on safeguarding referrals.

Staff reported that when they referred a safeguarding directly to the local authority, they were not receiving feedback on the actions taken.

All staff received safeguarding supervision each month, to review all the safeguarding cases on their caseload.

Staff access to essential information

Staff kept detailed records of people' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. All patient's notes reviewed had comprehensive information on the patient. This included safety summaries and plans, care plans, details about the patient's physical health, capacity assessments and other as required assessment tools. All staff had access to the records system, staff in the Durham team had access to the trust's systems and the local county council systems.

When a location still had some paper notes, as a backup, these were stored securely in a locked room.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes to prescribe medicines safely and reviewed each patient's medicines regularly and provided advice to people and carers about their medicines.

Two teams stored medication on site, these medications were depot for people, depots are slow release antipsychotic medicine given by injection. We reviewed 5 medication charts they were all up to date and reviewed regularly. The rest of the teams did not store medication on site. If it was prescribed by the Doctor, this prescription was either written by the doctor on site or a request was made to the people GP to create the prescription.

Community mental health services for people with a learning disability or autism

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. As well as working towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). Each service had information in the reception area regarding STOMP.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance, although this monitoring tended to sit with the patient's GP. Administrators at the service kept a record of all people prescribed anti-psychotic medication and would tell staff when they were due for blood tests, health checks and reviews.

The service had conducted an away day with staff to explore how they could improve the monitoring of patient's physical health in the organisation. All staff informed us of this away day and the learning that had occurred.

Track record on safety

The service had a good track record on safety.

The service had reported no serious incidents between 1 April 2022 and 30 May 2023

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff we spoke with were aware of how to report incidents through the incident database, Datix. All staff had access to Datix and were able to raise any incidents. Incidents submitted to Datix were discussed every day at the huddles and lessons learnt were disseminated through these meetings as well as emails.

Incidents were reviewed by a dedicated Datix team, Advanced nurse practitioners, service managers and the patient safety team had recently received training to sign off datix's at level one. Staff were made aware of any incidents and lessons learnt that happened elsewhere in the trust via the morning huddles and trust wide emails.

Staff were able to provide examples of incidents that they had reported, and the actions taken.

Is the service effective?

Good ↑

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

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people and with families and carers to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Community mental health services for people with a learning disability or autism

Staff completed a comprehensive mental health assessment of each patient and made sure that people had a full physical health assessment and knew about any physical health problems. All people had a comprehensive care plan that met their mental and physical health needs.

Positive behaviour support plans were in place where required and supported by a comprehensive assessment. All clinical staff were trained in positive behaviour support and provided these assessments for people. The North York, Yorkshire and Selby team had a new positive behaviour support lead in place. The role of this lead was to recruit and oversee positive behaviour support practitioners and to ensure the overall Trust strategy for Positive Behaviour Support including training, recruitment and professional leadership.

All care plans, safety summaries, care act assessments and hospital passports were reviewed regularly by staff and updated annually or as the needs of the people changed. Care plans were personalised, holistic and strengths-based.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. They ensured that people had good access to physical healthcare and supported them to live healthier lives.

Staff understood and applied NICE guidelines in relation to behaviour that challenges. This included support for families, early identification and assessment, psychological and environmental interventions, medications and interventions for co-existing health and sleep problems.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the people in the service, in line with best practice and national guidance (from relevant bodies eg NICE). Interventions included the creation of positive behaviour support plans, communication assessments, anxiety management, sensory assessments, psychological interventions, occupational interventions and physical healthcare management. Interventions were provided in line with the Transforming Care programme aim of reducing admission to hospital for behaviour that challenges.

Staff understood people positive behavioural support plans and provided or supported others to provide the identified care and support.

Staff made sure people had support for their physical health needs, either from their GP or community services. We saw evidence in patient records of physical health appointments, carers informed us how staff had assisted them in getting appointments for their relatives. The service had access to integrated GPs, who liaised the local GP practices to ensure people had access to required appointments and advocated for the patents when required.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff supported people to use the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) tool which was a is self-rating scale for measuring the side-effect of antipsychotic medications so these could be managed. The service also used Health of the Nation Outcome Scales (HONOS) for recording patient outcomes.

Staff used technology to support people. We observed staff communicating with people using an app that used images for communication.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Community mental health services for people with a learning disability or autism

Skilled staff to deliver care.

The teams included or had access to the full range of specialists required to meet the needs of people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had a full range of specialists to meet the needs of the people. This included access to consultant psychiatrists, qualified nurses, health care assistants, psychologists, occupational therapists, physio therapists, speech and language therapists and a positive behaviour support lead.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training. Staff were able to access specialist training for their role in learning disabilities and autism, and for professional development. This included training in the assessment and diagnosis of autism and in meeting people's sensory needs.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported all staff through regular, constructive appraisals of their work. Appraisals took place yearly at the Trust with quarterly reviews. All staff we spoke with were happy with the frequency and the structure of the appraisal process. Data submitted by the trust shows that appraisal rates for 2022/2023 was 78%. This data was for all adult learning disabilities services within the trust.

Managers supported non-medical and medical staff through regular, constructive clinical supervision of their work. The services provided multiple opportunities for supervision, these included clinical supervision, caseload supervision, safeguarding supervision, trauma informed care supervision and positive behaviour support supervision.

Data showed that clinical supervision for North Yorkshire, York and Selby was 100% and management supervision was also 100%. Clinical supervision for Durham, Darlington and Tees was 79% and management supervision 73%. This data submitted by the trust was for 2022/23 for all adult learning disabilities services within the trust.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings took place monthly as well as regular away days, all staff we spoke with felt well informed and supported by their managers.

Multi-disciplinary and interagency teamwork.

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss people' needs and improve their care. Additional multidisciplinary meetings were arranged for specific people when needed, people and carers were invited to these meetings. All staff informed us that they were able to work extremely effectively across the multidisciplinary team daily. All staff had a good knowledge of each patient.

Staff made sure they shared clear information about people and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation and external to the organisation. We observed meetings regarding patient care with external organisations, these meetings were well attended, and all attendees had a good knowledge of their patient as well as the patient's preferences.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust supplied training data for all adult learning disabilities services, the data includes inpatient. This showed an uptake rate of 83% of required staff had completed Mental Health Act level 1 training for the North Yorkshire, York and Selby team and 92% for Durham, Tees Valley and Forensic team. The North Yorkshire, York and Selby team had an uptake of 83% of required staff had completed Mental Health Act level 2 training, with Durham, Tees Valley and Forensic at 86%.

The trust had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had a range of relevant Mental Health Act policies and procedures. Staff knew how to access the policies and procedures.

Staff provided people with easy access to information about independent mental health advocacy where appropriate.

Care plans clearly identified people subject to the Mental Health Act and identified the Section 117 aftercare services they needed. We found evidence of some people requiring 117 after care services, these plans were detailed, and staff were knowledgeable about the process and the patient.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The trust supplied training data for all adult learning disabilities services, the data includes inpeople. This showed an uptake rate of 92% of required staff had completed Mental Capacity Act training for North Yorkshire, York and Selby team and 90% for the Durham, Tees Valley and Forensic team.

The trust had a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff were aware of who to contact for help and support in relation to the Mental Capacity Act. The service had capacity and best interest champions within the teams.

Staff gave people all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All capacity assessments were recorded in the patient notes along with information around best interest meetings held and the outcomes. Staff provided people with assistance at meetings if they had any concerns.

Community mental health services for people with a learning disability or autism

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. This included mental capacity assessments which were decision and time specific and responsive assessments when patient's needs had changed.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

At the previous inspection we found that in 6 care records there was no evidence of capacity assessments for people. At this inspection we reviewed 3 care records at The Orchard and found all 3 had appropriate capacity assessments.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They understood the individual needs of people and supported people to understand and manage their care, treatment or condition.

During the inspection we met with 10 people and 10 carers. We observed interactions between staff and people during clinic appointments and off-site visits. Staff were discreet, respectful, and responsive when caring for people.

Staff gave people help, emotional support and advice when they needed it. All carers and relatives we spoke with told us that the staff had provided them with advice and support as well as emotional support. Relatives spoke of how the service stepped up or down the level of support provided dependant on patient need. Staff supported a patient multiple times in conjunction with their school to prepare the patient for experiences using social stories. They also worked with a local dentist to provide care and treatment in a patient's home.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff used appropriate communication methods to support people to understand and manage their own care treatment or condition. We observed staff using an electronic tablet with pictograms to communicate with a patient while on a visit.

Staff directed people to other services and supported them to access those services if they needed help. Carers informed us that staff had supported them to gain access to essential equipment needed for their relatives, that they had struggled to get alone i.e., transfer chairs and communication devices. Staff stated that they would support people to access other services where appropriate, including dentistry appointments. Staff signposted people to relevant services and supported them by making referrals.

People said staff treated them well and behaved kindly. One patient told us their care was "really, really good, I like my nurse and psychiatrist" and other people told us that the service "couldn't be better" and was "great".

Community mental health services for people with a learning disability or autism

Staff understood and respected the individual needs of each patient. Staff spoke to us at length about each patient and had an in-depth knowledge about the patient, their treatment, and the level of support they required from the service. During observations of appointments, we saw staff taking a holistic approach to understanding the patient's need.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards people and staff. Staff were passionate about their people, all staff we spoke with felt confident in raising any concerns about care and treatment with management or the relevant organisation.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Staff informed and involved families and carers appropriately.

Involvement of people

Staff involved people and gave them access to their care plans. We reviewed 29 patient records and found that each care plan had evidence of patient involvement. People we spoke with were aware of their care plans and told us they had been actively involved in creating them.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication difficulties).

Staff involved people in decisions about the service, when appropriate. The trust had a patient group that reviewed information that was submitted to the quality assurance group, to see if they had additional information to add. People were also invited to take part in recruitment. A patient was involved in developing a staff training exercise to help staff understand how best to approach and care for people with a learning disability.

Staff always empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care is delivered.

People could give feedback on the service and their treatment and staff supported them to do this. Each site had feedback tokens that consisted of smiley, neutral and angry faces they could use to provide feedback on the service. Systems House and Eastfield clinic had a 'tree of hope' in reception where people and carers could post messages for other people and feedback on staff. Services had 'you said, we did' displays in reception areas to show the changes that had been made as a result of patient feedback.

The service utilised the Carers trust triangle of care model to work with people and carers.

Involvement of families and carers

Staff supported, informed and involved families or carers. All people and carers we spoke with spoke very highly of the service, they felt supported by the staff and involved in the care of their relative. Relatives who lived long distances from the people and the service were assisted with joining meetings online. Carers spoke about individual staff members and how they had supported them via referrals or just talking to them.

Community mental health services for people with a learning disability or autism

The service had carers champions and a carers champion network, staff supported carers via this network to have carers assessments, financial support and any other support required.

With patient consent the service involved carers in the care plans, safety plans and PBS plans. Staff told us this helped to provide a holistic view of the people.

Is the service responsive?

Good  

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

Access and waiting times.

The service was easy to access. Its referral criteria did not exclude people who would have benefitted from care. Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment. Staff followed up people who missed appointments.

The service had clear criteria to describe which people they would offer services to and offered people a place on waiting lists. Waiting lists numbers varied dependent on the service and the team. Systems House and Eastfield clinic reported psychology waiting lists of 8 people.

Data submitted by the trust showed a total of 96 people on waiting lists across adult learning disability services, with one patient waiting between 1 to 2 years.

Anyone could refer themselves to the service, if the service wasn't appropriate staff signposted people to relevant organisations.

The service met trust target times for seeing people from referral to assessment and assessment to treatment. Urgent referrals were seen quickly and non-urgent referrals were within the trust target time. The service had a target of initial assessments for referrals within 24-48 hours, following this the service had a target of 28 days for initial appointment. Staff told us that if they went over the 28-day target this tended to be because of patient preference i.e not available within the time period for the appointment. Urgent referrals were seen within 48 hours, sites had dedicated urgent referral appointments allocated each day.

Staff tried to contact people who did not attend appointments and offer support. Each morning in the huddle, teams discussed people who had not attended their appointments, a plan to contact and rebook was put in place.

People had some flexibility and choice in the appointment times available. Staff told us that they meet with people at a time and location that was best for them, we observed an appointment at a people place of work.

Staff worked hard to avoid cancelling appointments and when they had to they gave people clear explanations and offered new appointments as soon as possible. Staff were not able to provide examples of times when appointments had been cancelled due to low staffing levels. Staff recognised the importance of consistency in scheduling appointments to support engagement with autistic people.

Appointments ran on time and staff informed people when they did not.

The service used systems to help them monitor waiting lists/support people. Waiting lists were reviewed daily in the morning huddle via a 'teams' chat. Appointment text message reminders were utilised and technology such as tablets were used to support communication with people.

Staff supported people when they were referred, transferred between services, or needed physical health care.

The facilities promote comfort, dignity and privacy.

The design, layout, and furnishings of treatment rooms supported people' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. All interview rooms had sound proofing to protect privacy and confidentiality.

The service had considered and responded to the needs of people with autism in the environment. Staff told us that if they had any concerns about the environment for the patient, they would see them in a place better suited for them, this could be at home or another place they felt comfortable.

Meeting the needs of all people who use the service.

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. We observed staff supporting people with communication and specific needs.

Staff made sure people could access information on treatment, local service, their rights and how to complain. Information was available in the reception areas, some teams sent out an information pack with the first appointment letter with all relevant patient information including rights in easy read format.

The service provided information in a variety of accessible formats so the people could understand more easily. Information was available ion easy read format for people in all services. However, the service did not have access to other languages but could access an interpreter service.

Listening to and learning from concerns and complaints

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

People, relatives and carers knew how to complain or raise concerns. All carers and relatives we spoke with were aware of how to complain if they wished to do so. No one we spoke with had felt the need to raise a complaint with the service.

Staff understood the policy on complaints and knew how to handle them. Staff and service managers were able to explain how complaints were managed.

Community mental health services for people with a learning disability or autism

The service had received 20 complaints in the 12 months prior to our inspection. The main themes of the complaints received were concerns around staff behaviour, issues with appointments and lack of communication from the service. Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and people received feedback from managers after the investigation into their complaint.

Staff protected people who raised concerns or complaints from discrimination and harassment.

People received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for people and staff.

Team managers had a good understanding of the services they managed and could explain how collaborative working between different professionals within their team contributed to the high-quality care for the people. All staff spoke very highly of their team mangers and the support they provided to the teams.

Senior managers had a clear understanding of the pressures of the community teams and had regular meetings with the team managers. Staff were aware of who the senior managers were and spoke highly of them.

There were leadership development opportunities available to the team managers and other staff members. The service had supported a staff member in their education to become an occupational therapist after starting work with the service as a support worker.

The community matrons would base themselves at sites throughout the week which enabled them to have a strong understanding on the daily routines of the service and this meant that they were visible and approachable to staff and people.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were aware of the trusts vision and values and could explain how they applied to their role. Managers discussed the vision and values in staff supervision and appraisal.

Community mental health services for people with a learning disability or autism

The trust vision and values were displayed in all reception areas of services. This included information on the Trust's 'journey to change', a 5-year plan that had specific goals in relation to co-creation of services with people, staff and partners.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected and valued by their team manager and worked closely and collaboratively within their teams. Some staff would support teams in other areas and spoke highly of the other teams in the service. All staff stated that the culture of the service was patient focused looking at the right care, right support, right time. This was evidenced in the way they discussed people and their work.

Staff knew about the whistleblowing policy and how to raise any concerns and felt they confident in doing so.

Managers felt confident that staff would come to them to raise any concerns they have. All staff spoke highly of the team managers and the support they provided.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The service monitored its performance against trust targets using key performance indicators. These were discussed with staff in daily meetings and the community matrons.

All staff we spoke with were aware of the governance structures in place for the service. Staff were able to highlight areas of risk for escalation through the governance structures via the morning huddles and speaking with the service managers. The service managers were supported by matrons, who reported to the general managers.

Quality assurance meetings took place on a weekly basis with managers from across the Trust. Meetings with the service managers, matrons and general managers took place weekly and fed into the quality assurance meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the risk register at team and service level and could escalate concerns when required. Staff were able to submit risks for the trust risk register through the morning huddles which were escalated by managers through the quality assurance groups.

Service managers attended leadership supercells fortnightly to discuss key themes emerging and risk. The main risk for the service was staffing, there had been a severe lack of staff in the York and Selby Team recently. The vacancies had been recruited to, but managers were concerned with future planning for staff due to the lack of registered nurse training places in Learning disabilities in the area.

Managers were able to escalate quickly when risks are identified. Managers highlighted difficulties in recruitment as this was impacting on risk and performance.

Community mental health services for people with a learning disability or autism

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the relevant equipment needed to complete their role such as computers and mobile phones. All staff had issues with the PARIS records systems which staff told us was slow and could crash regularly. Staff also told us that the internet would go down regularly leaving them unable to use the systems. The service was preparing for the implementation of a new records system called Cito, staff were undergoing training and adapting patient records in preparation.

Staff expressed frustration due to the implementation of a new supervision system, they told us that this new system meant there were now 3 online systems for recording performance, and this made more work for them. Managers told us that the supervision was also harder to track on this new system and for assurance they were using spreadsheets to log supervision time.

Engagement

Managers engaged actively with local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

We observed staff working closely with external providers to ensure high quality care for people. Staff told us they worked collaboratively with external providers to ensure continuity of care. We observed a meeting with external stakeholder Autism plus, determining the best way to training staff providing care and treatment to a patient in their home.

Learning, continuous improvement and innovation

Staff informed us of the quality improvement programmes that take place within the trust, most recently the teams had completed a quality improvement exercise around the monitoring of physical health for people. The service also held rapid improvement workshops for areas of improvement staff had identified.

The teams were seeking accreditation for a speciality health team for admission prevention in Durham.

Forensic inpatient or secure wards

Good ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. All environmental risks assessments were reflective of the ward environment except the Northdale Centre (Hawthorn and Runswick) which had a collapsible shower rail which was not included in the assessment, this was added by the end of the inspection.

Staff could not observe patients in all parts of the wards. There were blind spots on Newtondale ward which were not mitigated. Following the inspection, the service advised they were aware of and costing the mitigation of these. Sandpiper, Eagle and Osprey, Northdale (Hawthorn and Runswick), Lark, Mallard, Kestrel and Kite and Ivy and Clover wards had blind spots which were mitigated by CCTV. Staff had access to the live feed of the CCTV however there was not always staff in the office monitoring the CCTV. Staff were present in communal areas to mitigate the risk.

The ward complied with guidance and there was no mixed sex accommodation. All wards were single gender.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems and alarms. Staff wore portable alarms. Nurse call buttons were mostly in patient bedrooms. However, on Swift ward there was an accessible bedroom with no nurse call bell or emergency pull cord for summoning assistance and no grab rails for the toilet to make mobilising easier. We saw this was resolved following the inspection by images of the completed work.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. This was an improvement since the last inspection. Furniture was to a high standard and the wards were going through modernisation and redecoration. Those wards that had been redecorated had lowered ceilings and soundproofing to reduce the noise on the wards, this was particularly helpful for the wards caring for autistic patients.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff maintained the cleaning records.

However, staff were not following the food storage requirements on Swift ward, the contents of the freezer were not orderly and labelled. According to the food handling procedure “All items should be appropriately packaged to prevent exposure to frost and ‘freezer burn’ and labelled with day dots identifying contents, date frozen and use by date.” This was not happening.

Staff followed the infection control policy, including handwashing. Staff were mainly bare below the elbow apart from on Sandpiper ward where we saw support staff who were not bare below the elbow.

Seclusion rooms

There were seven seclusion rooms in the service. We viewed the seclusion rooms and found they allowed clear observation. Staff could not get the intercom to work when the inspection team were shown the seclusion room in Newtondale ward, this was resolved by the end of the inspection. Other seclusion rooms had working two-way communication. All seclusion rooms had a toilet and a clock.

The seclusion room on Fern ward was not in use as there was an infestation of ants in there and treatment was underway during the inspection. The seclusion room on Clover ward was not in use as it had been damaged by a patient. The room was also very warm, and the estates team were reviewing this. The seclusion room on Jay ward was not in use due to required repairs however we saw that a patient from acute services had used the room the week before the inspection whilst the room required repairs. The seclusion room in block 9 (which was the old swift ward) was not in use as the ward was vacant pending refurbishment. This meant four out of seven seclusion rooms were not in use at the time of the inspection. If patients needed this level of intervention there would not be an available room as all other seclusion rooms were in use. The estates team were prioritising the repairs during the inspection and there was an ongoing piece of work to improve the seclusion facilities.

None of the seclusion rooms had access to outside space. The Mental Health Act Code of Practice states, “Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas.” One patient had been nursed in seclusion for nine months and they did not have easy access to outside space. To enable access to outside space the service had to pause patient movement across the service. This required significant planning.

Clinic room and equipment

We saw that clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We reviewed all clinic rooms, and they were organised.

Staff checked, maintained, and cleaned equipment. All equipment that required calibration had been calibrated except auroscopes. The service had arranged for these to be calibrated following the inspection.

Safe staffing

The service mostly had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. Although there were staffing challenges, the service had introduced mitigations to support the safe management of staffing with the role of a staffing coordinator, a manager was allocated to this role. Their responsibility was to ensure there was the appropriate skill mix of staff on the wards. Situation reporting meetings took place daily which ward managers provided data for, this included any seclusion reviews required, if any mechanical restraint had been used and if staff were trained to use the devices, ensuring there were sufficient numbers of staff trained in basic life support, staffing levels, patients on increased observations, if patients leave took place, and any actions required. The modern matrons and senior staff in conjunction with the staffing coordinator worked together to address the actions, for example, by relocating staff to other wards. The service was rated as red, amber, or green in relation to safety. We reviewed two weeks reports from 1 to

15 May 2023 and found that the service had to adjust their staff response availability when there were staffing challenges, this included managers supporting. The service was rated as amber in relation to staffing, with actions to mitigate the risk. This meant the service had a good oversight of the safety of the service and the staffing challenges and worked together to address this. The oversight of staffing had improved since the last inspection.

The service had high but reducing vacancy rates. The service employed 543 staff, there had been 67 staff leavers between 1 April 2022 and 31 March 2023, this was a turnover rate of 12%. The highest turnover rate was for Fern ward with 35% turnover, however the ward was not open at the time of the inspection. The service had closed some wards to manage the staffing challenges.

As at 1 March 2023, the service had 44 vacancies, 2 were for allied health professionals and 10 were for nursing staff this was a vacancy rate of 2.3%.

Some wards were fully staffed at the time of the inspection which included Kestrel/Kite and Nightingale wards.

The service bank use was between 13% and 35% for each ward between 1 March 2022 and 1 March 2023. The service agency usage was between 0% and 11% for each ward between 1 March 2022 and 1 March 2023. The highest bank usage was Kestrel/Kite ward with 35%, the highest agency use was Newtondale ward with 11%.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Induction checklists were in use, which included the layout of the ward, and patient information.

The service had reducing turnover rates.

Managers supported staff who needed time off for ill health.

Sickness levels were variable across the service but reducing and ranged from 20% on Lark and 19% on Nightingale wards and 6% on Merlin ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers met daily in a morning to discuss safe care and staffing levels and made changes to rotas and allocations where needed. Each ward rated their staffing for the shift on a red, amber and green rating, any areas of concern were highlighted for mitigation and staffing levels were added to the staffing system. This meant managers had oversight of staffing and worked together to try to improve the staffing situation.

Patients had regular one to one sessions with their named nurse.

Patients told us they had their escorted leave and activities cancelled, due to staffing. However, situation reports from 1 to 15 May 2023 recorded that no activities and leaves were affected due to staffing levels. The trust had set up a leave team, which was a staff team to support patients on leave. This included leave in the grounds, community leave and home leave. We reviewed data from the leave team which showed in February 2023 there were 160 occasions of community leave and 12 occasions of home leave this was for a total of 105 patients. In March 2023 there were 207 occasions of community leave and 6 occasions of home leave supporting 109 patients. In April 2023 there were 204 occasions of community leave and two occasions of home leave supporting 91 patients. All wards had support from the leave team.

Forensic inpatient or secure wards

We reviewed cancelled leave information for the last six months and found that Merlin, Kestrel/Kite and Sandpiper wards had not had any cancelled leave. Mandarin, Ivy/Clover and Swift wards had one cancelled leave. Northdale (Hawthorn/Runswick) ward had four cancelled leaves. Linnet ward had six cancelled leaves. Nightingale ward had seven cancelled leaves. Lark ward had 10 cancelled leaves. Mallard ward had 11 cancelled leaves. Eagle/Osprey ward had 20 cancelled leaves. Newtondale had 27 cancelled leaves and the highest was Brambling ward with a total of 37 cancelled leaves. This meant there had been some cancelled leave due to staffing challenges. However, this had improved since the last inspection as at that time cancelled leave was taking place daily.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff did not consistently share key information to keep patients safe when handing over their care to others. We reviewed the handover information and found that on Ivy/Clover, Northdale

(Hawthorn/Runswick) and Lark wards that handovers were not completed in full and did not include the essential information of patients risks and how best to support them. One page profiles/patient at a glance sheets were not in use on the wards for patients with a learning disability or who were autistic. Staff told us that the handover would provide all of the essential information, however the ward handovers did not provide this on every ward. This meant new staff would not know how best to support patients and risks to be aware of unless they read their electronic records which would not be realistic with the staffing levels and requirements of the role.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. **There were nine medical vacancies out of 31 within the service. There were two levels of on call, one for junior doctors and one for consultants. The on call was split into a mental health on call and a learning disability on call.**

Managers could call locums when they needed additional medical cover. There was a locum consultant psychiatrist working on Mandarin ward.

Mandatory training

Staff had not always completed and kept up to date with most of their mandatory training. Registered nurses told us that they only completed basic life support training and not immediate life support training. The trust told us that the basic life support training covered what was required for immediate life support training, but staff remained unsure about their skills. The content of the training was explored at the well led inspection as the concerns were trust wide.

Basic life support training levels were 67% for the service. This meant the service training compliance for BLS was below 70%. The service mitigated this by the daily situation report to ensure there were BLS trained staff on shift to be able to respond to incidents. This included moving staff around to ensure there was appropriate skill mix.

The mandatory training programme was comprehensive and met the needs of patients and staff. This had been updated to include autism and learning disability training following the Health and Care Act 2022. Training levels were:

- 71% for the ‘Tony Atwood’ training
- 39% staff had completed the ‘Oliver McGowan’ training
- 49% staff had completed the Face to Face Autism Level 2 training

This was ongoing training which staff were being allocated to complete.

There were high levels of training completion for other mandatory courses. The positive and safe physical intervention training was above 75% for all ward based staff. All other mandatory courses were above 75% compliance for the service except:

- Moving and handling part 1 49%
- Moving and handling part 2 50%
- Listen up 48%
- Rapid tranquillisation 1 50%

This was raised at the well led inspection and action required across the trust. This was a continued breach from the last inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was discussed in staff supervisions.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. T**he ward staff had regard to Mental Health Unit (Use of Force) Act 2018 and its guidance and complied with requirements**.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Patients had HCR 20's in place to assess their risk including violence and their offending history. Risk safety summaries and safety plans were completed for all patients. These were tailored to the individual patient.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. However, this was variable in relation to handover documentation. Ivy/Clover, Northdale (Hawthorn/Runswick) and Lark wards handovers were not completed in full and did not include the essential information of patients risks and how best to support them.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service had a blanket restrictions overview grid which included each ward and the type of restriction and whether for that ward there was a blanket restriction, they were individually assessed or there was no restriction. The grid was regularly updated and was proportionate to the ward and level of risk within the ward. This was an improvement since the last inspection where we issued a requirement notice to ensure restrictions placed on patients were individualised, proportionate, regularly reviewed and removed as soon as possible.

Staff identified and responded to any changes in risks to, or posed by, patients. Daily huddles took place which included the full multidisciplinary team. Risk was shared and reviewed in this meeting.

Forensic inpatient or secure wards

Staff did not always follow procedures to minimise risks where they could not easily observe patients. There was CCTV on the wards, with a live feed in the nurses office, however there were not staff in the office at all times observing the CCTV. There were blind spots on Newtondale ward which were not mitigated. Following the inspection, the service advised they were costing the mitigation of these but there was not an interim action plan in place at the time of the inspection

Staff mostly followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, concerns were raised regarding searches on Swift ward, not being proportionate to risk. We reviewed records on site and requested additional information following the inspection. The items the trust reported finding and removing during searches were not identified on the records within the ward, this meant the records were not consistent with the findings.

Use of restrictive interventions

Levels of restrictive interventions from 1 April 2022 to 31 March 2023 were 1064 uses of physical intervention in the service. Of the physical intervention used, 33 occasions were in the prone position and 33 included mechanical restraint. Review of the prone restraints showed they were either where patients had placed themselves in that position during restraint, staff then moved the patient into a supine position, or when staff were removing restraint belts or exiting seclusion. This was for the shortest time possible.

We reviewed the oversight of the use of mechanical restraint. Prior to the inspection the trust submitted data about the use of mechanical restraint in the forensic service. We reviewed the incidents on site to ensure the trust had the appropriate safeguards in place and were using the least restrictive interventions. The safe use of mechanical restraints equipment procedure stated that the use of mechanical restraint had to be authorised by written approval from three staff band 8 and above, one must be the patients Responsible Clinician or nominated deputy and “Following the approval of any mechanical restraint device, an intervention plan should be developed and agreed within the multi-disciplinary team, including the patient, family and/or carers if appropriate.” We found that one incident had the fully completed authorisation and completed risk assessment prior to the use of mechanical restraint. Two incidents had the authorisation forms completed but not in full. With a gap for one signature and a missing date. Four forms had been completed but no risk assessment for the rationale. For one incident the service could not locate the authorisation forms or completed risk assessments or authorisation. Three incidents were for a patient that had been discharged and there were no forms available. Forms were stored in the security office with no clear process or scrutiny of the completed forms. Risk assessments were not on the forms and were usually on the electronic record system or in an intervention plan. However, there was no oversight of this process, and the service could not be assured that they had all the necessary safeguards in place.

However, we reviewed the community meeting minutes and found that on Kestrel and Kite wards, there were restrictions of when patients could access money from the safe, access to razors and their mobile phones. This was a blanket restriction.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We observed staff using de-escalation techniques.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Records showed the observations were completed following the administration of the medicine.

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed patients in seclusion and observed one of the seclusion reviews, the required documentation and checks were in place. This was an improvement since the last inspection as seclusion reviews were not always being completed in line with the Mental Health Act code of practice.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were three patients being nursed in long term segregation. The required documentation was in place and staffing levels reflected the allocated staffing for the patients.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards including the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. Information was available for patients about the use of force, including different types of interventions. Staff were encouraged to work through this with patients, to explain the information and offer support. There was also an easy read poster explaining possible restrictive interventions which maybe used.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Training levels for the service was safeguarding level 1 89%, safeguarding level 2 96% and safeguarding level 3 86%. Staff were kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Records showed that action was taken following safeguarding incidents, with referrals made to the local authority and police where required. This was an improvement since the last inspection where we issued a requirement notice regarding action taken to safeguard patients.

Staff followed clear procedures to keep children visiting the ward safe. Visiting rooms were available including family visiting rooms.

Staff access to essential information

Staff mostly had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could mostly access them easily. However, we saw on Ivy/Clover ward that access to the computers and electronic care records was difficult as there were several staff who needed to access the system and managing this within the observations and staffing was a challenge.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. They were mainly electronic. Any paper based records, usually observations were stored in the locked office.

Forensic inpatient or secure wards

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Medicines were reviewed as part of the regular multi-disciplinary team. Patients were supported to self-administer medicines where appropriate, and we saw evidence of regular checks taking place.

Staff completed medicines records accurately and kept them up to date.

We saw prescription records were nearly always completed in line with the providers policy, however we found medicine charts did not always refer to accompanying recording charts that were in place such as insulin and blood glucose monitoring. We saw evidence of pharmacy reviews on all wards we looked at.

We found one patient record on Nightingale ward that did not include evidence that a patient had had their observations completed following their depot medicine (slow release antipsychotic medicine given by injection) being administered. The trust policy stated that observations should take place for three hours following the Olanzapine depot.

Staff stored and managed all medicines and prescribing documents safely.

Treatment rooms were clean and tidy, and we found oxygen cylinders were stored securely. This was an improvement since the last inspection.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Clinic and medicines management was well managed.

Staff learned from safety alerts and incidents to improve practice. Patient safety briefings were shared with staff which included incidents that had happened and action that staff needed to take, for example, changes in practice, increase of observations. Wards usually included these in the handover too.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed 72 prescription cards and found that two patients were prescribed medicines above the British National Formulary limits. These patients received regular monitoring to ensure there was no adverse reaction to the medicine.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

The provider had an onsite physical health care service which supported patients with their physical health, there was access to nurses, GP, dentist and podiatrist. At the last inspection we found that not all the appropriate health monitoring had taken place. Whilst there had been significant improvements, we still found examples where ward based monitoring forms for High Dose Antipsychotic Treatment (HDAT), Diabetes and where appropriate bowel monitoring were not always completed in line with providers policy or in line with intervention or safety plans. We saw examples where blood glucose levels had exceeded the expected ranges, but no documented actions had been taken and another example where blood glucose levels were to be checked four times daily however changes to frequencies of monitoring had been made but not documented, meaning records were not accurate. We also saw examples where there were no care plans in place to support patient's physical health needs.

Forensic inpatient or secure wards

Whilst bowel charts were in place on most wards for patients prescribed Clozapine, we found two patients on Newtondale where no bowel monitoring was taking place. This placed the patient at risk of harm.

We also found all wards were not using the most up to date monitoring forms for Clozapine side effect and blood monitoring.

We saw on Ivy/Clover that a patient with a high BMI did not have an intervention plan in place to support with this and try to manage the risk.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Records showed that incident reports were completed. This is an improvement since the last inspection as at the last inspection, incidents were not being reported in line with the trust's incident reporting procedure.

Staff raised concerns and reported incidents and near misses in line with trust policy. The ward managers reviewed the incidents, then they were reviewed by modern matrons and service managers. This meant senior leaders were aware of incidents and could ensure learning and changes in practice took place following incidents.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff told us and records showed that debriefs took place, psychology were involved in the facilitation of these. However, a patient told us and records confirmed for another patient that they had not received a debrief following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Records showed that actions following incident investigations included patient's wishes and preferences.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was discussed at handovers and via the safety alert briefings and ward safety reviews.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Changes included if appropriate, reporting an incident directly to the police and not assuming that the safeguarding team would do this. Records showed that this had happened.

Forensic inpatient or secure wards

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were mainly, but not always personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The occupational therapists assessed people's cognition, sensory needs and daily living skills using recognised screening tools, for example; Large Allen Cognitive Level Scale (LACLS), Allen Routine Task Inventory (RTI), Assessment of Motor Process Skills (AMPS), Adult/Adolescent Sensory History (ASH- also known as Spiral), Sensory Processing Measure (SPM).

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Within 24 hours of admission the occupational therapy team contributed to the ward falls decision tool and moving and handling risk assessment. However, some of the physical health monitoring including for side effects for some medicines was not always completed in a timely manner.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The trust called the plans intervention plans. We reviewed 36 care records and found they all had current risk assessments and intervention plans. We saw detailed plans for patients with epilepsy and those that required reasonable adjustments due to their gender. However, there were two plans for patients at risk of choking which did not include the reason or circumstance when they choked. This meant staff may not be prepared to respond if they did not know the full details for the individual.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were current in the records we reviewed.

Care plans were not always personalised, holistic and recovery orientated. Some of the plans contained medical terminology and others were written in the first person but not in the language that patients would use. This meant staff were sometimes writing the plans without fully involving the patient.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. There were a variety of members of staff from different disciplines to contribute to the care of patients. Psychology staff provided psychological

interventions including SCHEMA therapy, Cognitive Analytical Therapy (CAT), Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing therapy (EMDR), attachment therapy, Dialectal Behavioural Therapy (DBT), Compassion Focused Therapy (CFT), treatments in fire setting intervention programme, gender specific treatment, beyond violence for women, violence reduction treatment programme with CBT and art therapy.

The physiotherapy team provided assessments and treatments in relation to pain and injuries and provided preoperative and post operative support to patients.

The speech and language therapists conducted eating and drinking assessments, dysphagia assessments and support regarding communication, including training for staff in communication skills and making information more accessible. Recently the team had started to do some collaborative work with patients, including a creative writing group which enabled patients to develop their neurolinguistic skills.

The speech and language therapy team worked closely with the dietician team who provided nutritional screening and interventions. The dieticians had been involved in co production with patients for the creation of a cookery book which had won awards for the promotion of healthy lifestyles.

The dieticians worked closely with the fitness instructors and physiotherapists to facilitate the sports and nutrition group.

Staff delivered care in line with best practice and national guidance. The service was following NICE guidance NG10 Violence and aggression: short-term management in mental health, health and community settings in relation to physical intervention.

Staff identified patients' physical health needs and recorded them in their care plans. This included diabetes and epilepsy.

Staff made sure patients had access to physical health care, including specialists as required. There was a health centre in the service which had general nurses and a GP and access to other health professional including a podiatrist. Referrals to other services were made as needed, this included physical health trusts for surgery.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Dieticians were involved for patients with dietary requirements including needing to increase or reduce their intake. They also facilitated the "LEAN" group to assist patients with weight management.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The dieticians worked with psychology staff to facilitate therapy in relation to emotional eating. The dieticians also worked closely with the fitness instructors to offer comprehensive support for patients who were overweight.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists used MOHOST (Model of Human Occupation Screening Tool) and GAS-Light (Goal Attainment Scaling) goals and PREOMS (patient reported experience and outcome measures). The dieticians used the St Andrews Nutritional Screening Instrument (SANSI) to identify areas where patients required support. The psychological professions used a variety of rating scales for specific mental health needs and patient relevant treatment and assessment, these were reviewed at the weekly psychology referrals meeting, where new referrals were discussed and allocated, and updates were provided for ongoing work with patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Monthly environmental audits took place and annual fire risk assessments were completed. Ward managers completed weekly audits. Clinical leads and pharmacists completed medicines audits. Nurses completed clinic audits. The service used the stepped care model as a multidisciplinary team to support patients through their recovery journey. This started with assessment followed by safety and containment then regulation and control, progressing to exploration and change and concluding with integration. There was a therapy document for patients to help understand where they were in their recovery journey and the therapies they were accessing.

Managers used results from audits to make improvements. The modern matrons created monthly reports which were submitted to the service improvement and development group meetings, these contained an action plan. Weekly supercell meetings took place with senior leads to discuss topics including bed management, ward visits, feedback from external sources, these were reviewed, and actions identified to make progress. Minutes showed that progress was being made.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. Specialists included dieticians, doctors, occupational therapy, physiotherapy, psychology, social work, speech and language therapy.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff completed a thorough induction and mandatory training including learning disability and autism training.

Managers gave each new member of staff a full induction to the service before they started work. There was a service induction which included compassion focused trauma informed care, an introduction to the roles of the members of the multidisciplinary team, dialectal behavioural therapy, autism, support for staff, behaviours that challenge, boundaries and safeguarding along with the opportunity to shadow as supernumerary staff members.

Managers supported staff through regular, constructive appraisals of their work. Staff records showed appraisals took place.

Managers supported staff through regular, constructive clinical supervision of their work. The trusts supervision policy stated that staff should receive clinical supervision and management supervision on a minimum of three monthly intervals. We reviewed 22 staff records and found that staff were receiving supervision in line with the policy. This was an improvement since the last inspection as staff were not regularly receiving supervision at the last inspection.

Managers shared information with staff during handovers or via email as it was difficult to hold team meetings which the whole team could attend. This was the same issue at the last inspection. We reviewed the team meeting minutes for the six months prior to the inspection and found that Merlin and Lark did not have any minutes of meetings. Team meetings had changed to WIG (ward improvement group) meetings. There was a standard agenda which included what had gone well and what had not gone so well, staffing, activities, incidents, complaints, safeguarding and a review of restrictive interventions. The attendance at the WIG meeting was mainly the multidisciplinary team with occasionally a nurse or health care assistants in attendance.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Members of the multidisciplinary team had facilitated training, this included communication skills and dysphagia training.

Managers made sure staff received any specialist training for their role. This included talking mats training to aid communication with patients who found it difficult to express themselves verbally. Some staff had completed or were in the process of completing a masters in autism. Staff were also in the process of attending Hopes training which is a human rights based approach to working with individuals in segregation developed from research and clinical practice. Staff had also accessed trauma informed care training.

Managers recognised poor performance, could identify the reasons and dealt with these. Records showed action was taken, including additional training.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two meetings and records showed they took place, usually fortnightly.

Staff did not always make sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed the handover information and found that on Ivy/Clover, Northdale (Hawthorn/ Runswick) and Lark wards that handovers were not completed in full and did not include the essential information of patients risks and how best to support them. One page profiles/patient at a glance sheets were not in use on the wards for patients with a learning disability or who were autistic.

Ward teams had effective working relationships with other teams in the organisation. We saw this when other members of the multidisciplinary team visited the ward or staff supported patients to access the hub for activities.

Ward teams had effective working relationships with external teams and organisations. The service was part of the adult secure provider collaborative

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The training compliance for the service was 92%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Forensic inpatient or secure wards

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There were details on display in the wards of the advocate and how to access them.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. A leave team had been set up in the service to increase the amount of leave patients were able to take. The leave team had 12 members of staff working Monday to Sunday from 8:00am until 6:00pm, this averaged to five staff per day. The team worked independently from all the secure inpatient wards. The team had allocated leave staff to certain wards to provide consistency to patients.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. There had been a recent Mental Health reviewer visit to Kestrel/Kite ward on 17 May 2023. Patients told the Mental Health Act reviewer that they had their rights explained regularly and had access to the IMHA and a solicitor. They had either had a tribunal or were waiting to have one imminently. Actions from the visit included that there was a blanket restriction around patients being able to vape or use electronic cigarettes on the hospital site and the involvement of carers in meetings, especially when they could not access them remotely. Getting through on the phone was another issue raised by carers.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. The training compliance for the service was 93%.

There was a clear policy on Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed easy read medicine information was used to assist in the assessment of a patient's ability to consent to treatment.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. This was an improvement since the last inspection.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Examples included for managing finances and physical health needs.

Forensic inpatient or secure wards

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They mostly respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We completed six short observations framework for inspection 2 (SOFI2) which are structured observations which capture people's experience of care. We observed staff were discreet, respectful, compassionate and responsive when caring for patients. However, we saw on Clover ward that staff regularly entered through this ward to access the office, they were not supporting the patient on the ward, this was disruptive, and staff did not always acknowledge the patient. This meant staff were not respecting the persons living space.

We spoke with 41 patients. The majority of patients told us that staff were helpful, kind and supportive.

Patients talked positively about the activities they were involved in including cooking, drama, pet therapy and fitness.

Staff gave patients help, emotional support and advice when they needed it. We observed staff responding respectfully when patients needed emotional support. Patients with more restrictions told us how staff supported them to shop online to ensure they were involved in their purchases.

Staff supported patients to understand and manage their own care treatment or condition. Records showed multidisciplinary meetings took place to discuss care, treatment, and future plans. These varied in content and detail across the wards. Patients could describe their support to us and what they were focusing on.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us and records confirmed that patients accessed external services in relation to physical health needs and protected characteristics.

Patients said staff treated them well and behaved kindly. Patients said staff were supportive and would spend time with them including playing board games and talking. However, four patients told us that some staff do not protect their privacy and dignity by entering their room without knocking. Also, one patient said that some staff are not sympathetic to their situations, for example by saying "rise above it" and not implementing trauma informed care.

Staff understood and respected the individual needs of each patient. Care we observed was individually tailored, with staff respecting if patients wanted to have some time alone or interacting with others. One patient told us that staff did not understand their needs, particularly unfamiliar staff and this meant that staff misinterpreted their communication.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Patient information was stored in locked offices and staff did not talk about other patients in the communal areas or where other patients could overhear.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was information on display on the wards regarding how to give feedback including how to complain, activities available, mutual expectations. Information was on display about positive and safe care which was the trusts physical intervention and when this would be used and what patients should expect in relation to being least restrictive.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were given a copy of their care plans and records confirmed if patients had declined to have a copy of their care plan. Patients told us they were involved in creating their care plan and staff asked questions such as what helps when they are struggling.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). This was discussed with patients in their reviews and one to one sessions. We saw that there were accessible intervention plans and communication passports in use on Northdale(Hawthorn/Runswick) these included pictures and plain English. Chalk boards were in use on wards and included staffing, activities and other information to be shared with patients. For one patient nursed in long term segregation, staff had developed bespoke plans on the wall in the communal area to help the patient with remembering what was important to them and staff with how best to support them. This was an improvement since the last inspection, as previously the service were not providing accessible information to patients.

Staff involved patients in decisions about the service, when appropriate. We observed the united voices meeting which had eight patients representing different wards. The meeting was very interactive, and each patient was given the opportunity to feedback on the issues discussed and raise any issues from their ward. There were terms of reference for the group, the group met twice a month. There was a chime fund which was a pot of money for improving patient experience on the wards, requests were discussed at the ward in their community meetings and then a representative attended the chime meeting to propose the request. Feedback and outcome was provided by the chime fund committee. In April 2023 the chime fund had approved a PlayStation, TV, air fryer, garden furniture, table tennis table, karaoke machine and PlayStation games. This was an improvement since the last inspection.

Monthly community meetings took place on each ward. A new agenda including an action log had been introduced and included ward management, safe wards, activities, chime fund, united voices, patient involvement opportunities and ward positives. We reviewed the minutes from the last three months and found that actions and suggestions were not always acted upon or discussed at future meetings on Brambling ward, Ivy ward, Mandarin ward, Merlin ward, Northdale (Hawthorn and Runswick wards). Patients refused to attend on Eagle and Osprey wards. Other wards showed progress from previous meetings. Patients volunteered to be involved in interviewing staff, being involved in research and the creation of a patient newsletter.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us that they were involved in their care, they attended their reviews and were asked for their views. Patients could give feedback about the service and make suggestions for improvement at the united voices meetings.

Staff made sure patients could access advocacy services. There were posters on display in the wards about the advocacy services and how to contact the advocate. Patients told us they saw the advocate and could raise issues with them.

Involvement of families and carers

Staff informed and involved families and carers appropriately. This was an improvement since the last inspection.

Staff supported, informed and involved families or carers. There were staff who were carer leads on each ward. There were monthly carer meetings for each ward, hosted via video call.

The service had created an introductory film about the service for carers, this included a tour of the service and introduction to staff to assist carers in the understanding of the service where their loved one was and what to expect if they were visiting the service.

The service hosted a Christmas with carers event. There was a planned carers, families and friends open day and quiz night planned for June 2023.

There was a creative writing course for carers that were cofacilitated by a theatre company.

The service had developed involvement opportunities for carers including involvement in interviews, conferences.

The service had co-produced with a theatre company and carers of loved ones who are in the service a screen play voicing their experiences of the service and their loved one's care.

Staff helped families to give feedback on the service. The service encouraged carers to attend the monthly feedback meetings and also promoted the lived experience advisory group (LEAG) – provider collaborative monthly meeting.

Feedback was collected from carers at the Christmas event, feedback was positive with carers saying how well their loved ones looked, enjoying meeting other carers. Areas for future consideration included more time with loved ones and seeing more senior staff.

Monthly carer newsletters were created and sent by the service which included a service update and the future planned carer events.

Is the service responsive?

Good ↑

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Forensic inpatient or secure wards

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. This was monitored through a dashboard which could be filtered down to a ward level.

There were patients from out of the area. Part of this reason was due to specialist bed availability.

Managers and staff worked to make sure they did not discharge patients before they were ready. This was discussed as part of the multidisciplinary reviews with patients.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. As patients progressed in their recovery, they may move wards within the service, however for a number of patients there had to be approval from the Ministry of Justice for this.

Staff did not move or discharge patients at night or very early in the morning. Admissions into the service were planned and assessments were completed by the multidisciplinary team prior to admission.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. This was reviewed by the use of a dashboard which managers could filter to extract the information they required. The longest length of stay was on Clover/Ivy ward. This patient had a community placement identified and the service were working with the new provider to make the transition as successful as possible.

Staff carefully planned patients' discharge and worked with the ministry of justice, care managers and coordinators to make sure this went well. Patients had discharge plans in place called making feasible plans. There was one record we reviewed on Kestrel/Kite ward that did not include a discharge plan. We saw accessible discharge plans in place for patients that required this, one was on the patient's wall and included a timeline of previous placements and where their future placement would be. Discharge planning had improved since the last inspection.

Staff supported patients when they were referred or transferred between services. One patient told us about the comprehensive support they were receiving in their transition to their future placement.

The service followed national standards for transfer. Liaison took place with the Ministry of Justice where required.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could mostly keep their personal belongings safe. There were quiet areas for privacy. The food was not always of good quality but patients could access hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw patients' rooms that had a variety of belongings reflecting their hobbies and interests.

Patients had a secure place to store personal possessions. However, patients on Brambling ward told us that they couldn't use the safes in their rooms, either because they were broken, or staff had not helped them to set them up.

Forensic inpatient or secure wards

The service had a full range of rooms and equipment to support treatment and care. Each ward had a communal lounge and an activity or sensory room dependant on the need and preference of patients. We saw sensory rooms and calm rooms with calm boxes and relaxing activities. Activity rooms with pool tables and games. Staff and patients could access the rooms. Dependent on the level of security of the ward, some rooms were locked and required access with staff supervision due to the potential risk items in the room. On Ivy ward there was a broken TV in the activity room. The wards were gradually undergoing refurbishment. Whilst wards were being refurbished, patients moved to another ward. Wards that had been refurbished included lowered ceilings with sound proofing which was helpful for autistic patients who may be sensitive to noise.

The service had quiet areas and a room where patients could meet with visitors in private. There were family visiting rooms at the main reception for visits with children. Some visits with adults could take place in rooms on the wards, dependant on risk assessment.

Patients could make phone calls in private. Dependant on individual assessment patients could access mobile phones and smart phones. Some patients required staff supervision when using their phone or making phone calls, this was individually assessed. For patients without a phone or those that didn't want a phone, there were ward phones that could be used.

The service had an outside space that patients could access easily. All wards had access to an internal courtyard with ease of access. Patients were involved in gardening and patients told us and showed us the work they had done in the gardens with planting. The service had a large outside space within the secure perimeter. This had benches and garden areas which patients with ground leave could access.

Patients could make their own hot drinks and snacks and were not dependent on staff on most of the wards. However, on some of the medium secure wards, with higher levels of security, where risk assessed as unsafe to have hot drinks in the communal areas, patients could access cold drinks independently and asked staff for hot drinks.

The service did not offer a variety of good quality food. Eleven patients told us that the food was of poor quality, the food provider had gone into liquidation and the trust were operating a reduced menu due to this. A step-in arrangement was in place with an alternative supplier who were nominated by NHS Supply chain and menus offering more choices were in development. The Trust operates a 'cook/freeze' methodology across its inpatient wards. Patients told us they often used their own money to buy food. There were menus displayed on notice boards, however the food being provided for patients did not reflect what was on the menu. We saw patients' food purchases being delivered to the wards. This meant patients were not receiving high quality food. However, the trust were aware of this issue and we saw posters on the ward explaining the issue to patients. The trust also told us that they were in the process of sourcing a new food provider so the current situation was not a long term concern.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Within the service there was a timetable of courses for patients to access which included introduction to pet therapy, equality, diversity and human rights, cooking for wellbeing, sport and nutrition and painting for wellbeing. There was a new specialist teacher that had joined the service and was offering English and literacy courses.

Brambling ward had therapy rabbits which patients cared for and there was information on the notice board about how to care for them, this developed patients' skills and responsibilities.

There was a sports hall, gym and football pitch at the service with the opportunity for patients to exercise independently or part of group sessions including badminton, circuits and yoga. Records showed that the gym was regularly used by patients from 11 of the wards, from Monday to Friday.

Vocational opportunities were available for patients within the service, there was a pre vocational group where patients developed skills in interviewing and CV writing. There were voluntary work opportunities within the library, shop, café, gym and domestic roles for patients to apply for. There were 18 patients working in a variety of these roles at the time of the inspection. This enabled patients to develop their skills and prepare for their future.

There was one patient volunteering in the local community in a food bank, this was achieved with support from the occupational therapy department initially and they were now doing this independently.

Staff helped patients to stay in contact with families and carers. We reviewed leave data for February, March and April 2023 and found that the leave team had facilitated 20 home visits. Visits also took place at the service. Carers were invited to multidisciplinary review meetings. Patients also contacted carers via phone as risk allowed.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There was a variety of activities taking place in the activity centre. A weekly timetable was created, and wards were contacted to see which patients wanted to attend. There were patients from different wards attending the sessions and this was managed by the staff to ensure there was no risk or safeguarding concerns between patients. Activities included gardening, graffiti art, pottery, music, drama, floristry and painting and decorating. We observed patients participating in a fitness session, a floristry session and a woodwork session.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were examples of staff using Talking Mats to aid communication with patients. Also, the use of pictures and symbols in care plans to make information more accessible for patients. All wards were on the ground floor so were accessible for people with mobility needs. However, on Swift ward there was a patient with mobility needs and the accessible bedroom did not have a nurse call bell or emergency pull cord for summoning assistance. The en suite bathroom did not have any levers at the toilet and the bathroom on the ward was not accessible with no levers for moving and handling. This meant the environment did not meet their needs. However, we saw this was resolved following the inspection.

On Mallard ward, staff cared for older patients, with associated physical health needs. There had been patients at the end of their life who wished to die at the service, staff had received training in end of life care and could facilitate the patients wish. The ward worked closely with community health teams and chaplaincy services to provide the care at end of life and facilitate the patient's wishes after death. There was a physical health MDT weekly for the patients. Staff used a physical health MDT board for each patient to record the health appointments and additional risks including falls, pressure ulcers and venous thromboembolism (VTE) and additional assessments including pain and moving and handling. This meant the ward was providing care that met the complex needs of the patients which was regularly reviewed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This was displayed on notice boards in the wards or in folders in the office, which could be shared with patients for those

wards with higher levels of security where items were regularly damaged and removed from notice boards by patients. This was an improvement from the last inspection. However, on Swift ward, the staffing information did not reflect the staffing levels for that day, it had not been updated and on Clover ward, the information on display regarding activities, had not been updated and displayed activities from previous days.

The service had information leaflets available in languages spoken by the patients and local community. Information could be provided in different languages.

Managers made sure staff and patients could get help from interpreters or signers when needed. There was access to an interpreter and translation service.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us they had Halal meat where needed. There were meals available for people with physical health needs including diabetes. The dietician service along with patients had created a healthy eating cookery book "Cook healthy, eat, repeat – 'A recipe for a healthier lifestyle'" which had won an award at the Positive Practice in Mental Health Awards 2022. This book was available on wards for patients to use when cooking.

Patients had access to spiritual, religious and cultural support. There was a chaplaincy team at the service, which visited the wards weekly. There were multi faith rooms within the service. Patients told us about church services they attended at the service. Another patient talked about the service meeting their cultural and faith needs and facilitating access to the Imam.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. There was information on display in the wards. Patients told us they knew how to complain. Formal complaints were managed through PALS (Patient advice and liaison service) who provided the outcome of the complaint. Informal complaints were managed locally on the ward by the ward manager. This included discussions in the community meetings and ward rounds. Complaints from March 2022 to March 2023 were reviewed for the service. There were 148 complaints, most were in relation to patients care and treatment, records showed staff were responsive and compassionate towards concerns raised.

The service clearly displayed information about how to raise a concern in patient areas. There were also you said we did boards within the wards to show the action taken following feedback.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Ward managers showed us the process and requests from PALS for information and responses sent.

Staff protected patients who raised concerns or complaints from discrimination and harassment. We saw this in records and community meeting minutes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. This included within ward rounds and individually to patients.

Forensic inpatient or secure wards

Managers shared feedback from complaints with staff and learning was used to improve the service. This was a standard agenda item at the ward improvement group meeting which all staff were invited to for each ward.

The service used compliments to learn, celebrate success and improve the quality of care. These were discussed at the ward improvement group meetings.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders provide clinical leadership. We saw leaders providing support to staff. Staff told us that changes in senior leadership had been very positive, they felt supported by service managers and modern matrons and leads of the different disciplines.

Leaders had the skills, knowledge and experience to perform their roles. We met with senior leaders and leads of different disciplines, they were knowledgeable about their area of responsibility, could give examples of achievements and areas to still improve. They had good links with peers and access to current best practice.

The organisation has a clear definition of recovery, and this is shared and understood by all staff. As part of the staff induction, they received a welcome pack to the service to help them orientate around the service and their role. Within the pack was the kind of service they want to be; “We will co-create safe and personalised care that improves the lives of people with mental health needs, learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate, and responsible.” Staff we spoke with were very clear about the trusts journey to change and understood that change was required to improve the service and standard of care delivered.

The service had models of care in place. These included professional excellence, they aimed to achieve this by providing compassion focused trauma informed care, safety, stabilisation and containment, exploration, regulation and change and avoidable harm. Their community collective leadership focused on shared governance, empowerment and professional councils. The investment in people included education, innovation and service improvement, research and development, wellbeing and resilience and safe staffing. These were shared with new staff at induction.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Leaders from ward managers, modern matrons, service managers, leads of disciplines and the general manager understood the service well. They gave examples of changes in practice and improvements that had been made, they were visible in the wards and supported the ward staff to deliver care to patients. When we provided high level feedback to the service of what we had found on inspection, they told us this aligned with their understanding of the service.

Forensic inpatient or secure wards

Leaders were visible in the service and approachable for patients and staff. During the inspection we saw senior leaders who were visible within the service, this included the general manager, associate director of nursing and quality, when they were escorting us to wards, patients knew them and spoke with them, they had been involved in the sporting events in the service and were approachable to patients. Patients seems at ease with them.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff know and understand the vision and values of the team and organisation and what their role is in achieving that. The core values of the service were "we are respectful, we are compassionate, and we are responsible". Following the last inspection there had been significant change in leadership, structures, and the culture of the service. During interviews and observations of care, we saw and heard that staff were following the values of the service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. There had been a "big conversation" to get feedback from staff and identify areas for improvement, this was collated into the journey to change, which staff talked regularly about and were familiar with. Registered nurse professionals council meetings took place monthly. We reviewed the last three months minutes and found that discussions included nursing and education, topics for discussion, positive news, induction and feedback from reviews and other meetings. Health care assistant council meetings took place monthly and discussed issues relevant to their role, guest speakers and lone working. An issue that had been raised was food for staff. If staff could not access their break due to staffing pressures, they suggested food be provided by the service. The Working Time Regulations 1998 states that staff should have a 20-minute rest break if they're expected to work more than six hours during the day. This was being explored by managers.

Staff could explain how they were working to deliver high quality care within the budgets available. Managers understood the staffing budget and their flexibility for this to meet the needs of patients, for example on Mallard ward they had recruited a registered general nurse to assist with the physical health requirements of patients.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued. There were meetings for staff with peers in the same role. Team huddles took place and wellbeing was discussed as part of this. Staff had access to use the gym and also other exercise opportunities within the service.

The service had a staff group that feels positive, satisfied and has low levels of stress. Staff told us things had improved with the changes in senior leadership. However, staffing was still a challenge and we observed staff being very busy on shift with a variety of demands on them on wards including Ivy and Swift.

The provider recognised staff success within the service – for example, through staff awards. Greatix was a way of praising staff, these were discussed in meetings and positive feedback given to staff.

Staff feel valued and part of the organisation's future direction. Staff told us and minutes showed that staff had opportunities to provide feedback about the service.

Staff felt positive and proud about working for the provider and their team. Staff told us about the investment in their training that they had received including support to access their nurse training. Staff talked positively about the progress made, the variety of activities available for patients and the thorough induction that new staff had received into the service.

Staff appraisals included conversations about career development and how it could be supported.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service also offered weekly reflective practice sessions where staff could discuss an experience at work that they wanted to share and reflect on. These had been well attended in March 2023 but not since then. This could be due to staffing levels as we saw in minutes that some staff were unable to attend certain events due to staffing levels.

The service monitors morale, job satisfaction and sense of empowerment. Managers discussed this in individual staff supervisions.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Several senior staff, especially ward managers had started as preceptor nurses in the trust and progressed to a ward manager or modern matron role.

Teams worked well together and where there were difficulties managers dealt with them appropriately. We saw staff from other wards supporting different wards, they were made welcome. Meetings we observed were respectful and staff were supportive of each other.

The service had completed closed culture reviews on each ward in December 2022 and January 2023. A cultural assessment tool was developed for the ward visits. These were completed by senior staff that did not work on the ward. Themes picked up by these reviews included agency staff not engaging with patients and staff impact on wellbeing when involved in several incidents of violence and aggression. Themed feedback had been collated from the ward culture reviews and they included staffing, food and improvements to the estates. The actions were being overseen by the service and leaders were aware of the review and the findings and had started to explore how to address the findings. Improvements to the environment were underway and had been completed in some wards.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance policies, procedures and protocols are regularly reviewed and improved and include an equality impact assessment. There had been recent changes with the meeting structures. The modern matrons created monthly reports which were submitted to the service improvement and development group meetings, these contained an action plan. Weekly supercell meetings took place with senior leads to discuss topics including bed management, ward visits, feedback from external sources, these were reviewed, and actions identified to make progress. Minutes showed that progress was being made. Therapy team huddles took place weekly. One week focused on performance and the other on service development.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There were consistent agendas in use for ward improvement group meetings and allied health professionals lead meetings.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Monthly Secure Inpatient Services Improvement and Delivery Group Meetings took place where feedback from patients and carers and reviews of outcomes and learning from incidents was discussed, there were clear actions identified and minutes showed progress being made with the actions.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Staff completed clinic room audits and medicine audits. However, they were not always clearly dated. This meant it could be difficult to identify which day the audit was from.

Data and notifications were submitted to external bodies and internal departments as required. This had improved since the last inspection, systems and processes had been developed to record data to allow for improved monitoring and oversight of the service. This meant managers could identify areas that had improved and areas that required further improvement.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. We saw good working relationships between members of the multidisciplinary team. Colleagues could refer to other members of the team for specific needs of patients, we saw referral and caseload management processes in place for dietetics, occupational therapy, physiotherapy, psychology and speech and language therapy.

The trust had a whistle blowing policy in place.

The provider's governance framework ensured that the provider was complying with the Mental Health Units (Use of Force) Act 2018 and its guidance. Information was available for patients about the use of force. Managers reviewed the use of force and we saw the use of positive behaviour support plans to get to know patients better and understand their triggers for behaviour with the aim of reducing people's triggers and being consistent in their responses.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at facility or directorate level. Staff at facility level could escalate concerns when required. Ward managers and modern matrons were aware of what risks were on the risk register that related to their service.

Staff have the ability to submit items to the provider risk register

The service had plans for emergencies – for example, adverse weather or a flu outbreak. There were plans for staffing challenges too, which included the members of the multidisciplinary teams supporting the wards where there were no other staff available, this had reduced as staffing had started to improve.

The service monitored sickness and absence rates. These were discussed at supercell meetings and senior leaders ensured that managers understood how to support colleagues and what the trust's policies and procedures were.

Where cost improvements were taking place, they did not compromise patient care. Budgets were discussed within the Ridgeway Secure Inpatient Services Improvement and Delivery Group Meeting, including the provider collaborative budget which the service were part of along with a neighbouring trust.

Forensic inpatient or secure wards

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from facilities and directorates that were mostly not over-burdensome for frontline staff. However there had been lots of changes and new systems had been brought in. Every morning each of the service groups met. Ward managers shared the staffing reports, safeguarding concerns and physical intervention uses. Any reg flags were then shared and mitigated by the staffing coordinators. Staff completed electronic incident reports which managers then reviewed and depending on the severity these were then reviewed by modern matrons. There had been a new system introduced for managers to record staff supervision on, there had been initial challenges with the system and the information was not reflecting actual supervision sessions, we viewed paper records to review the completed supervision sessions. Our observation was that staff had to record information in a variety of places, which could be repetitive at times and seemed time consuming for staff to complete.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. We saw there was usually two computers in the nurses office, when the ward was busy, staff could find it difficult to record their daily notes and access the system.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Staffing reports were extracted from another system, the modern matron completed a monthly quality assurance review including the review of patient records.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. These were ready for review and discussion at the senior leaders meetings.

Staff made notifications to external bodies as needed. We saw safeguarding alerts made where needed.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. There was a mixture of paper and electronic paper records which were all stored in the locked nurses office. Information regarding the service was emailed to all staff.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so. The provider collaborative was in place where the service worked with a neighbouring trust to provide the secure services, they met regularly to discuss service provision including bed availability and referral of patients to specialist services where needed.

Ensured service confidentiality agreements are clearly explained including in relation to the sharing of information and data. Staff's role in respect to confidentiality was included in the Managing concerns of potential conduct (Disciplinary) Procedure.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Forensic inpatient or secure wards

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on. Weekly community meetings took place for patients, where information was shared with patients. Staff were invited to monthly ward improvement group meetings, however ward based staff found it difficult to attend due to staffing challenges. Information was usually shared with staff via handover, supervision or email. On Sandpiper ward, we saw that they discussed the patient safety briefings in handover. Also, within supervisions, the patient safety briefing had been embedded into the agenda for the month so that staff received the same update for consistency. Staff received weekly Ridgeway briefings which provided updates on internal and external information relevant to their role. Patients and staff had co created the Ridgeway News, a monthly publication for patients and staff to share news on activities and education taking place, new staffing and sharing poems and art work that patients had created and celebrating success.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. A variety of carer events took place, carers were encouraged to give feedback about the service.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Weekly ward visits took place by two senior leaders. However, the same wards were allocated for the same days each week, this meant that the ward would know staff were visiting and this would not be unannounced.

Directorate leaders engaged with external stakeholders – such as commissioners and the provider collaborative. Regular meetings took place to review service delivery and encourage innovation.

Learning, continuous improvement and innovation

The service encouraged creativity and innovation to ensure up to date evidence based practice is implemented and embedded. Community meetings showed that patients were invited to be involved in research that one of the consultant psychiatrists were doing. The service had a variety of students from medical, nursing, occupational therapy and psychology courses, the service welcomed the feedback from students and the sharing of current evidence based practice.

All staff have objectives focused on improvement and learning. These were discussed in staffs' appraisals.

The service had a staff award/recognition scheme. Greatix was a way that people could give praise to staff, these were then discussed in team meetings. Staff had access to join the coaching programme at the trust.

Community-based mental health services of adults of working age

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔

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

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff working in the services had alarms which they could take into interview rooms and staff were available to respond.

Staff followed infection control guidelines, including handwashing. Signage within the local sites where sanitary facilities were available to staff and patients advised about good handwashing techniques.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. The teams had a range of equipment within clinic rooms and staff had access to equipment to meet the needs of patients and carry out physical examinations and diagnostic tests.

All areas were clean, well maintained, well-furnished and fit for purpose. We saw the team locality sites were well maintained.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning staff were employed by the trust and cleaning tasks were completed outside of the services business hours.

Posters were displayed around buildings to advise staff and patients of good hand hygiene. Signs were on office doors indicating the maximum numbers of people who could use the area at any one time. At the Scarborough teams base we saw that rooms were available for patients who had accessibility needs.

Staff made sure equipment was well maintained, clean and in working order. For example, we saw at the Middlesborough base the clinic rooms had labels attached to equipment to confirm it had been cleaned.

Safe staffing

The service did not have enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. However, this resulted in long waiting times in some teams.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe.

Community-based mental health services of adults of working age

The trust provided us with staffing figures for the end of March 2023. In total there was a budget for 196 whole time equivalent staff. Due to the trust offering flexible working the whole-time workforce was 174 staff. The trust had mitigated the gap and, in most cases, had an over-established position. The whole-time equivalent hours worked equated to 185 staff, with 22 staff vacancies across the service at the end of March 2023.

In March 2022 Easington South team went into business continuity due to staffing issues and had a 50% vacancy list including three band 6, one band 7 and one band 8 (associate nurse consultant) registered nurses, two social workers and one support worker. Initially Easington North team picked up new referrals for the South team to support them, this arrangement was stopped as Easington North's waiting list increased. The combined Easington North and Easington South team caseloads at the time of our inspection was 849 patients, when the expected target was 500.

Some mitigations had been put in place. For example, Easington South had 135 unallocated patients, where patients did not have a care-coordinator allocated. This had reduced from 250 patients, and the reason the team entered business continuity. Seventy patients were considered 'on-hold' where a care coordinator had left. The leadership team reviewed all the 'on-hold' patients and reallocated high-risk patients' quickly. All other patients were new referrals or unallocated. The longest waiting time for a patient to be allocated was from August 2022. This was not in line with trust targets, which should be 21 days from when the referral was made from the access team to allocation to a care coordinator. The modern matron was reviewing all the unallocated cases. The team managers did not have a caseload. Newly qualified staff had a capped caseload.

The perinatal mental health (PNMH) team also had staffing issues. The early intervention psychosis teams in Scarborough had been allocated patients from the perinatal service, The trust provided us with information to explain this decision. The North Yorkshire and York perinatal mental health (PNMH) was in business continuity due to vacancies of senior practitioners in the service. One of the actions taken to mitigate risk was to reallocate patients within the PNMH team's caseload to the community team most appropriate to each patient's needs. The community team staff supporting business continuity included psychology, nursery nurses and occupational therapists. Medical oversight remained from the PNMH Consultant. Therapy in reach provision was provided from PNMH staff. As a result of this decision some patients had been reallocated to the early intervention in psychosis team, which was in keeping with the early intervention in psychosis pathway as patients were referred to and from the perinatal team for support during and after pregnancy.

Staff turnover varied, for example, Redcar and Cleveland early intervention in psychosis and Redcar and Cleveland access teams had a zero percent staff turnover. The highest turnover rates were in the Redcar and Cleveland affective disorders and Middlesbrough affective disorders teams which were 20 and 32 percent respectively. The trust continued to work on their turnover rates to understand the reasons people were leaving.

We observed in the daily safety huddles that managers had planned to cover staff sickness and absence. In some teams, managers covered visits to patients, or rearranged appointments if patients agreed and this was safe to do so. For example, rearranging a physical health examination to the following day or week.

Sickness rates were variable across the service with highest rates of sickness being in the Scarborough community team (16%) and the York community team (16%).

Managers supported staff who needed time off for ill health. When we spoke with team managers and staff, staff sickness was not reported as a factor of transformation. Staff told us managers covered sickness, and we observed in safety huddles that managers picked up work to support their teams.

Community-based mental health services of adults of working age

Medical staff

The service usually had enough medical staff and most teams had at least one dedicated consultant psychiatrist. At the Whitby team we spoke with a recently appointed psychiatric registrar who was complimentary about the induction and support they had received as this was their first senior developmental post. Other psychiatrists we spoke with were also positive about their role and the transformation. Easington South team had vacancy for a consultant psychiatrist and the North team psychiatrist was covering South team patients. York outreach and recovery team had a locum psychiatrist covering this team, and there had been no permanent psychiatrist for over a year since the full-time psychiatrist retired.

Mandatory training

Not all staff had completed mandatory training. The trust did not provide data at team level for adult mental health services, however for all adult mental health services across the North Yorkshire, York and Selby care group, there were several mandatory training courses with low compliance which included:

- listen up (48%)
- face to face medication assessment (67%)
- resuscitation level 1 (56%)
- resuscitation level 2 (56%)
- positive and safe level 1 (73%) and level 1 updated (39%)
- positive and safe level 2 update (52%)

Across the Durham, Darlington, and Tees Valley adult mental health services these included:

- listen up (44%)
- face to face medication assessment (64%)
- positive and safe level 1 (59%) and level 1 updated (32%)
- positive and safe level 2 update (57%)
- resuscitation level 1 (51%)
- resuscitation level 3 (70%)

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool (the safety summary) and reviewed this regularly, including after any incident. Patient risk was also discussed in the daily safety huddle and any risks related to patient's safety were identified and arrangements made to follow up either by individual team members or with other stakeholders, who had lawful responsibility for the patient's safety, for example local authorities or the police.

We reviewed records and found that risk summaries had been updated following safety huddles and included the agreed actions identified. We observed safety huddles across all the teams we visited. In the adult mental health team based in York, covering the Central and South areas, we observed patient risk was discussed and staff reported on how they had arranged to follow up patients the same day. Another patient was known to have left the UK and staff had contacted the police and team manager with the patient, who confirmed they were safe and well. In the Whitby team safety huddle, we observed staff had contacted the police after being alerted to concerns about a patient who had not returned to a supported service by an agreed time, so the local authority contact was tasked with confirming the patient was safe. In the Middlesbrough and Scarborough teams the safety huddle was supported by the leadership team to monitor, for example referral and waiting times. Advanced nurse practitioners were managing teams in these localities, and we observed senior managers had been allocated to support the advanced nurse practitioners.

The safety summary used a format to identify record and respond to risk. For example, if the duty worker, led the safety huddle they completed a record and agreed outputs overseen by the leadership team. High risk patients were identified, and a multi-disciplinary meeting time was agreed for further and ongoing monitoring.

Any patient alerts were shared with the team, as well as 72 hour follow up reports, or referral onto the crisis or home base treatment teams for follow up. The meeting used the situation, background, assessment, and recommendation (SBAR) tool to facilitate and strengthen communication between the team and for recording outcomes from decisions.

The records we looked at had risk management plans in place where appropriate. Risk and safety plans were also discussed in safety huddles and multidisciplinary team meetings (MDT) and updated at that time.

Staff recognised when to develop and use crisis plans and advanced decisions according to patient need. We observed good examples of staff discussing the need to develop crisis plans with patients. One example we saw was observed in the hearing voices group we attended when staff supported a patient to write down, how they managed intrusive voices. This led to wider discussions around the patient identifying other stressors increasing the frequency of voices and staff identifying other social factors the patient could seek help from, for example the local housing team.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. There were close links with the crisis team who would notify teams of anyone who had contacted them out of hours. Teams had a duty system to monitor referrals and prioritised referrals or patients that needed to be assessed urgently to be seen within 72 hours. During our observations of safety huddles, community mental health framework reviews, visits to and interviews with patients, we observed and were told that staff monitored risk and made every conversation count where risk was known. For example, patients told us they could have increased contact with the care coordinator, by text, telephone, or face to face meetings. This included meeting in non-clinical settings and meeting for a coffee, so patients did not feel anxious about having to visit the community team base.

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Most teams did not have waiting lists but those that did were due to staffing issues.

Staff could discuss patients they were concerned about in daily safety huddles and MDT's. This included patients who were on leave from the adults of working age acute wards, patients who were disconnecting from the service, not progressing in treatment, or needing medicine review.

Patients awaiting an autism assessment were reviewed every six months and staff dealt with any mental health issues. We saw examples of patients awaiting assessments for autism or neuro diversity or had a confirmed diagnosis having

these reviewed within MDT meetings. For example, support workers screening patients for attention deficit hyperactivity disorder (ADHD). Though we noted there was a two-year waiting list for neurodivergent assessments dependent upon how services were commissioned in local integrated care boards. In one MDT clarification was provided that waiting lists were assessed and monitored to ensure that patients in crisis had their wait time reduced.

Staff followed clear personal safety protocols, including for lone working. Post COVID19 the trust had adopted good practice in offering patients' phone, video conferencing appointments and or texting patients.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received up to level three safeguarding training if appropriate to their role. The trust did not provide training data at team level, however across both care groups staff were compliant with all levels of safeguarding training.

We observed safeguarding concerns were discussed in safety huddles and MDT meetings. This included patients whose children were known to have safeguarding protection plans in place. This included staff proactively referring families where domestic abuse was known to stakeholders, for example to the police and local authorities.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The Trust had an up-to-date safeguarding policy in place, that staff could access via the intranet.

Staff knew how to recognise adults and children at risk of or experiencing harm and worked with other agencies to protect them. Staff had standard operating procedures to guide them on how to work with other services when children or family member were at risk of abuse, including domestic abuse. Teams were either integrated with local authority social work teams or worked very closely together. For example, standard operating procedures included attending multiagency risk assessment conferences. This was a meeting where information was shared on the high-risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, independent domestic violence advisors, probation, and other specialists from the statutory and voluntary sectors.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could raise alerts themselves and through the trust safeguarding lead and had support and guidance from advanced associate nurse consultants, team managers and modern matrons.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. All records were electronic and easily accessible to staff.

When patients transferred to a new team, there were no delays in staff accessing their records. In the safety huddle meetings outcomes to transfer patients to other team were observed, for example, the early intervention psychosis team transferring a patient to the home treatment team.

Records were stored securely and access to the records system was protected. Staff had personal protected passwords, which were not shared with colleagues.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Staff received, stored, transported, and administered medicines safely. For example, in all the team sites we visited, we saw medicines were stored appropriately and stocks of intramuscular antipsychotic medicines were monitored by community and pharmacy staff. Stocks of medicines were reconciled, and expiry dates checked by pharmacy staff. Staff also had access to locked cases, with cold storage facilities to transport and administer medicines in the community. Access to clinics where medicines were stored was through digital access, with staff requiring passes. Keys to access medicine storage was through security protected storage.

Staff reviewed and accurately recorded each patient's medicines regularly and provided advice to patients and carers about their medicines. For example, we saw prescriptions for intramuscular antipsychotic medicines were reviewed and rewritten every three months as per the trust policy.

Staff stored and managed all medicines and prescribing documents safely. Patients' prescriptions were stored in locked clinic rooms and only staff had access to these records.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. During the review of patient records, we noted that staff had access to original inpatient prescription records. The trust policy allowed pharmacists to rewrite prescriptions for long-acting intramuscular antipsychotic medicines if there had been no changes made to these by medical staff.

Staff learned from safety alerts and incidents to improve practice. Safety huddles included discussions around patients who attended clinics to received medicines administered deep into the muscle or collect medicines prescribed by a psychiatrist. If patients did not attend this could be reported through the incident reporting system, dependent upon individual risk.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We observed examples of patients discussing with medical staff their experience of taking medicines by mouth or through a needle deep into the muscle during community mental health framework reviews. We saw patients shared how the medicines benefitted them, but also side effects, for example weight gain or drowsiness. Medical staff discussed the risks and benefits of reducing and increasing medicines according to NICE guidance. This included physical health monitoring, monitoring side effects and bringing forward review with medical and clinical staff. During contact with staff at patient's homes or site-based clinics, staff reviewed side effects using a recognised assessment tool.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Community-based mental health services of adults of working age

Staff knew what incidents to report and how to report them. All staff we spoke with were aware of when and how to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. All staff interviewed were aware of what type of incidents needed to be reported.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) between September 2022 and March 2023, there were 29 reported incidents that met the serious outcomes or death criteria where the patient was involved with adult community services. Most of these incidents were categorised as apparent/actual/suspected self-inflicted harm and not attributed to involvement with the community teams.

The trust used a dashboard to report deaths and ensure mortality and serious incident reviews were being completed. Reports included a breakdown of the themes of all the learning identified and included areas such as, care records, harm minimisation, policy compliance, referrals, transfers, communication, and intervention planning.

The Chief Coroner's Office publishes the local coroners reports to prevent future deaths which all contain 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.

In the last year, there had been no 'prevention of future death' reports sent to Tees, Esk and Wear Valleys NHS Foundation Trust relating to this service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. In discussions with patients, carers, and families they told us they had received apologies from the trust when they had raised concerns or made complaints and received an explanation.

Managers debriefed and supported staff after any serious incident. We saw evidence that staff were supported after serious incidents.

Staff were able to describe how they supported each other after patients had self-harmed in the community and discussed what they could have done differently. Staff described debriefing from incidents as a positive experience and part of personal development.

Managers investigated incidents thoroughly and usually involved patients and their families where appropriate. Staff had meetings with manager as part of the incident investigation process, which included reflecting and learning to improve individual practice.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were able to request feedback from incidents they reported as part of the incident reporting system. Staff told us they requested a debrief with managers using this system.

Staff met to discuss the feedback and look at improvements to patient care. Safety huddles, staff and reflective practice meetings were provided to reflect and learn from incidents.

Community-based mental health services of adults of working age

Is the service effective?

Good ➔➔

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a thorough mental health assessment of each patient. Formulation of risk assessment could take up to 12 weeks while staff and patients coproduced a care and treatment plan.

During daily safety huddles information related to risk was shared amongst team members, so teams had a shared understanding of patient risks on one another's' caseloads. Teams had a duty worker who would also monitor risk through calls received from patients, families, or stakeholders. The duty worker would triage risk and share information with care coordinators or other staff supporting patients and escalate risk. In the safety huddles we observed that higher risk patients were discussed, and actions agreed on how to respond to identified risk.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff reviewed and updated care plans when patients' needs changed. We reviewed care plans and found patients had an up-to-date care plan in place.

Care plans were personalised, holistic and recovery orientated. Patients told us care plans were coproduced and reviewed between them and their care coordinator, psychologist or other staff involved in their care.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Care coordinators were from a range of backgrounds including nursing, social work, psychology, and occupational therapists.

Patients could access psychological therapies, and this ranged from individual sessions to group work with online sessions offered. Access to psychological therapies varied across teams as the number of psychology staff varied between teams. There was a full time qualified psychologist in the Ryedale team who oversaw the Whitby and Ryedale psychological professions provision, including the work of the assistant psychologist and clinical psychology trainee

(doctorate in clinical psychology). The trainee and assistant psychologist was supporting the Managing Emotions Group, as part of a research project with the trust and university. Teams had support and therapy workers who worked with the psychologist and psychology assistants. Patients were supported to access local charitable and stakeholder service to access art therapy, gardening, cafés, and education and leisure facilities.

The managing emotions group was a response to increased referrals relating to issues in managing emotions. The group adopted skills from evidence-based therapies, for example cognitive and dialectical behaviour therapies and mindfulness. The aim of the group was to help patients develop better skills for managing their emotions. The group used the short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWEBS) to measure wellbeing at the start and end of each group. Feedback from the group was patients found sharing their and other patients' stories helped them understand they had similar experiences. Patients described the facilitators and other patients as knowledgeable, compassionate, showing empathy and improving their mental health. The research will continue to be evaluated over a longer period. The trust planned to offer more groups in the future as a rolling programme, guided by patients' needs identified at assessment. The trust was also considering other groups, for example to support patients living with anxiety.

We saw an example of how intensive home treatment was used to provide a patient with support at home, as an alternative to hospital admission. The patient was fully engaged with the decision, and very positive about the benefits this had on their mental health. The patient lived in a rural location and support at home was provided by a support worker and the patient's family. The offer also included psychological therapy, occupational therapy, medication, and advice. The benefits highlighted of using intensive home treatment or 'hospital at home' as a pilot, and as described by the patient as, a reduction in acute distress, reduced harm, improved mental health, because the patient continued with their daily life and activities, the patient stayed at home and reduced the possibility of the patient experiencing trauma and crisis. Support consisted of the team psychologist appointments alongside daily contact by telephone and home visits from the adult community and crisis teams working alongside family and other trust teams to support the patient in the community. This period of positive support did not result in an acute inpatient admission.

The trust was a member of the carers trust triangle of care membership scheme. Community teams (all trust services) completed self-assessment tool based on six key standards, this was achieved and in 2019 and the Trust was awarded 2-star accreditation (the highest level). This included the development of a carers charter developed by carers for carers whose family members or significant others received care from the trust. The trust trained 333 members of staff from across the Trust during 2022/23. The carer support role was introduced as part of the triangle of care and included carer leads, or champions were in place within each community team. Their role was to act as the link person within their locality to make sure a network or support forum was in place. We spoke with three staff who were carer champions as well as other team members who were engaged with carers. Staff highlighted the positive role of carer support. Examples given were the carers newsletter, carers were involved in providing feedback on improvements to services, the carers support groups in local areas led by carer champions gave carers a local voice.

In North Yorkshire, York, and Selby a clinical psychologist from the trust had worked with other stakeholder leaders on partnership working around dual diagnosis services for patients who had mental health and substance misuse needs. The 'Better Together' and 'Bridging the Gap; programmes were two innovative practices which brought together a practitioner network of multiagency and multi professional partners, to provide shared training between mental health and substance misuse services to increase confidence, competence, and communication between system partners. Examples of partner agencies were the police, the trust, local authority and local drug and alcohol services. The outcome has been a pledge that services worked more closely to break down challenges between different services, to make every conversation count between patients and professional groups so an infrastructure was created. Learning from this approach created three key principles of the person comes first, so multiple teams communicate, and the need

of person is at the centre. Secondly the let's talk approach where services communicate by contacting one another for a mutually supportive discussion to offer help within the limitations of their role or service. And thirdly the commitment to sharing training, learning, expertise, and emerging practices. This was aimed at creating a more skilled network to support people using services. This model had been reported in a publication for addiction treatment specialists and health and social care professionals working with people with drug and alcohol related issues. The trust aimed to use the learning from this approach as part of the community mental health transformation programme.

In October 2021 the trust formed the community mental health transformation vision. Part of the vision identified within the trust services; a large proportion of patients were not allocated to a community treatment team. One outcome of this work was the creation of the community navigator role across the Tees valley. This role was aimed at guiding patients to the right services and connecting them with their local community to access support and other services to improve their wellbeing and social connection. There were 11 community navigators in post and their role was to support patients navigate service boundaries and were patient not service led. Examples of how staff supported patients were supporting them to access local libraries, attend peer support groups, access advice services, housing, drug and alcohol recovery services, gender services, LGTBQ+ support groups and accessing psychological therapies. In 2023 the local Healthwatch organisations awarded the service a community innovator award.

Staff made sure patients had support for their physical health needs, either from their GP or community services. The trust had improved integration with primary care GP services and the NHS Right Care tool. Teams had established care pathways with local GP surgeries, so they shared information and diagnostic testing, so patients' physical health was monitored. Advanced nurse practitioners held weekly or monthly calls with local GP practices to discuss patient's physical health care needs, monitoring and prescribing of medicines. This included arrangements for using shared care protocols, so GPs could prescribe medicines for patients. Arrangements included sharing diagnostic results for monitoring the effects of high dose antipsychotic medicines in monitoring the risk of CVD. Examples of local cooperation included patients attending physical health monitoring at team locations to have blood tests by trust staff, could also take blood tests on behalf of GPs for patients where GPs could not obtain blood. The results of these tests were shared with the GP.

Patients attending for the administration of deep into the muscle antipsychotic medicines had their physical health monitored as per the National Institute for Health and Care Excellence (NICE) guidance CG178.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Healthy eating and stop smoking services were available. Patients told us that they had stopped smoking and using alcohol because of support from community teams.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. For example, the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) tool which was a is self-rating scale for measuring the side-effect of antipsychotic medications, or general anxiety and depression rating scale (GAD).

Staff used technology to support patients and some patients continued to access support online. Patients had access to apps to help them understand their mental health and access mindfulness and other therapies. The physical health teams also used haematology analysers; compact devices designed specifically for point-of-care blood testing. These devices helped staff analyse patients' blood when they were prescribed antipsychotic or mood stabilising medicines.

Patients did not need to attend their GPs for these blood tests, which was done at local sites and blood results were known within hours, so patients could receive their medicines on site if the therapeutic levels were safe. Patients told us the benefits to this technology was they did not have to make several trips to have tests and their results were known the same day.

Staff continued to offer a blend of online and face to face appointments, as patients had highlighted the benefits of this approach post the COVID19 pandemic.

Patients were also able to access group sessions online. Staff took part in clinical audits, benchmarking, and quality improvement initiatives.

Managers used results from audits to make improvements. An example of this was asking staff to use the correct codes when recording quality assurance tools.

Skilled staff to deliver care.

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Most teams within the services had a full range of specialists to meet the needs of each patient. Teams were made up of managers, consultant psychiatrist, psychologists, occupational therapists, therapy staff, nurses, and support workers. In some areas the teams were integrated with local authority social workers and where they were not, there were close working relationships.

Managers mostly made sure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care. Staff were supported to attend training courses to increase their skills with different members of teams sharing their expertise with staff.

Managers gave each new member of staff a full induction to the service before they started work. We saw that new staff completed the trust induction programme and new care coordinators or post registration qualified nurses had protected caseloads.

Managers supported staff through regular, constructive appraisals of their work. Staff told us they received regular managerial and clinical supervision and trust data supported this. North Yorkshire and York had 85% compliance rate and Durham Tees Valley had 94% compliance rate. Where a manager was not a registered clinician, arrangements were in place so that registrants could receive clinical supervision from a senior practitioner.

The trust was aware that recording of supervision was complex and told us that the data collated may not be accurate and that it was likely that more supervision was taking place than was recorded in some teams. Compliance was variable across all teams.

In quarter 4 of 2022-2023 83% of adult mental health staff in the North Yorkshire, York and Selby care group and 88% in the Durham, Darlington and Tees Valley Care Group were compliant with clinical supervision.

In the same quarter 85% were complaint with managerial supervision in the North Yorkshire and York care group and 88% in the Durham, Darlington, and Tees Valley Care Group.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meeting minutes were emailed to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had completed autism training since the last inspection in 2021. Staff were trained to complete physical health checks, including taking blood.

Multidisciplinary and interagency teamwork.

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each community team held a multidisciplinary team meeting and had case load supervision where teams could discuss and reflect on practice.

The management team, which comprised of the team leader, consultant psychiatrist, clinical psychologist, advanced practitioner, and social care manager led daily safety huddles. In safety huddles staff could refer to patient details displayed on team white boards in staff areas. We observed huddles taking place in each of the teams we visited and found them to be, short, effective, and comprehensive. The huddles offered the opportunity for each patient who needed to be discussed be reviewed, share any work, cover absences, review risk and review any key dates for physical health checks. Follow up reports were given form the previous day and follow up actions discussed from previous huddles.

Teams had advanced nurse practitioners, to support staff who monitored patients' physical health and linked into patient's GPs to discuss the physical health monitoring of patients being treated with long term antipsychotic medicines. Team bases had equipment to monitor patients' physical health equipment, so could monitor patients' health, for example blood pressure or electrocardiogram (ECG). An electrocardiogram is a simple test used to check patient's heart's rhythm and electrical activity, for the risk of heart conditions. Easington North and South teams had implemented the combined care pathway with primary care.

Staff had effective working relationships with other teams in the organisation including the inpatient wards and crisis teams. For example, patients were referred to the perinatal team for support during and after pregnancy.

Staff had effective working relationships with external teams and organisations including statutory stakeholders, housing, drug, and alcohol services and third sector support organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. In discussion with staff, they told us they were up to date with Mental Health Act training level one and two and trust data reflected this.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Team managers, advanced nurse practitioners and modern matrons were available to offer support, guidance, and advice on the use of the Mental Health Act code of practice. An example of this was patients who were on a community treatment order having their rights refreshed with the when attending outpatients' physical health or medicine administration clinics.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The trust Mental Health Act administration team were available to support staff with guidance and advice on the use of the code of practice.

Staff followed clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust policies and procedures were available on the trust intranet.

Patients had easy access to information about independent mental health advocacy. Patients who had community treatment orders could access independent Mental Health Advocates.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. This included patients who had deep into the muscle medicines administered at on site clinics.

Care plans clearly identified patients subject to the Mental Health Act, for example community treatment orders.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. In discussion with staff, they told us they had completed their mandatory training on The Mental Capacity Act and trust data reflected this.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff could access the related policies and guidance on the Mental Capacity Act on the trust intranet. describe the guiding principles of the

Staff knew where to get accurate advice on Mental Capacity Act. Staff could access guidance or advice on Mental Capacity Act from advanced nurse practitioners. Team managers or modern matrons.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. During interviews with our expert by experience and inspection team members, patients told us staff always took time to make sure they understood information, and their decisions were respected.

We saw evidence that staff assessed and recorded capacity to consent in the records, where they had noted patients did not always understand medicines and provided information leaflets on the medicines prescribed for patients.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history. Staff could not provide any specific examples but could describe scenarios using describe the guiding principles of the Mental Capacity Act.

Community-based mental health services of adults of working age

The service monitored how well it followed the Mental Capacity Act and made changes to practice when were necessary. The trust reviewed its policies through its governance frameworks and any changes to policies and guidance were shared through improvement forums, for example the fundamental standards meeting.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good  

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients were respected and valued as individuals and were empowered as partners in their care, practically and emotionally.

Staff were discreet, respectful, and responsive when caring for patients. We saw good interactions between staff and patients during the inspection. Most patients said that staff were meeting their needs, though they had experienced changes in care coordinators, this had improved. In the Easington South team patients said they had waited for 12 months for another care coordinator.

Patients described positive relationships with staff and their families. Patients and relatives described relationships that were strong, caring, respectful, supportive, and valued by patients and staff. Patients described partnerships, where they were involved in decisions about their care.

Some patients said getting through to teams in York and Middlesborough was difficult, because the phone lines were constantly busy.

Staff provided a range of therapies patients could choose from, as well as practical help. Patients said they valued the range of individual and group therapies available. Emotional support was described as valued, and patients were offered flexible times to meet with staff to accommodate individual health or work needs. Patients told us staff provided them with information about therapies, medicines, advocacy services and support and recreational groups provided by local charities and stakeholder services.

We spoke to twenty-five patients and three family members and reviewed information we had received from patients and families before the inspection. We received some negative comments related to the crisis service telephone and patients being able to speak to staff in the crisis team.

However, the integrated and early intervention in psychosis teams were described as responsive when patients contacted them despite some teams having vacancies. Two patients told us during discussions with an expert by

experience that they had asked to change worker, because they did not feel comfortable or listened to by that staff member. The change had been made without question and had been dealt with by their care coordinators. Patients expressed unhappiness about external services not provided by the trust, for example specialist counselling for survivors of abuse.

Staff supported patients to understand and manage their own care treatment or condition. We observed meetings between staff and patients where staff explored patients' current presentation and what they could do to support them.

Feedback from patients was continually positive about the way staff treated them. Patients told us staff went the extra mile and their care and support exceeded their expectations, they were involved in medicine reviews, helped them research information on medicines and listened to their concerns about the side effects of medicines. Patients were positive about the range of therapies available, for example cognitive behavioural therapy, which they could access from the teams.

Patients we met in Middlesborough told us about how community support workers supported them to attend other community groups, work with local housing associations, utilities companies and local charities to help them access support and volunteering opportunities. Patients described their relationships with staff as being the best therapy they could have and positive transformational life experiences as a result.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us staff supported then to access a wide range of activities in their local communities throughout the trust. This included hearing voices support groups, swimming, keep fit (on prescription), art therapy, archery, community choir, voluntary work, gardening groups, further education, housing support, debt advice and community cafés as some examples. Patients highlighted the benefit of having support from staff to access service until their self-confidence improved to attend activities themselves.

Staff understood and respected the individual needs of each patient. Patients told us how respectful relationship with staff were and gave examples of not sharing information about their care and treatment with families. Patients told us staff respected their choices, even when they were unwise and could impact negatively on their health, and these choices did not hinder their good relationships.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients and staff. We observed a therapy group and the staff leading the group reminded patients about the ground rules of respecting one another's experiences, views and values, and the behaviours within the group. During home visits to patients, one patient described how their care coordinator was always respectful and tolerant, when the patient was not at their best. During another visit we observed a support worker advising a patient on speaking up and who to contact, when their neighbours made personal comments.

Staff followed policy to keep patient information confidential. Staff ensured during the inspection that any patients were aware that anything discussed during our observation of reviews, home visits and therapeutic activities was with the patient's permission and treated with confidence. Patients also told us that staff would not share information with anyone they did not wish it to be shared with. For example, some family members.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Community-based mental health services of adults of working age

Involvement of patients

Staff involved patients and gave them access to their care plans. As part of this inspection, we asked patients about how the trust made progress against the NHS mental health implementation plan 2023 to 2024 development of new and integrated models of primary and community mental health care. Patients told us as part of the personalisation of their care, they were involved in shared decision making about their care and treatment. Their care and treatment were coproduced around care, support planning and a choice of services offered to them.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients told us staff helped then understand their care and treatment and we observed this during our visits to see and engage with patients. For example, we observed a therapy session in one of the early interventions in psychosis teams, when staff helped understand their life experiences and showed empathy and shared their own life experiences. This included advising the patient on preparing for meetings, by using timelines and identifying triggers to what increased their distress and hearing voices. The patient told staff how using a video to help their family members understand their experience of hearing voices had an immediate impact and reduced their distress.

Staff involved patients in decisions about the service, when appropriate. We saw an example at Huntington House, York, where a patient with Autism had worked with the reception staff to improve directions to the waiting area, to support other neurodiverse patients attending for appointments.

Patients could give feedback on the service and their treatment and staff supported them to do this. At each team site we visited reception staff offered patients a feedback questionnaire, and there were patient information packs containing feedback forms. Patients told us when they attended MDT meetings, they were asked about the service they received, and how the service and or their care and treatment could be improved.

Staff supported patients to make advanced decisions on their care. In Scarborough we observed a patient discussing their plans to reduce personal risk during a visit with their care coordinator. The patient told us they were in the process of developing an advanced decision, with the aim of reducing hospital admission and this was something they had discussed with their care coordinator over time.

Staff made sure patients could access advocacy services. Patients were aware of local advocacy services and patient's families also told us they could advocate on behalf of family members.

Staff informed and involved families and carers appropriately. Family members told us they were invited to MDT meetings and were supported by family support workers.

Involvement of families and carers

Staff usually supported, informed, and involved families or carers. We spoke to three carers who said that they were happy and felt involved and that some patients attended appointments with a family member. Patients highlighted how they were supported as family members and carers, and the positive effect this had in helping to maintain and heal relationships between them and their families.

Staff helped families to give feedback on the service. Family members could give feedback to care coordinators, the friends and family test and in MDT meetings families could also provide feedback via a complaints or compliments process.

Community-based mental health services of adults of working age

Staff gave carers information on how to find the carer's assessment. We saw evidence of carers support and signposting within teams. For example, the early intervention in psychosis team friends and family groups in York and Scarborough.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times.

The service was not always easy to access. Staff assessed and treated patients who required urgent care promptly although some patients who did not require urgent care were waiting too long to start treatment. Its referral criteria did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they offered services to. If patients required an urgent response, they were seen within 72 hours and for non-urgent responses 28 days. Where access teams were the first point of contact for patients, the triage process acted as a filter to risk assess which service patients would be referred to. Otherwise, in County Durham, Darlington, Teesside, North Yorkshire, and York they provided a listening, support, and signposting service. Urgent referrals were through self-referral to the crisis and home treatment teams and or GP. For patients known to services access could be through the care coordinator or named worker.

The service was not always meeting trust target times for referral to assessment and assessment to treatment. There were variations in how long people were waiting for treatment across the core service.

Teams continued to receive high rates of referrals. The trust told us that the Durham and Tees Valley teams averaged 1200 referrals to access teams per month and covered a catchment area of similar size to Hartlepool, Stockton, Middlesbrough, and Redcar teams combined. The York team had seen a 30% increase in referrals since COVID19 with no additional investment to the team from commissioners. In contrast the Whitby team averaged 50 referrals per month and had no patients on the team waiting list.

The trust monitored access and waiting times across the service which included the time from referral to first contact and referral to second contact. Waiting lists included patients who were unable to or did not attend planned appointments which led to a longer waiting times.

Patients waited longer than 1 month for their first contact, at the time of the inspection, data provided by the trust showed that 319 people were waiting for their first contact for 1 to 3 months, and 238 people were waiting for 6-12 months. The Durham and Darlington Access team had the most people waiting however they also covered a greater population.

Patients waited longer than 1 month for their second contact, at the time of the inspection data provided by the trust showed that 755 people were waiting for their second contact for 1-3 months, 438 people were waiting 3-6 months and 191 people were waiting 6-12 months. The Durham and Darlington Access team and the York and Scarborough mental wellbeing access team had the most people waiting.

96 people had waited 1-2 years for their second contact, these were in the Harrogate and Ripon community team and the Stockton Affective disorder team.

36 people had waited 2-3 years. 32 of these patients were waiting for appointments with the Tees ADHD team and 4 for the Harrogate community team.

Staff monitored the needs of patients on waiting lists through the keeping in touch (KIT) process. This was implemented by teams to monitor patients awaiting assessment where they did not have an allocated care co-ordinator.

Where patients were unable to be allocated an initial assessment appointment date identified within 4 weeks, the patient was overseen by the duty desk. The patient was also sent a letter every 4 weeks to outline their waiting time and advice on what to do if their needs changed. If teams were unable to undertake additional assessment, intervention and or treatment due to waiting list times then patients allocated to KIT were placed on hold and informed to expect 3 monthly telephone contact which was the minimum standard. More regular contact would be arranged with individual patients. Patients GPs were informed the of current wait times. Telephone contact included information on the on current wait times for their assessment and / or intervention. Patients were provided with an opportunity to identify any changes in their presentation or if there if any additional support was required.

A recent review of the referral information showed that 60% of referrals were not entered onto caseloads. In response teams completed a planned number of triage assessments each month, ensuring patients were on the correct waiting list through a supportive and psychoeducation conversation with each patient. The team had lost access to the counselling psychology students which had previously increased capacity to deliver brief intervention, though students were planned to return to the team in October 2023 and increase the capacity for brief interventions.

The trust had created a post initial assessment and referral into secondary care adult mental health generic combined pathway. The purpose of the pathway was to support staff to provide consistent, assessment, formulation of need of need and delivery of care to individual patients. The pathway was focused on trauma informed and recovery focused care. This approach was aimed at being more person centred and staff having more time to know what was important to patients before treatment or other interventions were offered. The combined pathway took account of geographical differences due to local commissioning arrangements within the integrated care boards and that this would impact upon timescales for receiving services. The pathway allowed the trust to see benefits of clinicians having access to a wider choice of interventions that would only be offered when patients need were fully understood. The pathway had four phases. Phase one was getting to know you to develop the formulation of need. This offer was up to 6 sessions over a maximum of 12 weeks. Following this the patients moved to phase two or be signposted to other services and interventions not offered until completion of formulation of need. Phase two was interventions and treatment and phase three review. Phase four was preparing to move on from or to other services and or be discharged.

Patients had some flexibility and choice in the appointment times available. Most teams offered out of hours appointments, but the service was predominately 9-5pm. Patients told us appointments could be flexible to accommodate working and family commitments, this included medical and clinical reviews taking place at patients' home addresses.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff sometimes had to cancel or move the appointments times due short notice staff sickness. Patients told us teams were proactive in contacting them if appointments needed to be rearranged.

Staff supported patients when they were referred, transferred between services, or needed physical health care. If a patient needed to access the service again within 12 months of discharge, then they could refer themselves directly back into the service. For example, we noted two handovers from the early intervention in psychosis to the integrated teams in the safety huddles.

Following the trust's big conversation in 2021, they listened to people using services who told them that their models for treatment of people with experience of trauma or with a personality disorder had resulted in negative treatment. The trust had replaced these protocols with a harm minimisation protocol. Patients told us that this had improved some aspects of their care, however they felt that the new processes needed further embedding to ensure a culture change alongside a policy change.

The facilities promote comfort, dignity and privacy.

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Staff used a combination of home visits and online facilities to support patients.

Interview rooms in the service were not always soundproof to protect privacy and confidentiality. We saw posters up notifying people of this.

Meeting the needs of all people who use the service.

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and adjust for people with disabilities, communication needs or other specific needs. Most premises had disabled access and patients could be seen at home or through online facilities. The new hub in Middlesborough had a lift if patients required access, though all patient facilities were located on the ground floor. Staff and patients gave examples of where advocates had been used to help people raise complaints.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information about complaints were incorporated into information packs, as well as displayed in reception areas for patient and the public.

The service provided information in a variety of accessible formats so the patients could understand more easily. Patients told us information could be accessed online and through Apps on their personal phones.

The service had the facility to request information leaflets available in languages spoken by patients and the local community and whose first language was not English.

Managers made sure staff and patients could access interpreters or signers when needed. There was access to an interpreter service through the trust and or local authority.

Listening to and learning from concerns and complaints.

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

Community-based mental health services of adults of working age

Patients, relatives, and carers knew how to complain or raise concerns. We received mixed feedback and spoke to patients and carers who had raised concerns and had felt listened too. One carer said they were satisfied with the outcome of a complaint and one patient was still awaiting the outcome and so remained dissatisfied with the service. Information on how to make a complaint was contained within packs given to patients.

Informal complaints were managed through the patient advice and liaison service and the trust had a defined process for the management of formal complaints. Across all the community mental health teams of adults working age the trust received 54 complaints in the last 12 months. Seven of these complaints were either upheld or partially upheld and 23 complaints still in the investigation process. There had been 874 informal complaints through the patient advice and liaison service.

Staff understood the policy on complaints and knew how to handle them. Staff described how they would always attempt to resolve issues with patients at the time. Staff provided us with examples where patients had made complaints against them, for example when therapeutic relationships became challenging when patients did not agree with trust practice guidance. Patients were encouraged to complain and conflict resolution offered, or a change of staff was agreed.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. In discussions with staff about the complaint process they told us they had been part of the complaint process if the complaint was about them. The complaint process included meeting with their manager to discuss complaint resolution, reflection, and learning.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff confirmed if a patient made a complaint against them, then an alternate staff member would support the patient until the investigation process was completed.

Patients received feedback from managers after the investigation into their complaint. During interviews with our expert by experience, patients and relatives confirmed they received feedback after they had complained, and one family member said they disagreed with the outcome and were signposted to the national health service complaint ombudsman.

Managers investigated complaints and identified themes, they shared feedback from complaints with staff and learning was used to improve the service. Some complaints had related to individual staff and managers had responded by changing the patients care coordinator. We also saw an example of staff changing the location of the patient's appointment after a concern was raised.

The service used compliments to learn, celebrate success and improve the quality of care. Following feedback from patients the trust was undertaking a review of the complaints handling service in line with the NHS complaint Standards to provide a quicker, simpler, and more streamlined complaint handling service with a focus on early resolution.

Is the service well-led?

Good ↑

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

Community-based mental health services of adults of working age

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Team managers had a good understanding of the services they managed and could explain how collaborative working between different professionals within their and other community teams contributed to high-quality care for the patients. All staff spoke positively about team managers and said that they were available, visible, and supportive.

Senior managers had a clear understanding of the pressures within community teams and had regular meetings with the team managers. They felt able to escalate concerns to locality managers and felt supported to increase staffing levels when needed. The three heads of service understood the pressures and demand on the service in their areas. Staff were aware of who the senior managers were and spoke highly of them.

There were leadership development opportunities available to the team managers and other staff members. The community matrons and advanced nurse practitioners were visible and approachable to patients, staff, families, and carers and had oversight of the daily routines of the service.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were aware of the trusts vision and values and could explain how they applied to their role. Managers discussed the vision and values in staff supervision and appraisal.

The trust vision and vales were displaced in all reception areas of services. This included information on the Trust's 'journey to change', a 5-year plan that had specific goals in relation to co-creation of services with patients, staff, and partners.

Since the last inspection in 2021 the service had undergone a significant organisational restructure, moving from three operational localities to two care groups which was fully implemented by April 2022. The trust had two care groups, Durham, Darlington and Tees Valley and North Yorkshire, York, and Selby. Each care group had its own managing director and care group board. The care group boards were comprised of a lived experience director, group medical director, group director of therapies, group director of nursing and quality. In the North Yorkshire, York and Selby care group, there was also one care group director for all service areas. In Durham, Darlington, and Tees Valley there were four care group directors, with one for adult mental health service, which included community mental health services.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected and valued by their team managers and worked closely and collaboratively within their teams. Staff supported each other and we saw examples in Teesside of good staff resilience, despite staffing pressures. Staff demonstrated a patient centred service, and we observed good interactions between staff and patients in the sessions we were part of. Staff were positive when they discussed patients and their work.

Staff knew about the whistleblowing policy and how to raise any concerns and felt confident in doing so. Staff were aware the trust had a freedom to speak up guardian and could raise concerns through individual staff side trade unions.

Managers felt confident that staff would come to them to raise any concerns they have. All staff spoke highly of the team managers and the support they provided.

Staff highlighted the main cultural challenges were recruitment and retention of staff and were aware in some teams this was an issue, and understood the trust were addressing this issue, but could not influence the numbers or experience of applications for roles.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The service monitored its performance against trust targets using key performance indicators. These were discussed with staff in daily meetings and with the community matrons.

All staff we spoke with were aware of the governance structures in place for the service. Staff were able to highlight areas of risk for escalation through the governance structures via the morning huddles and speaking with the advanced nurse practitioners, Team managers, modern matrons, and service managers.

Team managers attended the care group fundamental standards meeting. This was not part of the formal governance process, but actions were recorded rather than formal minutes and this meeting was attended by the trust community and inpatient services. A monthly report was produced and shared via the formal governance groups. We saw the most recent report from May 2023. This included examples about the new patient record system which was going live in 2023. Staff were able to give feedback about the going live date and completion of training modules. Feedback was provided that training modules could be repeated while the system was new, and some teams were early adopters and team champions would support staff.

Environmental safety checklists for community team bases were due in July 2023 and the chief pharmacist was to be invited to the next meeting to share the new pharmacy audit process. Other examples were, community teams were reminded to submit quality assurance tools on time, for example the accurate recording of patient on a community treatment order and how to ensure that carer assessments were recorded.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the risk register at team and service level and could escalate concerns when required. Staff were able to submit risks for the trust risk register through the morning huddles which were escalated by managers through the quality assurance groups. Managers highlighted difficulties in recruitment as an issue impacting on risk and performance.

Service managers attended leadership supercells fortnightly to discuss key themes emerging and risk. Key risks identified on the risk register were staff recruitment and retention and waiting times for patients to be allocated to a care coordinator.

Managers were able to escalate quickly when risk are identified.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had accessible and usable information systems and the equipment they needed to complete their role such as computers and mobile phones. All staff had issues with the trust records system, which staff told us was slow, and there was regular interruption to this system and access to records. Staff were aware a new records system was being introduced in 2023 and they were in the process of completing training for the go live date.

Staff expressed frustration due to the implementation of a new supervision system, they told us that this new system meant there were now 3 online systems for recording performance, and this made more work for them. Managers told us supervision was also harder to track on this new system and for assurance they were using spreadsheets to log supervision time as a workaround.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

We observed staff working closely with external providers to ensure high quality care for patients. Staff told us they worked collaboratively with external providers to ensure continuity of care. For example, care coordinators and care support workers supporting patients to raise concerns about their accommodation, with housing associations including standards of accommodation, including repairs and noisy neighbours.

Complex commissioning arrangements existed across the trust due its geography spanning more than one integrated care system. This did cause differences to wait times in different catchment areas one example was the way in which autism and attention deficit hyperactivity disorder assessments were commissioned. The trust also worked with several different local authorities. We saw that regular meetings took place and managers had regular communication. There were close relationships with GPs and teams were working closely with primary care GP practice areas to improve the assessment and manage physical health monitoring in team localities.

Learning, continuous improvement and innovation

Staff informed us of the quality improvement programmes that take place within the trust, most recently the teams had completed a quality improvement exercise around the monitoring of physical health for patients. The service also held rapid improvement workshops for areas of improvement staff had identified.

Wards for people with a learning disability or autism

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

People were being cared for in accommodation that was safe, clean, well-maintained, and fit for purpose. The exception was the respite service at Unit 2 Bankfields Court. We observed that paint was peeling off walls in places, some curtains were not on rails properly and some window restrictors had been removed from a window as they were broken. The window did not fully open, but it was wider than recommended by the Health and Safety Executive (HSE). The provider took immediate action and arranged a visit from their Estates team the same day.

Environmental risk assessments were completed annually, or sooner if required, and identified any potential risks or hazards. We saw that the environments in which people stayed were personalised to their individual needs. For example, on Talbot ward at Lanchester Road Hospital we saw bespoke signage on the walls reminding staff about the need to reduce noise levels and footfall to reduce distress to this person.

People had easy access to nurse call systems and staff had easy access to alarms.

Suicide prevention environmental surveys and risk assessments were completed and staff informed us that they were done annually or after every incident. The assessment included all rooms at the location to identify any potential points which could be used to tie a ligature, information on how the risk was being managed and any action points required including requests for estates works.

The service was clean. The provider's infection prevention and control policy was up to date. Staff received training in infection prevention and control. Cleaning schedules were carried out daily.

People were being cared for on wards that complied with eliminating mixed-sex accommodation guidance.

People's living spaces had been adapted for long-term segregation where this met their need to live in spaces without other people.

The wards did not have seclusion facilities. One person was staying in circumstances which amounted to seclusion in line with guidance outlined in the Mental Health Act Code of Practice and appropriate checks and safeguards were in place.

Clinic rooms and equipment

Clinic rooms were clean and tidy and contained the correct emergency equipment. Staff maintained equipment and ensured that this was regularly cleaned and maintained in line with the manufacturer's instructions.

Wards for people with a learning disability or autism

Safe staffing

The service did not always have enough substantive staff and block booked agency staff. However, there was an improving picture in terms of recruitment and staffing numbers were improving with reduced incidents of low staffing due to the closure of some wards at Lanchester Road Hospital.

The service used a staffing tool that was reviewed in daily huddle meetings to check staffing levels across the service and ensure the correct skill mix.

The trust employed 236 staff across these services and there were 12 nursing vacancies, 7 for allied health professionals, and a 0.5 medical vacancy.

There had been 40 staff leavers between 1 April 2022 and 31 March 2023 with a turnover rate of 8%.

Sickness rates were variable across the wards. The highest rate of sickness in the previous 12 months was on Bek ward which had sickness rates of 28% for additional clinical staff, 43% for nursing, and 56% for additional technical staff sickness. Talbot ward had sickness rates of 29% for allied health professionals and 12% for additional clinical staff. Aysgarth and the Lodge Bankfields had 10% sickness rates.

There was always a qualified nurse on duty, at Bankfields court there were four nurses on duty during the day and three at night. At the respite services there was one registered nurse on duty during the day and night. At Lanchester Road there was always one nurse on duty for day and night shifts and the individual person was always supported by four staff.

Staff escalated appropriately when there were not enough staff to provide safe care. In the 12 months prior to the inspection, staff had reported 63 incidents of low staffing. However, there had been no reports since December 2022 and staff told us staffing levels had improved since the last inspection and that it was rare for the service to be short-staffed.

The trust's safer staffing reports included several red flags which would indicate low staffing numbers such as; staff being unable to take breaks, more than 50% of agency staff on the ward, and being unable to support leave. None of these wards had red flags reported on the latest safer staffing report in February 2023.

People using the services had core teams of staff which supported them to receive care which was consistent. People's carers and relatives told us that managers tried to provide consistent core teams and there was usually at least one core staff team member on each shift. One told us, "[Name] has a regular staff team. It's not always his core staff but there's always one of them, so there's always someone who knows him well. I honestly believe if he had the choice, he would stay here rather than coming home. It gives me peace of mind."

The service used bank and agency staff when there were gaps in staffing. Between 1 March 2022 and 1 March 2023 the service had used bank and agency staff for a percentage of shifts as follows:

Talbot 11% (bank) and 5% (agency)

Bankfields court 14% (bank) and 29% (agency)

Bankfields court 2 11% (bank) and less than 1% (agency).

Two family members raised concerns about the number of agency staff being used at the services and had concerns they did not have the skills and experience to care for their relatives. Some staff had also raised concerns about agency staff with managers. In response, managers had produced a written document that reiterated the expectations of agency staff and this was discussed and signed at the staff member's supervision. Agency staff completed a full induction to the service. Where possible, the service used the same agency staff. However, a rapid induction tool had been designed and was completed for agency staff who were working at the service for the first time.

Sickness rates were variable across the service with a lower rate of 6% staff sickness recorded at Bankfields Court and a higher rate of 29% on Bek ward at Lanchester Road.

Exit interviews were carried out with departing staff to identify reasons for their departure.

Family members and carers told us the service had enough staff to keep people safe and for them to take part in activities. One told us, "[Name] has a regular staff team. It's not always his core staff but there's always one of them, so there's always someone who knows him well. I honestly believe if he had the choice, he would stay here rather than coming home. It gives me peace of mind."

Mandatory training

The trust provided training data for all adult learning disability services. Not all staff had completed and kept up to date with their mandatory training. Some training was not achieving the trust target of 90%. Most notably mandatory training which is important for staff and people's safety had low rates of compliance across the service, including:

moving and handling parts 1 and 2 (47.73%)

positive and safe care level 1 update (42.62%)

positive and safe care level 2 update (59.64%),

adult basic life support (67.77%)

The trust told us that access to training had been complex following the pandemic and this related to accessibility of trainers and of locations for training to be completed.

At our last inspection of the service, we told the trust that they must ensure that staff were trained in the specialist care of people with a learning disability and autism. The trust told us that staff were receiving bespoke autism training in May 2023, were moving through training in the SPELL framework and refreshed training in positive behaviour support. The trust continued to roll out the Oliver McGowan training programme.

Assessing and managing risk to patients and staff

Assessment and management of people's risk

Staff carried out an assessment of people's individual risk when they were admitted to the service.

Wards for people with a learning disability or autism

Staff were knowledgeable about the people they supported and their individual risks. For example, we saw that one person had an about me board in their living space which shared their likes and dislikes for support and ways in which to communicate with them to support them and reduce risks.

In all records we reviewed, staff had used a recognised risk assessment tool and risk assessments were regularly reviewed and updated.

People had risk assessments in place which included that suicidal/self-harm behaviours were managed through individual intervention plans. Any increase in risk would instigate a further risk assessment and subsequent care planning that may include enhanced observation and engagement.

People had individual engagement and observation plans described in their intervention plans, which outlined the level of intervention they required to remain safe.

Staff encouraged and supported people to take positive risks. For example, to access the local community and take part in activities of their choice. Staff talked to us about how individual blanket restrictions on the wards had continued to reduce, for example that two people were now able to have access to the kitchen who had not been able to previously.

Five people were being supported in single occupancy care and support which was the trust's term for long-term segregation because staff had assessed this as being the most suitable option to meet their needs in line with their individual risk assessments.

Since our last inspection several people had made advancements in socialising and accessing outdoor space more frequently with a view to them leaving long term segregation. The trust were working with HOPE(S) practitioners to review whether people could move on from long-term segregation. HOPE(S) is a national programme that focuses on a human rights-based approach to working with individuals in segregation, developed from research and clinical practice.

All people living in long term segregation accessed the local community and had S17 leave. Staff were proud that people at Bankfields court were now able to visit each other to socialise and able to leave their accommodation to meet other people. Staff told us that although the current arrangements may not fit with traditional models of long-term segregation, they continued to put safeguards in place to protect people and would only remove the long-term segregation safeguards when it felt safe and appropriate to do so.

In line with the provider's safe use of long-term segregation policy, people in long-term segregation had weekly reviews with their multi-disciplinary team with oversight from their consultant psychiatrist, and a detailed multi-disciplinary review took place monthly. An external review was carried out quarterly, including input from an independent mental health advocate and responsible commissioner.

Restrictive practice

Since the time of our last inspection staff told us that they felt the use of restrictive practice on the ward had reduced.

Between March and May 2022 (at our last inspection of the service) staff had recorded there had been a total of 2201 restraints, 1634 at Bankfields Court and 567 at Lanchester Road. There had been 3 prone, 1609 supine, 185 standing, 3 kneeling, 209 seated 33 seated pat bag, 48 escorted and 241 as other.

Between 1 April 2022 and 31 March 2023 there had been 3,443 incidents of restraint across the whole service. There had been 43 incidents of prone restraint, 1587 of supine restraint, and 172 episodes of rapid tranquilisation.

Data provided by the trust showed that in the last 8 months the numbers of restraint had reduced. There were 1426 episodes of restraint between the four months of September and December 2022 and 987 between the four months of January and April 2023.

There remained high levels of restrictive interventions which included 33 episodes of prone restraint, 1067 episodes of supine restraint and 92 episodes of rapid tranquilisation. Prone restraint is a type of physical restraint holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone and being placed prone onto any surface. Due to the high-risk nature of this restraint, the 2015 Mental Health Act Code of Practice which states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position". NICE guideline NG10: Violence and aggression also recommends avoiding prone restraint, and only using it for the shortest possible time if needed.

The use of rapid tranquilisation had reduced. Rapid tranquilisation is an intramuscular injection used for the management of severe agitation and aggression. At this inspection we saw that the use of rapid tranquilisation had been significantly reduced and a person-centred care plan was in place to support the person. A family member told us, "Originally there were 100 plus incidents every six weeks, now there are 3 or 4."

We were also concerned that staff undertaking restraint within this service could potentially not have all completed the required training to do so safely, however we observed the daily management processes that mitigated this risk.

There were no seclusion rooms at the service. One person was being supported in seclusion and their living environment had been adapted to accommodate this. The service used a multi-disciplinary team (MDT) approach to the person's seclusion. The trust told us that four nursing reviews were carried out with this person per day, regular MDT meetings took place, and leaders monitored seclusion through the person's care plan. Because this was a deviation from the trust's seclusion policy, we saw that best interest decisions were in place. However, this is not in line the Mental Health Act Code of Practice which outlines that nursing reviews must take place every two hours.

Safeguarding

The trust's safeguarding adults and children's policies were up to date. Staff knew how to access them and who to contact if they needed any advice.

Staff understood how to protect people from abuse and had received specific safeguarding training. Staff compliance with safeguarding level 1 training across adult learning disability services was 95.52%, level 2 was 96.80% and level 3 was 80.46%.

Managers made safeguarding referrals when they had concerns about people's safety and welfare and followed up safeguarding referrals to ensure they were aware of any outcomes.

Any safeguarding concerns were identified on admission and documented in care records. Safeguarding was discussed in the daily MDT meeting to enable any concerns to be dealt with quickly.

Wards for people with a learning disability or autism

Medicines management

Staff followed systems and processes to prescribe and administer medicines safely. Guidance for the administration of medicines was detailed, person-centred and in place for all people. Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. Prescription charts were completed fully and no issues were identified in the records we reviewed during the inspection. Staff usually recorded the reason for administering PRN (when required) medicines in the daily notes. However, this was not consistently recorded for all people. We brought this to the attention of staff for review.

Medicines and prescribing documents were stored securely. Treatment rooms were clean and tidy. The pharmacy team attended onsite to complete stock checks and medicines optimisation audits regularly.

Staff followed national practice to check people had the correct medicines when they were admitted, or they moved between services. A robust process was in place for the people we looked at and medicine's reconciliation had been completed in a timely manner. Risk assessments and protocols were in place to manage the use of medicines and PRN medicines safely when accessing the community with staff.

The service was working towards achieving the aims of STOMP. STOMP is stopping the over medication of people with a learning disability, autism or both with psychotropic medicines. Examples were seen where this had been completed effectively and psychotropic medicines had been stopped or reduced successfully.

Track record on safety

The trust had an up-to-date incident reporting and serious incident review policy. This described how the trust learnt lessons, identified good practice and improved services as a consequence of an incident review.

Staff knew how to report and record incidents on the trust's internal incident reporting system. Incidents were reviewed by leaders and at daily huddle meetings.

Compliance with incident reporting training across adult learning disability services was 97.22%.

Between April 2022 and April 2023 learning disability inpatient services had recorded 579 incidents on the national reporting and learning system. Of these incidents, 472 were reported as no harm, 105 were reported as low harm, 4 were reported as moderate and 1 as severe.

The service had not reported any unexpected deaths or never events.

Staff described how outcomes from incidents were shared and any lessons learned were disseminated among staff. A 'learning from serious incidents' bulletin was produced that described what had happened, areas of good practice and areas for development.

Staff were able to give examples of how changes had been made in the service because of incidents which had occurred in other areas of the trust.

Staff attended regular handover, debrief and team meetings where they were able to share concerns, discuss incidents and work together to resolve problems.

Wards for people with a learning disability or autism

Since our last inspection, the service had undertaken a number of measures to improve the safety of the service and as a result there had been less incidents. Improvements included but were not limited to:

the adult learning disability transformation programme

service wide action planning and review

the use of quality assurance tools and audits

working closely with another care provider

staffing review

enhanced practice development leadership

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Assessment of needs and planning care

Staff carried out an assessment of people's physical and mental health needs on admission.

All people using the service had care plans in place which included positive behavioural support plans where this was required. Care plans were holistic and detailed, but quality was variable across the service, in some cases they required further detail or more regular updates.

People's care planning documentation was person centred and holistic, it included specific detail such as; summary of history and diagnosis, moving and handling plans, communication plans, behaviours and triggers, discharge planning, leave and current focus and achievements.

For two people we saw that further detail was needed in their care plans, this included that one person did not have a one-page profile in place and no photograph on their missing person's information. For another person we saw that there was not enough detail to enable staff to respond consistently to a person's distress.

People's physical health needs were not always being monitored appropriately and records were not always accurate. For three people, the National Early Warning Score (NEWS) tool, which improves the detection and response to clinical deterioration in adult patients, was not being completed correctly. Scores were incorrectly calculated, which meant observations were not being carried out as often as they should be.

People had easy to read health and hospital passports in place. Hospital passports are designed to give hospital staff helpful information about the person being admitted. For example, how the person communicates.

Wards for people with a learning disability or autism

Best practice in treatment and care

Staff provided a range of care and treatment which was suitable for people using this service.

People had support to manage any physical health needs. As well as having access to onsite professionals, each patient was registered with their own GP. People were supported to attend their GP when required, so they received appropriate and timely support and treatment. Staff had also arranged for some health appointments to take place at the service, so people did not have to go to the surgery.

Staff had offered talking therapies to people and they had yielded positive results. Talking therapies are effective and confidential treatments delivered by fully trained and accredited NHS practitioners. They can help with common mental health problems like stress, anxiety and depression.

Staff were using the HOPE(S) model of care to support people to move on from long term segregation. HOPE(s) practitioners were based within the services several days each week. Staff were also using a variety of methods to build skills for independence to support people's discharge from hospital.

Positive behaviour support plans were detailed and person-centred. They included triggers, warning signs and intervention plans to enable staff to support the person appropriately and safely.

Staff used a variety of tools to communicate with people using the service which included talking mats, picture symbols and the use of electronic applications.

Staff supported people to live healthier lives. This included support with exercise and support with nutrition and hydration.

Staff took part in clinical audits, benchmarking, and initiatives. The service took part in the trust's quality assurance programme. Staff carried out clinical audits within each service including of medication and clinic checks. Managers carried out regular record audits to make sure records were accurate and up to date. However, these were not entirely effective as they had not identified issues we found with care records and physical health records.

Staff used recognised rating scales to monitor outcomes and progress. For example, the service used data relating to incidents and restrictive interventions to monitor people's progress and identify themes and trends where support could be changed to reduce risk of incidents being repeated.

The service had been supportive of the independent care and treatment review process and actions were in place where required to make improvements to care and treatment.

Skilled staff to deliver care

Staff received a comprehensive induction to the trust, followed by a local induction to the service.

Since the last inspection, a training development plan had been put in place. This included specific training in learning disability and autism, including the Oliver McGowan training and SPELL. SPELL is a framework for understanding and responding to the needs of people with autism.

Staff told us they received regular supervisions and an annual appraisal. The trust confirmed that in Q4 of 2022-2023, 87% of staff had been in receipt of clinical supervision and 100% of eligible staff had been in receipt of managerial supervision. In March 2023 77% of staff in adult learning disabilities teams had undertaken an appraisal.

Staff we spoke with told us that the team met regularly for team meetings and team huddles to discuss risks, issues and learning within the service and from the wider trust.

Multi-disciplinary and interagency team work

People received care that was delivered by a multi-disciplinary team which included; psychology, positive behavioural support practitioners, consultant psychiatrists, doctors, an associate nurse consultant, physical health practitioners, speech and language therapists, occupational therapy and nurses and health care assistants. Multi-disciplinary meetings took place every morning with each person and care planning was completed from a multi-disciplinary approach. The meeting was carried out by video call from Bankfields Court so staff at Lanchester Road could attend remotely.

Handovers took place at the end/beginning of every shift. This ensured staff were kept up to date about the people they supported.

Staff had worked with external partners to support people in their discharge from the service. The trust had sought support from stakeholders to make improvements to the service.

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

The trust had a variety of policies in relation to the Mental Health Act. These were readily available to staff. Staff knew how to contact Mental Health Act administrators for support when needed.

Staff had received training in the Mental Health Act and in most cases demonstrated a good knowledge of the Act and Code of Practice. However, some staff told us they were confused about the concept and application of long-term segregation and seclusion.

People had their rights under the Mental Health Act explained regularly in a way they could understand.

People had access to advocacy services when required and we saw that some people had been supported by their advocates to raise concerns about the length of time it was taking for onward placements to be identified.

Staff ensured that people had regular access to section 17 leave from the ward which was appropriately planned and reviewed.

Good practice in applying the Mental Capacity Act

The trust's Mental Capacity Act (MCA) policy was up to date and readily available to staff. Staff had received training in the MCA. They had a good knowledge of the Act and knew where to go for support.

People were supported to make decisions. Care records showed how the MCA was appropriately used when the person lacked capacity to make a specific decision about their care and support, decisions were made in the person's best interests.

Leaders had identified that people may require applications for deprivation of liberty safeguards when they were discharged from the service.

Wards for people with a learning disability or autism

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

During the inspection we observed that staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs and supported them to understand and manage their care, treatment or condition.

Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional needs and sensory sensitivities. Staff were able to tell us about people, such as their specific individual needs, and their likes and interests. People's living spaces had been personalised to meet their individual needs.

Staff knew when people needed space and privacy and respected this. Staff directed people to other services and supported them to access those services if they needed help.

Family members and carers spoke positively about the caring nature of staff. One told us, "I think the quality of care is very, very good. You can feel whether they do actually care and they do." Another told us, "There's a real bond and they [staff] go above and beyond all the time."

Involvement in care

Staff involved people in planning their care and support. However, not all care records contained evidence of this. Some people attended weekly meetings to discuss and review their care. Other people were represented by their family members and carers. Family members and carers told us they were involved in putting together care plans.

People were listened to, given time and supported by staff to express their views using their preferred method of communication. Staff supported people by using Makaton, social stories, electronic devices and applications and signage and pictures. Staff took the time to understand and develop a rapport with people.

Staff respected people's choices and wherever possible, accommodated their wishes. We saw evidence of care which was highly personalised, people had notice boards to share key information with staff. We saw that staffing rota's contained pictures of staff who would be supporting people.

People were able to attend weekly patient meetings to share their views about the service and their care.

Staff informed and involved families and carers appropriately. All families and carers we spoke with told us staff kept in touch regularly and contacted them if they had any concerns about their relative. Staff supported people to visit their families and made phone calls and used photographs to share memories and milestones with people's families.

Wards for people with a learning disability or autism

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

The service was closed to new admissions at the time of the inspection and there had been no recent admissions. Most people had been admitted from the local area.

The people who were being supported by the service had complex needs. The service was working with partners to support people to be discharged from hospital and had discharged some people to community placements since our last inspection, however lengths of stay remained significant. The average length of stay at Lanchester Road was 429 days. The average length of stay was between 768 days and 998 days at Bankfields Court. The average length of stay in the respite services was 4 days.

The service recognised that some people were experiencing delayed transfers of care and were working with partners to take action to address this. However, there were several challenges and outside factors that had contributed to the delays, such as lack of suitable community placements and accommodation.

Discharge plans were in place for 7 of the 9 people at Bankfields Court and Lanchester Road. People's long-term goals were documented and there were discharges planned for later in the year. However, two people did not have clear discharge plans in place.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported people's treatment, privacy, and dignity. The exception was the respite service at Unit 2 Bankfields Court, which needed refurbishment.

We saw that some people's living spaces were bare in places, and although staff told us these communal areas were not always accessed by people, they would benefit from redecoration. One carer we spoke with commented that the units were not very homely.

There were quiet areas for privacy and most people were supported in their own individual environments. Most people had their own private kitchen facilities and outside space that could be accessed easily.

Family members and carers told us the facilities were clean and fit for purpose.

Patients' engagement with the wider community

Staff supported people to take part in their chosen social and leisure activities on a regular basis. Within the inpatient services these included shopping, eating out, bowling, going to the cinema and gym, and daily living skills such as cooking their own meals.

Staff made sure people had access to employment and education opportunities. One person had a job and had been asked to speak at a conference.

Wards for people with a learning disability or autism

Staff helped people to stay in contact with families and carers. Family members and carers told us that they had good contact with their relative, including regular phone calls and visits were encouraged and accommodated.

Meeting the needs of all people who use the service

The service met the individual needs of the people they supported. All the accommodation was on the ground floor and was accessible for people with mobility needs.

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. Staff understood and supported people's cultural choices, religious beliefs and gender preferences. We saw that two people had been supported with their specific religious beliefs.

People's communication and sensory needs were being met. Each person had a personalised communication care plan in place that described their individual preferences, and an easy-to-read communication passport. Information was available in an accessible format. Makaton and story boards were used to aid communication.

Listening to and learning from concerns and complaints

Managers and staff treated concerns and complaints seriously. Staff had a good knowledge of the complaints process and told us they received feedback and details of lessons learned from complaints via bulletins and team meetings.

The provider's complaints policy and procedure were up to date and information was on display about how to make a complaint.

There had been no formal complaints made to the service in the last 12 months, but 3 had been submitted via the patient advice and liaison service (PALS). The complaints received by the service related to; staff behaviour outside work, staff not working within agreed care plans and one related to a financial reimbursement.

Family members and carers told us they knew how to make a complaint. Because staff were in regular contact with family members and carers, most concerns were addressed immediately before they became formal complaints.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Staff told us they knew who the senior leaders were and they clearly communicated the direction and vision of the trust.

Managers were visible in the service and had the skills, knowledge and experience to perform their roles. Managers knew people well and had a good understanding of their individual needs. Staff described that leaders were approachable and supportive.

There were good opportunities for staff development at all levels and this was encouraged and supported by managers. Staff and leaders had been encouraged to take part in learning and development opportunities to improve the quality of the service.

Leaders within the service had made significant progress in improving the quality of care since our last inspection. Leaders were using a quality improvement approach to enhancing the delivery of the service.

Vision and strategy

The trust had a clear set of values linked to its organisational strategy.

- Respect – listening, inclusive, working in partnership
- Compassion – kind, supporting, recognising and celebrating
- Responsibility – honest, learning, ambitious.

Managers and staff were aware of the trust's visions and values. Information on trust values was posted on notice boards on all wards.

Managers described how they and their teams fitted into the trust's vision and values. Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives.

Culture

The culture of the service had improved since our last inspection. There was a positive staff culture. Staff felt respected and valued and worked together as a team. One staff member told us, "Staff do feel valued." Another told us, "It now feels like a different place to work."

The trust had taken action where required when the behaviour of staff had not been in line with the trust's values or where safe care had not been provided.

Staff knew how to escalate concerns and were aware of the trust's whistleblowing and freedom to speak up policies. Staff had access to the trust's Freedom to Speak up Guardian. The guardian is an independent and impartial source of advice, whose role is to support any staff member who wishes to raise a concern.

Managers had listened to staff about what it meant to feel valued. As a result, a staff wellbeing action plan had been created and a wellbeing staff room had been developed. Staff contributed to the development and improvement of the service via 'you said we did'.

Managers told us they were confident staff would come to them with any issues or concerns. Staff we spoke with confirmed this.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and performance and risk were not always managed well.

The service used key performance indicators to measure and monitor performance, these were reported monthly to the care group board. Improvements to the service were overseen by the action plan and programme board.

Some governance processes were not entirely effective and embedded because they had not identified some of the issues we found during the inspection, such as, with the continuing high use of restrictive practices, physical health monitoring, the quality of some care plans, and the issues with the environment at the respite service at Unit 2 Bankfields Court and that some people did not have person centred environments to stay in.

Staff at all levels were clear about their roles and were involved in quality assurance processes. Staff completed a variety of weekly and monthly audits that were reviewed by managers. Daily management huddles took place where service managers and the modern matron discussed any issues that required immediate action. Audits and issues were escalated and discussed at the relevant improvement and delivery group.

Management of risk, issues and performance

Staff were able to escalate risks to the service level, care group and corporate risk registers. Leaders told us that the key risks relating to the running of the service were staffing and vacancies.

The trust had taken action to make improvements to the service since our last inspection. The chief executive had utilised the support of a system partner to visit the service and undertake reviews to support the service to improve. The partner trust had visited the service in June 2022 and again in March 2023. At the second visit in March 2023 they noted significant improvements since their visit last year. Citing the following positive improvements:

- S17 leave had increased, and they could see increased levels of interaction patient to patient which was “virtually non-existent last year.”
- Restrictive Practice Interventions had reduced.
- Staff morale had improved.
- There were improved connections with system and wider partners to support discharge and transition.
- Staff were receptive to change and wanted to engage with changes to the service and were committed, caring and open.
- Feedback from the external partner also stated that the trust needed to continue to progress with discharges and with continued reduction in the use of restrictive practice.

Information management

Patient information was stored on a secure electronic record system, which all staff could access. This system was used throughout the trust. However, the system wasn’t always fit for purpose and staff at the service had been involved in trialling a new electronic record system that was due to be rolled out across the trust later in the year.

Information governance and data security awareness were included in staff mandatory training. Compliance with information governance and data security training across adult learning disability services was 91.08%.

Engagement

People, family members and carers were involved in the running of the service. Family members and carers told us managers and staff kept them up to date and communication was good. Two people had been invited to support with interviewing for new staff.

People using the service were encouraged to participate in activities of their choosing in the community which included employment.

Managers and staff engaged well with other healthcare professionals and had good links with partner agencies. These included; the Challenging Behaviour Foundation and Skills for People, who helped support a patient council and took part in joint staff interviews.

The service continued to work with stakeholders and partners to make improvements to the service and to support discharge from the service.

Learning, continuous improvement and innovation

Managers and staff kept up to date with best practice. For example, the physical health doctor worked with trust physical health groups to research and discuss NICE guidance specifically impacting people with learning disabilities and autism.

The service had adopted the Five Good Communication Standards by The Royal College of Speech and Language Therapists and was working closely with HOPE(S), a human rights based approach to reducing long term segregation.

Managers involved staff in quality improvement projects. For example, staff had contributed to a new suicide prevention, environmental survey and risk assessment template. Quality improvement training had been rolled out to all staff. The training covered a number of areas to support and improve processes within the service and staff were allocated projects as a result.

The provider kept up to date with national policy to inform improvements to the service.

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

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of most ward areas, and removed or reduced any risks they identified. Each ward had an up-to-date environmental risk assessment which identified and mitigated risks on the wards. The exception we found, was that staff had not included within the written environmental or ligature risk assessment on Cedar Ward one specific ligature risk which we highlighted to the trust.

Staff could observe patients in all parts of the wards. Where there were blind spots across some wards, these were mitigated by concave mirrors, CCTV or zonal observations by staff to mitigate the risks.

The ward complied with guidance on mixed sex accommodation. Although the two psychiatric intensive care units continued to provide care and treatment for both men and women patients, staff now worked better to mitigate the risk more fully. There had been no same sex accommodation breaches in the trust based upon the national eliminating mixed sex accommodation guidance within the last 6 months. All wards had en-suite accommodation which assisted with privacy and dignity.

Staff had implemented several interventions across the two PICUs with the aim of ensuring that patients and staff feel safe from sexual harm. Both PICUs had fully introduced zonal observations with staff present in areas of the ward not within eyesight of the staff, such as bedroom corridors and outdoor spaces. We saw staff deployed in these areas during our inspection. Staff discussed sexual safety in the daily report out meetings so that sexual safety risks were considered for every patient by the multi-disciplinary team. Most wards had invested in assisted technology, including telehealth systems in bedrooms that could detect multiple occupancies within bedroom areas.

In future, managers at the trust proposed to have one male PICU (Bedale ward) and one mixed gender PICU (Cedar ward). This was recently approved by the trust board, and the wards will be moving to this arrangement in late spring of 2023. This reflected the larger demand for PICU beds for male patients.

For the period April 2022 to March 2023, there were 233 incidents categorised as sexual safety incidents across Cedar and Bedale wards. Of these, there were no severe incidents, 2 incidents categorised as moderate, and the rest categorised as low or no harm often involving disinhibited behaviour by patients. For the two incidents categorised as moderate, it was clear that staff intervened to prevent a serious incident from occurring and for lower-level incidents zonal observations had prevented incidents escalating beyond verbal incidents between patients.

Staff were now fully considering the layout of the ward group patients of the same gender together as much as possible. The provider had also now addressed a small number of environmental issues relating to sexual safety. These were the changes to the outdoor fencing on Esk ward at Cross Lane Hospital and appropriate screening of the facing male and female corridor windows at Foss Park so that patients could not see across into the corridors of patients of a different gender.

Staff knew about any potential ligature anchor points and mitigated the risk to keep patients safe. The Trust was in the process of fitting new bedroom doors across the wards which were alarmed to detect any weight bearing. The Trust had started the project on wards for women and the psychiatric intensive care unit as these were deemed to be higher risk areas. Installation of new bedroom doors will be completed in November 2023. En-suite bathroom doors had been replaced with saloon style anti-ligature doors. Bedroom and bathroom fittings were anti-ligature. On some wards, some of the windows across the ward communal areas were locked open or closed into position as a safety measure. This was mitigating risk relating to their design and the possibility of using the window as a ligature.

Although the trust had taken some actions to reduce environmental deaths, there had been two further deaths relating to the use of ligatures on these wards in the six months prior to our inspection.

The trust had a ligature reduction programme and other key pieces of environmental safety work that were overseen by the Environmental Risk Group

Staff had easy access to alarms and patients had easy access to nurse call systems. Some wards did not have nurse call alarms, but patients were offered individual alarms instead. These arrangements were well understood by patients and staff and posters displaying these arrangements were on the ward.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. All wards were clean and tidy, furniture and décor was in a good state of repair.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2022), the locations scored about the same as or better than similar locations across England for cleanliness and for condition, appearance and maintenance. The most recent scores were:

- Cross Lane – cleanliness 97.9%; condition, appearance and maintenance – 98.3%
- Roseberry Park - cleanliness 98.9% condition; appearance and maintenance – 98.6%
- West Park - cleanliness 97.9%; condition, appearance and maintenance – 99.5%
- Lanchester Road - cleanliness 99.7%; condition, appearance and maintenance - 97.9%
- Foss Park - cleanliness - 97.6%; condition, appearance and maintenance – 100%

Staff made sure cleaning records were up-to-date and the premises were clean. Staff completed cleaning records. Equipment showed that they were cleaned regularly and after use. There was identifying stickers on equipment to show it was clean.

Staff followed infection control policy, including handwashing.

Seclusion room

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

Both psychiatric intensive care units (Bedale ward at Middlesbrough and Cedar ward at Darlington) had seclusion rooms. The seclusion room used by Danby and Esk wards at Scarborough was not currently fully operational due to a number of factors. It could be used for a short period if required for a patient awaiting patient transport to transfer them to one of the trust's psychiatric intensive care unit in a different location and where such patients could not be managed on the wards, subject to senior managers approval. The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

The seclusion room on Cedar ward was at the end of the male bedroom corridor which may impact on patients' privacy and dignity when patients were being escorted through the bedroom corridor. The trust told us that there had been 10 episodes of seclusion on Cedar ward of female patients in the last 12 months. Staff looked to preserve patients' privacy and dignity by either using the courtyard entrance to the seclusion room or clearing the corridor to access seclusion. As part of the work to manage the gender split of the PICUs to support sexual safety, the trust was relooking at this issue as part of maximising privacy and dignity.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room included room for medicines storage, including proper storage for controlled drugs which met national guidelines.

Staff checked, maintained, and cleaned equipment. Staff completed appropriate checks to ensure that equipment was clean and ready for use.

Safe staffing

The service did not have enough nursing staff, who knew the patients well. Not all staff had received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients fully safe.

The service employed 651 staff and there had been 46 staff leavers between 1 April 2022 and 31 March 2023, this was an average turnover rate of 7%.

There were high vacancy rates in this service. There were 86 vacancies, 8 were for allied health professionals, 3 were for medics, and 68 were for nursing staff. This was a 13% vacancy rate.

Across the wards, these significant staffing pressures were primarily due to registered nursing vacancies especially across Middlesbrough, Darlington and Durham. Since June 2022, the 5 wards based at Roseberry Park Hospital were in formal business continuity arrangements due to the high levels of registered nurse vacancies. The wards across West Park and Lanchester Road hospitals also had vacancies but they were not as significant and therefore did not require business continuity arrangements and were managed through risk systems (including through the trust risk register).

Most wards expected to have two registered nurses during the day but regularly operated below this level. The wards operated with one registered nurse at night except for the psychiatric intensive care units who had two nurses at night as well. Staffing levels at night were not as critically low due to the requirement only to have one nurse on most wards.

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

In the three months prior to the inspection from December 2022 to February 2023, data confirmed that the wards were operating significantly below required qualified staffing numbers. For example, in all three months most wards had consistently low fill rates for qualified nurses during the days. These included:

- 13 out of 14 in December 2022, with 4 of these wards operating at 50% or below.
- 12 out of 14 in January 2023, with 4 of these wards operating at 50% or below.
- 13 out of 14 in February 2023, but none of these wards operating at 50% or below
- 13 out of 14 in March 2023 with 1 of these wards operating at 50% or below.

The two psychiatric units who had the most acutely unwell patients were also operating on low qualified staff numbers especially during the day.

The lowest qualified fill rates for days were Bransdale at 46% in December 2022, 40% in January 2023, and 44% in February 2023, and Overdale at 41% fill rate in December 2022. Managers said that safe staffing levels were maintained, with shortfalls being covered by ward managers, matrons and professional practice leads and staff from other wards. These additional staff were not included in the fill rate information. It was not clear how this was consistently achieved when there were also staffing shortages across each hospital.

On some of the wards we visited, the actual qualified staff on the day shift was one nurse when it was planned that there should have been two nurses. This meant that many of the day-to-day duties of a regular staff member who knew the patients well fell to a single nurse to report on and make decisions about patients' care and treatment, including administering medicines, and attending report out, multi-disciplinary meetings, hospital managers hearings and mental health tribunals. Qualified nurses were supported by associate nurses and physical healthcare practitioners on most wards who could carry out delegated duties such as physical health checks. In addition, psychology staff were involved in formulation meetings and some aspects of care planning.

The trust were trying to take specific actions to mitigate the risks of staffing shortages. These supported the delivery of safe and effective care and included:

- Formal updates and oversight monthly via the care group board, with an opportunity to present any new requests including support from other areas of the care group, where staff have the relevant skills and experience
- Block booking agency staff
- Shift incentives for staff completing additional hours
- Advertising and recruiting nursing associate and registered general nursing staff
- Enhanced recruitment events and social media advertising.
- Reducing the number of 'non-urgent' meetings and tasks that need to be undertaken by the service to allow additional time for Ward Managers and Matrons to support wards.

Managers limited their use of bank and agency staff to staff familiar with the service. Managers were block booking agency staff, where possible.

Not all bank and agency staff had received observations competency assessments to help them understand their responsibilities before starting their shift. The uptake rates of current temporary staff (bank and agency staff) for

competency assessment on observations was low with 60% of bank staff and 29% of agency staff having completed the assessment. The trust had developed a central electronic record to improve the recording and oversight of compliance. Bank and agency staff were required to have training in basic life support, management of violence and aggression and training on the care records system. Bank staff were required to shadow a shift prior to working on wards.

The service had mixed turnover rates. Some wards had high turnover rates such as Cedar ward with a turnover rate of 28% and Stockdale ward at 22%; while others had low turnover rates such as Bilsdale (4%) and Elm ward (0%).

Managers supported staff who needed time off for ill health.

Levels of sickness were variable across the wards. The three wards with the highest sickness rates were at Middlesbrough - Stockdale ward (14.1%) Overdale ward (12.6%), then Bransdale (10.8%) and then Cedar ward at Darlington had the next highest (also 10.8%). These were much higher than the NHS England average for NHS mental health and learning disability services which was 6.5% at December 2022. Some wards had sickness rates below this – Bilsdale (3.6%) and Esk ward (3.8%).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The trust undertook an annual staffing establishment review, signed off by the trust board. This used an evidence-based tool including professional judgement approach to review the correct staffing establishments based upon acuity and dependency of the patients. In 2021, this informed the recommendations to the trust board for investment in the staffing establishment across the acute and PICU wards. Due to the challenges in recruiting registered nurses, this proposal supported the introduction of activity assistants, 7-day ward admin and peer support workers to support the therapeutic milieu of the wards, as well as a skill mix review to introduce an additional band 6 nurse on day shift to enhance clinical leadership and the introduction of practice development practitioners. We saw additional staff working in these roles on inspection.

The ward manager could adjust staffing levels according to the needs of the patients. Managers increased the numbers of non-registered staff on duty to support the ward to help mitigate reduced registered nursing levels. The trust had a red flag system for when staffing levels fall critically low. This showed common themes including staff being unable to take a break, staff unable to provide a response to another ward when necessary and less registered nurses on shift than required. The trust reported 39 low staffing incidents and seven red flags for this core service between January and March 2023. Most low staffing incidents involved not being able to carry out nursing review safeguards for patients in seclusion because they required two nurses. However, the red flag incidents also included four episodes when there was not a second nurse to carry out the necessary seclusion review so it had to occur remotely or could not occur and one incident where staff from other wards were called to help respond to an incident as alarms were raised on numerous occasions but only one member off staff from another ward responded to the ongoing incident on the ward.

Some patients told us that they did not have regular one to one sessions with their named nurse. The routine audits that the trust staff completed (such as the monthly ward based self-assessment tool, modern matron audits and practice development review audits) did not monitor uptake levels of named nurse sessions.

Patients rarely had their escorted leave cancelled, even when the service was short staffed. Patients told us that activities occurred during the working week as there were activities co-ordinators working. However, patients told us that in the evenings and at weekends the opportunities for therapeutic activities was much more limited.

The service had enough staff on each shift to carry out any physical interventions safely. Most wards had a Band 4 associate nurse and physical health practitioners who oversaw physical health interventions.

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

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. **Some wards had non-medical approved clinicians and prescribing pharmacists which helped with some of the duties covered by the doctors. Although there was an out of hours duty rota, the one on-call medical cover was shared with other wards at this location and the mental health crisis team. This also meant that out of hours medics may provide telephone rather than face to face input. We saw there was a delay in 'clerking in' one patient who was admitted late the night before we inspected due to the unavailability of medical cover. We were told this was an unusual incident. There were no other identified impact of the shared arrangements on medical cover out of hours.**

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. Most staff across the wards had completed training as part of their induction and ongoing refresher training with an overall uptake rate of 83%. Some of the main topics included were: -

- resuscitation
- harm minimisation
- safeguarding
- health, safety and welfare
- moving and handling
- positive and safe care
- rapid tranquilisation
- observation and engagement

However, some courses were showing low uptake levels. The lowest uptake rates among staff on the acute and PICU wards were:

- Resuscitation - Level 1 - 1 Year - 20%
- Positive and Safe Care Level 1 Update - 30%
- Listen Up - 44%
- Positive and Safe Care Level 2 Update - 59%
- Positive and Safe Care Level 1 - 60%
- Prevent - 70%
- Fire Safety - 2 Years - 70%
- Safeguarding Level 1 - Corporate - 71%

- Resuscitation - Level 2 - Adult Basic Life Support - 1 Year - 72%
- Face to Face Medication Assessment - 74%
- Safeguarding Level 3 - 74%

The shortfalls in the positive and safe training may account for some staff not feeling fully confident in dealing with regular self-harm attempts over a sustained period from some patients with more complex needs.

Where training uptake rates were lower, managers had plans in place to ensure staff completed the training quickly to improve uptake rates and refresh staff knowledge.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust was aware that compliance with face-to-face training such as basic life support/resuscitation and positive and safe care training were below compliance on some inpatient areas. This was mitigated via daily staffing processes which ensured team were able to identify any skills shortfall and, where required, staff were moved to ensure wards had safe numbers of skilled staff. The trust were also addressing the challenges around accessing statutory and mandatory training by exploring external trainers for the north Yorkshire care group.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviours. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The improved systems to help staff record and understand patient risks were now fully embedded. Patient safety incidents were pulled through into the patient overview area of the patient's record so incidents could easily be found by staff including agency and bank staff.

We identified a small number of recent incidents which had not been fully recorded in the appropriate sections in patient's records. The risks were still mitigated as action was usually recorded elsewhere in care plans, safety plans or other parts of the record. In addition, the risks were fully mitigated in other ways such as through current observation levels, escorted leave and other arrangements.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff completed patient's risk assessment, safety summaries and safety plans which included management strategies. These contained detailed information about risks associated with the patient including history of risk, current self-harm risk, and physical health issues. Safety plans included primary, secondary and tertiary strategies to manage risks including action to the patient, staff and others.

Staff identified and responded to any changes in most risks to, or posed by, patients while on the ward. We observed 'report out' meetings and saw risks were discussed and agreed within multidisciplinary teams. At these meetings, staff were making checks on records to ensure that risks, incidents, observation levels and leave decisions were properly and consistently recorded. This helped to ensure that systems were in place so that clinicians had up-to date and correct information when making decisions to keep people safe and managers could be assured that information, they received was accurate. Each ward had daily ward safety reviews so that all staff had a shared understanding of risks relating to patients and the ward environment. This included housekeepers, bank and agency staff through to ward managers and modern matrons.

Staff were not always mitigating risks when detained patients went out on leave or informal patients left the ward, even though there had been some recent serious untoward incidents of patient out on leave from the ward. Modern matrons were auditing against the trust expectations regarding the recording of patient's leave conditions on the trust's formal section.17 form. The audits showed continued shortfalls in some areas of the expectations. Staff were also expected to complete a leave monitoring form which indicated that a risk assessment was carried out prior to leave from the ward being granted via a tick box but the actual risk assessment was frequently not documented anywhere else in the care record to evidence that a risk assessment had occurred.

Staff were not completing the leave monitoring form appropriately regarding the times of leave across all sites. Staff were not always recording the expected or actual return time and/or outcome of agreed leave for detained patients or the expected time of return agreed with informal patients. This included detained patients with unescorted leave who did not have staff with them. This meant that staff may not be supporting patients fully to adhere to their conditions of leave. The lack of recording meant that there may be a delay in staff taking action to consider detained patient as absent without leave or make enquiries about the whereabouts of informal patients.

We saw an incident where an informal patient stated they would be back for a certain time but did not return at that time. The expected time the patient was due to return was not recorded on the leave monitoring sheet. The patient later phoned the ward to state they were suicidal.

There were also examples of responsible clinician's authorising overnight leave with no specific expected return time detailed on the locally devised authorised leave forms. There was no locally agreed specific expected time of return for overnight patients either. This meant that staff could not easily oversee when patients were expected to return from overnight leave and when they would consider the patient as being absent without leave. It was not clear on some records that staff had discussed the outcome of leave to promote adherence to any conditions of leave in the future. There had been two recent serious incidents while patients were out on authorised section 17 leave, and we were concerned that these shortfalls meant that there was a risk of further incidents from happening.

Staff did not always feel fully confident when patients regularly and seriously self-harmed. From speaking to staff and looking at records, it was clear that they were caring for a greater number of patients who repeatedly self-harmed as a regular feature including cutting themselves, ingesting items, headbanging and ligaturing. The trust had a policy on harm-minimisation and the training uptake for staff on the acute and PICU wards around self-harm and harm minimisation was 93% as of 30 April 2023. However, some staff we spoke too did not feel fully confident in caring for patients who repeatedly self-harmed including the confidence to intervene or support the patient to take responsibility themselves where appropriate.

Staff followed procedures to minimise risks where they could not easily observe patients. Most substantive staff had received training in carrying out observations and engaging with patients. The training uptake for skills/competencies required to undertake supportive engagement and observations on the wards was 77% or above.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were reducing over time but more recent data had not been submitted nationally to understand the current picture. The national reporting tool identified a rate of recorded uses of physical restraint (excluding prone restraint) per 100 mental health inpatients on the trust's general mental health wards and this had reduced from 95.4 in the twelve months up to August 2020 to 85.7 in the twelve months up to September 2021. We did not have access to the extracted restraint data for the 12 months up to October 2022 to understand the current trend.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust had governance meetings to oversee and support reductions in restrictions. This included a restrictive intervention panel, a long term segregation and prolonged seclusion review panel, and care group reducing restrictive practice meetings. There were no significant blanket restrictions in place; patients had access to fresh air, mobile phones and their possessions. Patients also had access to hot water to make a drink. Where restrictions were in place, these were individualised decisions based on the patient's presentation and risk assessment or what we would expect to find on a mental health acute ward such as supervised access to razors. Some staff felt that the reduction in restrictions to allow canned drinks (except to patients with individualised, specific risks) caused difficulties to manage this risk fully on the wards.

Each ward door was locked but patients had ready access to fresh air through unlimited access to courtyards, grounds and gardens. We saw informal patients asking to leave the wards and staff responded to requests for the doors to be unlocked quickly.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. There were 2223 episodes of restraint and 2253 episodes of restrictive intervention for the period 1 April 2022 to 31 March 2023. This included 602 episodes of supine restraint and 39 episodes of prone restraint. Where staff restrained patients, this could occasionally result in prone restraint being used unintentionally. For example, if a patient manoeuvred into prone restraint and staff did not use this intentionally. It also included very short periods of prone restraint where a patient was resisting and required intra-muscular injections for mental disorder given compulsorily under the Mental Health Act. Staff were still required to record these as a prone restraint episode, so it could be reviewed.

The two psychiatric intensive care units had the most restraint episodes - Bedale PICU ward with 583 episodes and Cedar PICU ward with 426 episodes of all recorded restraints. This reflected that the PICUs provide care for people who are more acutely mentally unwell. The female general mental health wards across the trust accounted for the four wards with the next highest levels of restraint with Overdale ward (261), Elm (157), Bransdale (141) and Esk (123).

There were 5 episodes of mechanical restraint on the mental health acute and PICU wards; 3 of these related to patients being put in handcuffs by either the police attending the ward or a patient transport service as part of transferring a patient to another hospital following their risk assessment. The other two episodes were to move the same patient safely to seclusion using soft handcuffs. This involved getting agreement from senior managers prior to using mechanical restraint and a debrief following their use.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff we spoke to understood that restraint should only be used as a last resort and with the minimum restraint necessary.

Staff did not always follow NICE (National Institute for Clinical Excellence) guidance when using rapid tranquilisation. For those people who had received medicines in a crisis, staff were not always recording the required observations or recording that patients had refused them so we could not be assured that these had taken place. There were 880 recorded episodes of rapid tranquilisation for 1 April 2022 to 31 March 2023 – 277 of these were on Bedale PICU ward: 161 on Cedar PICU ward –reflecting that patients on these wards were more acutely unwell. Records showed evidence that patient's vital signs were monitored after rapid tranquilisation had been administered on most wards in accordance with the National Institute for Health and Care Excellence (NICE) guidance. However, these were not always clearly or consistently recorded or the forms evidencing the monitoring were not available, especially on Overdale and Tunstall wards. These two wards also had the highest numbers of rapid tranquilisation episode on the general mental health acute wards – with Overdale with 93 incidents and Tunstall with 72.

When a patient was placed in seclusion, staff kept records but could not always follow best practice guidelines around nursing and medical reviews due to staffing problems. There were 114 recorded episodes of seclusion for 1 April 2022 to 31 March 2023 – 67 of these were on Bedale PICU ward; 36 on Cedar PICU ward. There were 5 episodes of seclusion at Scarborough which was only used while awaiting a psychiatric intensive care unit bed. These episodes were still recognised as seclusion with the professional review safeguards still carried out.

The trust provided data showing that there had been a small number of seclusion episodes on wards without a seclusion room – Stockdale (3 episodes), Maple (2) and Bransdale (1). The trust subsequently clarified that these 6 episodes of seclusion were wrongly categorised against the wards where the patient was when the need for seclusion was recognised.

A small number of patients had been secluded on several occasions. For example, on Bedale ward 5 patients accounted for 42 out of the 67 episodes of seclusion. If a patient from Cedar ward required the use of a seclusion room and Cedar ward's facility was in use, the patient would be transferred to Bedale ward which accounted for the larger number of seclusion episodes being apportioned to Bedale ward.

When patients were subject to longer periods of seclusion, compliance for recording the necessary nursing reviews was variable with missing nursing reviews and frequent times when only one nurse had been available rather than two nurses as required the Mental Health Act Code of Practice safeguards. Initial and ongoing medical records and multi-disciplinary team reviews were not always recorded either or showed time delays, especially when these occurred out of hours. Staff had been reminded individually and in communications to either complete the record of the reviews or provide an explanation of why they were not able to meet the safeguards, including recording the attempts to get support.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were two recorded episodes of long-term segregation for 1 April 2022 to 31 March 2023 – both were on Bedale ward.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The trust had different levels of safeguarding training depending on the role and grade of staff. This ranged from safeguarding level 1 e-learning for all non-clinical staff to level 4 training for clinical staff band 5 or above where they were working with adults and children.

Most staff kept up to date with their safeguarding training. There were good uptake rates for all levels of safeguarding training with uptake levels at safeguarding level 1 e-learning for clinical staff at 94%, 96% for level 2 training, and 74% of staff uptake levels for level 3.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The trust had a safeguarding and public protection team who supported staff to identify and progress safeguarding concerns and alerts.

Staff followed clear procedures to keep children visiting the ward safe. Each hospital had a children's visiting room which could be used by families and meant that patients could maintain contact with their children without them having to come onto the main ward area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding children policy and a safeguarding adults policy which had both been reviewed in July 2022. These were clear, relevant up to date and included the process for staff to follow. The policies were in line with legislation and national guidance. For example, the safeguarding adults policy referenced the Care Act.

A recent sample audit of safeguarding adults concerns carried out through sampling records completed in August 2022, showed that adult mental health services compliance rating was RAG (Red Amber Green) rated as amber with a 62% compliance rate. This showed that 88% of cases were referred to the local authority appropriately. The main shortfalls related to recording and keeping patients informed, no evidence was found that the safeguarding was raised with the local authority and no evidence was found of a report to police in particular cases. An action plan was in place for improvement which included training improvements, system improvements and review of supervision criteria and safeguarding link team members allocated to areas with highest safeguarding numbers. In November 2022, the trust had commissioned an external provider to complete an internal audit of safeguarding as part of the trust's 2022/2023 internal audit plan. The trust were given a good assurance rating showing improvement.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. The trust used an electronic system to record patient information. Staff had access to the system and some agency staff now had access to ensure consistency. Some staff felt that the system could be better but were able to locate all relevant information. The trust was in the process of implementing a new patient record system.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could access information about the involvement of other teams or episodes of care on the patient records system.

Records were stored securely. Staff could only access patient electronic records if they had appropriate passwords and permission.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. There were systems in place for staff to obtain any medicines prescribed including if these were needed in an emergency or out of hours. Staff stored medicines securely. However, on two sites, we found that oxygen cylinders were not always stored in line with the trust's policy.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff were visible on wards and attended multidisciplinary meetings. Patients and families could speak with pharmacy staff about their medicines.

Staff did not always complete medicines records accurately or keep them up to date. All prescribing we saw had been signed and dated in line with policy. However, we saw evidence on two wards of some minor gaps in medicine charts where staff had not recorded if a medicine had been administered. Staff completed temperature monitoring records daily in relation to clinic rooms and fridges used for the storage of medicines. However, on four wards, we saw that where staff had recorded that fridge temperatures had been just outside of the recommended range, no actions had been documented.

Staff did not always store and manage all medicines and prescribing documents safely. We saw that some of the authorisation paperwork for mental health medicines was not always available for staff at the time of prescribing or administering medicines. This was where treatment for mental disorder was given to detained patients usually after three months, the relevant legal authority for treatment (known as a T2 or T3 form) needs to be in place or a section 62 form completed for urgent treatment. Some wards had this paperwork with the medicines charts; on other wards we were told paperwork was kept with administrative staff, though for some people staff could not find the paperwork at all. These legal forms should be kept with the medicine charts so nurses administering medicines can check they have the legal authority to give medicines to detained patients, who may lack capacity or who may not be consenting.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation was completed in a timely manner.

The service had process in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, for two people we saw that they had received over the maximum prescribed dose of their 'when required' medicines and there was no clear rationale documented for this decision. For some people prescribed as required medicines, there was not proper guidance to staff to state which were the first- and second-line options. When it was recorded, the instructions were not always followed at the time of administration and there was no clear rationale for departing from the instructions documented.

Staff did not always review the effects of each patient's medicines on their physical health according to NICE guidance. We found that for people prescribed medicines that required monitoring for example diabetes, clozapine or lithium the required monitoring was not always completed or recorded. For two diabetic patients, we looked at blood monitoring was not in line with their diabetic plan and where people had refused monitoring, this was not recorded. Where people required daily observations, these were not always recorded. For example, patients on Clozapine are at risk of constipation, bowel movement monitoring was occurring to prevent the risk of patients' becoming constipated. However, there were occasional lapses on two files we saw where it was not always happening as regularly as required with no adverse effect on the patient.

Track record on safety

The service did not have a good track record on safety.

There had been a number of serious incidents which had been repeated where risks had not always been mitigated for example in relation to patients being able to self-harm by tying a ligature.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy. There had been 11 serious untoward incidents between 1 April 2022 to 31 March 2023, including those which met the statutory duty of candour threshold across the mental health acute and PICU wards. These related to 6 deaths but one of these was reported as an expected death; 4 incidents categorised as severe incidents and one incident categorised as moderate harm. Three of the deaths involved patients using a ligature across certain doors as an anchor point. Of these 11 incidents, two of the wards had two incidents each (Maple ward in Darlington and Danby ward in Scarborough); seven of the other wards had one incident. Five wards had no serious untoward incidents which were both wards at Foss Park in York, Tunstall ward at Durham, Elm ward in Darlington and Esk ward at Scarborough.

We were concerned that one serious incident related to a patient whilst they were on leave from the ward, and during this inspection the trust had not ensured that leave processes were in place and correctly followed by staff to prevent repeat incidents.

The service had no never events on any wards. A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. In mental health services, the relevant never events within hospital settings were actual or attempted suicide of a person due to the failure to install functional collapsible shower or curtain rails and falling from an unrestricted window.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust had recently had three comprehensive independent investigations into deaths in their care. One of these reports included aspects which related to adult mental health services. The trust had progressed the specific recommendations relating to Tunstall ward in terms of the improving the environment to reduce the risk of ligatures but were still embedding some of the changes within other recommendations.

Staff received feedback from investigation of incidents, both internal and external to the service. Following a serious incident that occurred within one of the trust’s inpatient wards, managers disseminated a safety briefing in relation to keeping patients safe and well through observation and engagement. This identified the potential risks associated with observations and engagements/care rounds being carried out at similar time slots on each occasion. For example, on the hour, quarter past the hour.

Staff met to discuss the feedback and look at improvements to patient care. Each day, ward staff attended a safety drill which included all important messages about safety on the ward and learning from across the trust.

There was evidence that some changes had been made as a result of feedback. There was learning from serious incidents through leaders sending recommendation reports and safety briefings. Most staff could talk about recent incidents and lessons learnt.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patients had a multi-disciplinary formulation of their needs within 72 hours of admission. This included daily discussions at report out meetings and checking on progress against assessments and tasks to ensure patients' mental health, physical health and holistic needs were assessed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff completed safety summaries and safety plans which included most aspects of care and treatment plans to record how staff and patients would work together to help keep people safe and aid recovery relating to their mental health. These were completed to a good standard. Staff also completed intervention plans for patients, but on most wards rather than duplicating information in the safety plans, these tended to focus on physical health and other needs.

Staff had a good understanding of patients in their care and were able to comment as to what would constitute improvement and a change in behaviour for patients they were allocated to.

Staff regularly reviewed and updated care plans when patients' needs changed. Safety and intervention plans were regularly reviewed. Daily 'report out' meetings ensured there was appropriate oversight and action to address patient's needs, aid recovery and work towards discharge.

Care plans were personalised, holistic and recovery orientated. Some wards had implemented a new recovery focused assessment and care planning process. This involved asking a set of 11 questions where patients were asked to rate their satisfaction and needs for care across different parts of their life and treatment. It helped to guide a structured conversation and plan between staff and patients that was patient centred, with a focus on change and the patient's own priorities. Where we saw evidence of these engagements with patients, the plans produced were person-centred and centred around patients recovery goals.

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

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. This included staff following guidance from the National Institute for Health and Care Excellence (NICE) on the treatment of specific conditions including depression, schizophrenia, and personality disorder. Staff followed national guidance when patients were on high dose anti-psychotics (which were anti-psychotic medication given above recommended doses in a single or combined dose). Staff regularly monitored patients who were on lithium to ensure no long-term adverse effects.

Staff worked to meet the needs of autistic people but summary information about people could be better on some files. There were a significant number of autistic people with co-morbid mental health needs (such as anxiety, depression and schizophrenia) on some of the wards. There was evidence that staff had taken account of their needs and documented these for most autistic patients. This included having individualised positive behavioural support plans including traffic light systems and using reversible octopus toys so people could show their moods, communication aids (having picture cards, talking mats, and flash cards available via speech and language therapists) and having regard to people's sensory needs (such as people having noise cancelling headphones and permitting people to eat in their room if they could not tolerate mealtimes). Where appropriate, people also had a care and treatment review to see what further work needed to be done to work towards discharge. The trust employed an autism project team which included a nurse consultant who provided specialist supervision, consultation and support as required to the wards. This offer was to be enhanced further with plans to recruit to a small psychology-led team which would include training, inreach to the wards and which staff could draw on for support.

However, on a small number of care records, it was not always clearly indicated in the records what people's current and future needs relating to their autism were in the form of 'about me' document, one page profile or other care planning document which all staff could easily use. This was especially the case where the person was not known to the trust prior to their admission, or the person was suspected to be autistic but had not received a diagnostic assessment. The trust were working to address these shortfalls through a reasonable adjustment working group and autism steering group which were looking at improvements in four key areas for the wards:

- ward processes
- culture
- assessment, care-planning and discharge and
- training.

These priorities were identified at a trust-wide reasonable adjustment conference in July 2022 that looked to enhance how it cared for autistic people including when they were admitted to the inpatient wards.

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

Staff identified patients' physical health needs and recorded them in their care plans, but they did not always make sure this was correctly recorded and that appropriate checks were carried out. Staff supported patients to regularly use the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) tool which was a self-rating scale for measuring the side-effect of antipsychotic medications so these could be managed. This meant that staff could prescribe medication at a level that relieved patients' symptoms of mental ill health while ensuring that side effects were minimised.

Staff made sure patients had access to physical health care, including specialists as required. Most wards employed an associate nurse who carried out regular physical health checks on patients and identified and escalated concerns to the nursing or medical team.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff could refer patients to a dietician where necessary.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The wards had a no-smoking policy, and we saw staff reminding patients of this if they saw patients trying to smoke in the courtyards of the wards. Staff offered smoking cessation advice and support. Staff could refer patients to on-site gyms which were overseen by healthy living advisors/fitness instructors who were gym trained.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included the Lester tool, NEWS2 and brief psychiatric ratings scales (BPRS) and symptoms rating scales. The brief psychiatric rating scale (BPRS) is a tool clinicians or researchers used to measure psychiatric symptoms such as anxiety, depression, and psychosis.

Staff used technology to support patients. Most wards had telehealth systems in patient bedrooms. The system monitored some aspects of patients' vital signs, without staff having to enter their room. It also enabled staff to confirm that the patient appeared safe. It provided an alarm so staff could attend and respond appropriately if the remote vital signs monitoring system identified cause for concern.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Modern matrons carried out a monthly quality review. These reviewed standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team had developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.

In addition, practice development practitioners observed multi-disciplinary discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime and whether everyone in the team could contribute. Practice development practitioners worked with staff to complete robust risk assessments and ensured the quality of record keeping, including observation levels.

Managers used results from audits to make improvements. The trust had introduced practice development practitioners who had oversight of the wards in terms of audits and checked relevant paperwork has been completed appropriately. They carried out monthly audits and, where they identify issues, they were tasked with ensuring there was a plan to address shortfalls, which were also picked up in staff supervision or through training.

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

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, management supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Not all staff received clinical supervision.

The service had a full range of specialists to meet the needs of the patients on the ward. We spoke with a number of staff including the consultant psychiatrists, ward managers, registered and non-registered nursing staff and other professionals including the occupational therapists. Staff we spoke with were positive and motivated to provide high quality care. There were several staff in newer professional roles including non-medical approved clinicians, pharmacist prescribers, peer support workers and nursing associates.

Managers ensured substantive staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Not all bank and regular agency staff were supported with observations training. Staff we spoke with had a good understanding about supporting patients' recovery and address patients' individualised needs including promoting good mental health, psychosocial approaches, and supporting patients to adhere to the medicines prescribed for their mental health.

Managers gave each new member of staff a full induction to the service before they started work. This included trust wide and local induction, mandatory training and time shadowing shifts. Staff who were recently qualified nurses told us that they were provided with positive preceptorship and good support from staff within the unit and senior managers.

Managers supported staff through regular, constructive appraisals of their work. Staff told us they had received an appraisal. This was confirmed by data from the trust which showed 81% of acute and PICU staff had received a recent appraisal.

Staff did not have a full record that they had completed regular, constructive clinical supervision to support them in their work. Most members of staff had management supervision. The management supervision uptake rate for staff on the mental health acute and PICU wards for the period 2022 to 2023 was 77%. However, staff had more limited access to clinical supervision or were not always recording the clinical supervision appropriately. The clinical supervision uptake rate for the period 2022 to 2023 was recorded as 68%. Staff explained the shortfalls were either due to staffing difficulties or it was a recording and reporting issue. The trust had tried different methods to robustly record clinical supervision, but these have not been fully effective in accurately recording this information. Staff regularly attended and contributed to formulation meetings to reflect and discuss patients in their care.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers had not made sure all staff received all specialist training for their role. Only 55% of trust wide staff had completed understanding autism training which met most of the requirements relating to the new duty to ensure staff received appropriate training in line with the Oliver McGowan training requirement.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw examples where staff had been taken away from working on the wards and clinical duties because of alleged incidents until they were investigated fully.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Patients were discussed daily in multi-disciplinary meetings with medical staff, registered nursing and non-registered nursing staff and other professionals including psychologists and occupational therapists. Access to other professionals were via referral, for example dietician or speech and language therapy.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed several multi-disciplinary 'report out' meetings. There was comprehensive information on each patient to ensure that all members of the multidisciplinary team were kept up to date on current issues with patients and to inform decisions about future holistic care needs.

Ward teams had effective working relationships with other teams in the organisation. We saw there was effective liaison with crisis and community mental health teams to ensure patients were supported fully on discharge.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust supplied training data for all adult mental health services, the data includes community mental health teams. This showed an uptake rate of 93% of required staff had completed Mental Health Act level 1 training and 86% of staff had completed Mental Health Act level 2 training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Nurses who received detention papers had guidance on checking detention paperwork for common errors when detained patients were admitted to wards.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Responsible and approved clinicians and nurses we spoke with felt that the Mental Health Act administrative teams were approachable, supportive and had good systems for reminders to ensure professionals met their responsibilities under the Mental Health Act.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had a range of relevant Mental Health Act policies and procedures. For example, a 'Leave of Absence under section 17of the MHA' procedure. Staff knew how to access the policies and procedures.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Records showed that staff had considered whether specific patients would benefit from the services of an independent mental health advocate (IMHA) to support them to understand their rights.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff regularly repeated rights to patients and recorded the attempts they made. Detained patients we spoke with understood their rights including their right to appeal to the first-tier tribunal about their detention in hospital.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The detention papers were stored on each patient's record within the trust's electronic patient record system.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. On most wards there was a poster by the front door of the ward. except one ward where there was no poster, but this was addressed immediately at the time of the inspection.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Staff routinely recorded the patient's section 117 aftercare eligibility in each relevant patient's electronic record. The trust had an 'Inter-Agency Section 117 Mental Health Act' procedure which clearly identified who should be involved in aftercare considerations, including multi-agency decisions to remove aftercare eligibility and resolving disputes.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, guidance to staff on resolving disputes was incorrect.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The trust supplied training data for all adult mental health services, the data includes community mental health teams. This showed an uptake rate of 91% of required staff had completed Mental Capacity Act training.

There were no deprivations of liberty safeguards applications made in the last 12 months for the mental health acute and PICU wards. People receiving treatment on the mental health acute wards were usually detained under the Mental Health Act or agreed to an admission informally.

There was a policy on Mental Capacity Act and deprivation of liberty safeguards, but this was not fully clear about resolving disputes. The trust had a recently revised Mental Capacity Act policy and a Deprivation of Liberty Safeguards

procedure. These were available on the internet for staff, patients and the public to see. However, the Mental Capacity Act policy did not follow updated practice on resolving disputes. It incorrectly stated that the Care Quality Commission could get involved in disagreements about social care services and did not guide staff on other methods for resolving disputes involving incapacitated patients. Staff could describe and knew how to access the policies.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence that patients were supported to make decisions for themselves, for example through the provision of information in specific formats.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Where required best interest assessments had taken place. The trust had a separate form to record best interest considerations. However, these forms had not always been completed fully in all cases. We saw one example where a patient was being considered for serious medical treatment under restraint. But the best interest considerations did not include or record the views of family members of the incapacitated patient.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. At the time of the inspection, there was no-one under a Deprivation of Liberty order on the acute wards. The trust had systems in place to tell us when they knew the outcome of a deprivations of liberty safeguards application.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 48 patients who used the service. Patients were complimentary about the standards of care and about staff that provided the care and treatment. They reported the staff were caring and professional.

Most patients were very complimentary about the quality and choice of the food available. The one exception was one patient who commented on the limited availability of gluten free food. We were assured by the ward manager that such food was available.

Patients told us they had access to activities during weekdays, but there was less to do in the evenings and at weekends. Some patients told us that there was too much focus on physical activities such as walking and going to the gym. Some patients were not aware of the activities available as there wasn't always an updated activities timetable. We spoke with staff about this who explained that activities co-ordinators were still implementing activities initiatives, not all wards had full-time co-ordinators and activities were often planned 'in the moment' depending on patients' interests.

Staff gave patients help, emotional support and advice when they needed it but staffing on the wards led to some delays. Staff supported patients to understand and manage their own care treatment or condition. We observed care and saw staff responding to patients quickly and speaking with patients with dignity and respect. Many patients told us that staff were responsive to their needs and had regular 1:1s with nursing staff. Some patients told us that staff could be busy, and at times told us that nurse staffing levels caused minor delays in dealing with requests, when only a registered nurse could respond to their request. However, a minority of patients (10) across all the sites told us they did not know who their named nurse was, and they were not having proactive regular and meaningful 1:1 conversations with nursing staff to talk about their mental health, wellbeing and progress. They reported that this was due to nursing staff being too busy as the wards were short staffed. Patients did say if they asked to speak to a nurse themselves this was facilitated.

Staff directed patients to other services and supported them to access those services if they needed help. Staff worked in multi-disciplinary 'report-out 'meetings where other teams attended such as pharmacists, community teams and housing liaison staff. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made enquiries or changes where possible.

Patients said staff treated them well and behaved kindly. Most patients told us that staff were very friendly, kind and supportive and were very complimentary about the quality of care they received. They told us that staff always treated them with dignity and respect. Where patients raised less positive concerns, they were in the context of not wanting to be in hospital.

Staff understood and respected the individual needs of each patient. Staff had a very good understanding of each patient and their individual needs. Patients did not raise formal complaints with us. Patients who were detained under the Mental Health Act were made aware of their rights.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Leaders had carried out culture reviews to ensure recent concerns in mental health hospitals were not occurring on the wards with no such culture being identified. We heard examples of staff raising concern about how patients were alleged to have been treated and appropriate action was taken.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff completed an admission checklist when patients were admitted which showed that patients had been shown around and given information about the hospital and its rules.

Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment. Staff involved patients in decisions about the service, when appropriate. Patients felt involved in their care and treatment and that staff involved their carers as appropriate. Patients attended multidisciplinary meetings to discuss their care and treatment and records showed their views were considered.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had meetings where they could make suggestions for day-to day issues such as activities for that day and where they could comment on the running of the wards and hospitals. We saw examples of 'you said, we did' posters on the wards showing how staff progressed issues raised by patients.

Staff supported patients to make advanced decisions on their care. Staff respected patients' decisions to refuse permission to pass on information about their progress to relatives, where appropriate.

Staff made sure patients could access advocacy services. Information on advocacy services was displayed at each hospital. The advocacy service visited patients proactively. We saw staff were also ensuring patients who lacked capacity were referred for advocacy support, where they would benefit from the independent mental health advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 4 carers. Family members told us that they received regular updates and staff were happy to talk to them.

Staff helped families to give feedback on the service. The trust had a carer's working group which helped to ensure carers views were considered appropriately.

Staff gave carers information on how to find the carer's assessment. The trust had a carer's hub and website for carers which signposted people to information and support groups locally. On some wards, staff made proactive regular contact to make sure that the carer's needs were considered and addressed.

Is the service responsive?

Good 

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers had targets to try and ensure bed occupancy did not go above 85% but most wards regularly operated well above these rates. The trust recognised that 85% bed occupancy figure was the optimum maximum figure to provide safe and quality services. For the period February 2022 to March 2023, none of the wards went below 85% bed

occupancy, most wards had occupancy levels consistently at 100% or more. Figures initially sent by the trust showed Overdale ward had periods where bed occupancy was at 130% or more for 5 months out of 12. However, when adjusted to take account of the planned use of 'swing beds' which could increase capacity of this ward, these figures reduced on average to 118%. This meant that staff admitted patients to beds even when patients went on leave from the hospital. The trust were aiming for a reduction in bed occupancy to 95% by the target of 31 March 2023 but accepted this was highly unlikely to be achieved. The trust had a 'Beds Oversight Group' which monitored the bed occupancy plan.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The trust monitored the length of stay of patients. The median length of hospital stay of patients in the trust's acute wards was 32 days. This means that the trust is on track to meeting NHS England's targets of bringing the typical length of stay in all adult acute inpatient down to 32 days or fewer by 2023/24.

The wards had no out-of-area placements of patients outside the trust's geographical areas. The trust were using out of area beds within the independent sector due to the pressures on acute beds. Staff worked to get these patients transferred within the trust as soon as possible.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was usually a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. The trust tried to ensure patients were admitted to the nearest acute ward within the patient's locality. Sometimes a patient had to be admitted to an out of locality bed within the trust.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care. The trust had a well-established process in place for admission to psychiatric intensive care units known as the 'PICU pyramid.' Staff from the psychiatric intensive care unit would support staff on acute wards to engage patients to manage their behaviour and prevent an admission to a psychiatric intensive care unit using additional potential strategies. If a psychiatric intensive care unit admission was necessary it was a last resort, the staff usually had knowledge of the person and care plans were already in place. The system meant patients were transferred when needed without delay.

There were only two psychiatric intensive care unit across the trust which meant that patients were not always near family and friends.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust recorded the number of delayed discharges. The data showed that broken down by ward from 1 March 2022 and up to and including 1 March 2023, there had been 76 patients subject to delayed discharge across the acute and PICU wards. The wards with the most delayed discharges were Maple and Elm ward at Darlington and Stockdale ward at Middlesbrough.

Patients stayed in hospital even when they were well enough to leave. Where this was not in the full control of the trust, it led to delays in discharge of patients. The most delayed discharge days per ward were Tunstall ward in Durham (787 days; or 87 days on average per patient who was delayed), Ebor ward in York (780 days; or 86 days on average per patient who was delayed) and Maple ward in Darlington (718 days; or 48 days on average per patient who was delayed).

The reasons for patients' discharge being delayed were complex but included patients' complex needs (including treatment resistant schizophrenia), the need for bespoke placements, homelessness, the lack of available social housing or appropriate care home placements. There were appropriate escalation meetings to try and progress patients whose discharge was delayed.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The trust operated a purposeful in-patient admission model (known locally as PIPA) which aimed to ensure patients are given timely and appropriate treatment and discharge occurred as quickly as possible. The components of PIPA were:

• A reason for admission identified prior to or early in the admission

• A development of a clear formulation

• A clear plan as to goals to be achieved to facilitate discharge when clinically appropriate

Formulation meetings played a pivotal role in the purposeful in-patient admission model as well as proactive, multi-disciplinary daily reviews to identify and address any blocks or barriers to discharge.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Each patient had their own bedroom with an en-suite bathroom. Patients had access to their room 24 hours a day and could personalise their own rooms if they wished.

Patients had a secure place to store personal possessions. Patients had their own key to their bedrooms. Each room had storage for patients to store their possessions as well as a separate lockable safe for storage of their valuables.

Staff used a full range of rooms and equipment to support treatment and care. This included a clinic room, multiple lounges, dining room, kitchens and quiet rooms.

The service had quiet areas and a room where patients could meet with visitors in private. Each ward had a visiting area for patients to see relatives. Each unit had access to a family visiting area for children visiting.

Patients could make phone calls in private. Patients could have their own mobile phones, except if it had been risk assessed for individual patients on clinical or security grounds. The wards also had a cordless phone which patients could use.

The service had an outside space that patients could access easily. Patients had direct and unlimited access to a courtyard or garden area on each ward. On some wards there were schemes to encourage patients to plant in raised beds for growing plants and vegetables.

Patients could make their own hot drinks and snacks and were not dependent on staff. On the wards we went on, patients had access to hot water to make drinks. This was subject to regular review to ensure that any risks posed by particular patients were individually managed.

The service offered a variety of good quality food. Patients told us the food was largely good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients had access to activities which was led by the occupational therapists or activities co-ordinators, but their availability was not consistent throughout the trust. Some wards only had part-time activities co-ordinators, so most activities occurred Monday to Friday 9-5, but other wards had 7-day cover. The activities available varied and were discussed with patients to ensure patients maintained interest in the activities available; they included unit-based activities such as cooking, attending the gym, crafts, relaxation, bingo and games; and outdoor activities identified on an individual basis such as, walking groups. Some patients commented that some wards did not have a proper activities timetable or there was too much emphasis on activities that involved physical exercise.

Staff helped patients to stay in contact with families and carers. Staff considered the timing and availability of local transport when discussing and agreeing patients going on leave to family members.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards all had an adapted toilet and bathroom for those patients with limited mobility. If additional aids or support were required, staff would source these on an individual basis for patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There were numerous display boards across the wards providing information on a range of treatments, their rights as detained patients and local community facilities.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. The service provided a variety of food to meet the dietary and cultural needs of individual patients. There was always both a meat and vegetarian option available for patients. If patients required halal, kosher or other food to meet their specific needs this was ordered as required. One patient commented that there was not gluten free food available, but we were assured by managers who confirmed that it was.

Patients had access to spiritual, religious and cultural support but staff could do more to help religious observance for patients of Muslim faith. There were prayer rooms at each hospital. At Cross Lane Hospital, the copy of the Quran in the prayer room was not stored according to religious observance as it was not wrapped in cloth. In Foss Park, the prayer room did not show the direction of Mecca so Muslim patients may not be fully aware of the direction in which they should pray. We raised these with senior nurses in each hospital. There was a visiting chaplain available to patients.

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

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with understood their right to complain about their care and treatment in hospital. Patients felt confident that managers would investigate complaints fully.

The service clearly displayed information about how to raise a concern in patient areas. The trust's complaints process and the CQC's involvement in handling complaints under the Mental Health Act were both prominently displayed by posters on the wards.

Staff understood the policy on complaints and knew how to handle them. The trust's policy for handling complaints was available to staff, patients and the public on the trust's internet pages. For the 12 months up to March 2023, 79% of complaints to the trust's patient advice and liaison services for local or informal resolution were responded to within 15 days and 100% of formal complaints were acknowledged in 3 working days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with understood their role in supporting patients' rights to complain.

Managers investigated complaints and identified themes. There had been 210 complaints about the trust's adult mental health inpatient services sent to the trust's patient advice and liaison services, for local or informal resolution for the 12 months up to March 2023. Themes around these included treatment and care concerns, lack of information and staff attitude.

There had been a small number of formal complaints about the trust's adult mental health inpatient services. There were 32 formal complaints about the trust's adult mental health inpatient services for the 12 months up to March 2023. The most formal complaints related to treatment and care concerns which made up 25% of complaints made (8 complaints), discharge which made up 22% (7 complaints) and continuity of care which made up 12.5% (4 complaints). None of the complaints had been escalated to the final stage of the complaints procedure which was the parliamentary and health service ombudsman.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. A monthly PALS, complaints and patient and carer experience report is produced detailing themes from complaints. The learning from concerns is reported monthly to relevant subgroups and to Quality Assurance Committee.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

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

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Many of the ward managers had worked in clinical practice and in leadership roles on mental health wards for many years. The ward managers had a good understanding of the current issues about the running of their ward, as well as the legal frameworks such as the regulations we inspect against, the Mental Health Act and mental capacity legislation.

They had good clinical oversight of the hospital. Staff and patients were complementary about the ward managers in terms of their approachability and patient focus.

Staff morale was reported to be affected by the staffing issues on wards, in particular registered nurse vacancies. Ward managers were regularly used within the core staffing numbers due to staffing shortages; this meant that their tasks were not covered such as overseeing clinical supervision and mandatory training.

The ward managers were supported by experienced modern matrons, practice development practitioners and additional band 6 nurses during the day.

Senior managers were cited on the risks and issues within the trust and were working to address these.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The trust had the following values:

- Respect – listening, inclusive, working in partnership
- Compassion – kind, supporting, recognising and celebrating
- Responsibility – honest, learning, ambitious

The values were displayed across the wards.

The trust were committed to three big goals:

- To co-create a great experience for our patients, carers and families.
- To co-create a great experience for our colleagues
- To be a great partner

The trust had a 5-year plan known as the 'journey to change'. This had specific goals especially related to clinical, quality and co-creation goals. This included a reduction in suicides, reduction in restraints and seclusion episodes, improved emphasis on physical health and increased involvement of patients.

On some wards this work had begun through staff and patients working together to co-create patients' care plans where patients identified their top three priorities for recovery at the start of their admission, these were then reviewed to check progress. Staff were aware of the quality metrics that underpinned this work such as patients self-reporting their overall experience, whether they were treated with dignity and respect and safety on the wards.

Culture

Staff morale was mixed. Some staff told us that the staffing difficulties was making it very difficult to work; although most staff felt respected, supported and valued. Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they felt well supported personally and professionally from their immediate teams, nursing team and ward managers.

Staff told us that they had not always received clinical and management supervision as regularly as the trust requires. Staff told us that they are up to date with most mandatory training courses but there were some courses where uptake levels were lower. Staff received regular training and staff told us and records confirmed that staff had received a recent annual appraisal.

Morale within the staff team we spoke too was mixed. Many staff stated that morale could be better and cited staff shortages, the size of the trust, difficulties attending training further afield and long delays in recruiting staff as reasons for their view. Some staff told us that they work long shifts and are unable to take a break at times due to the staffing difficulties on the wards. Some people stated that recruitment processes need to improve significantly as there were sometimes long delays in managers being given approval to recruit and some occasional examples of recruitment adverts having incorrect information, such as the size and gender of the wards in the locality to which the advert related.

The trust supported professional development of staff, for example supporting staff in newer professional roles including non-medical approved clinicians, pharmacist prescribers, peer support workers and nursing associates.

There was information displayed in the hospital about how staff could raise concerns about people's care. Staff told us that they knew how to raise any issues through this process or anonymously.

Governance

The trust was still working through recommendations and improvement plans to address shortfalls in governance. Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

The trust had developed a journey to change, partly in recognition of the need to change and improve services, their oversight and governance.

The trust recently had three comprehensive independent investigations into deaths in their care which identified weaknesses in governance arrangements. The trust had progressed the specific recommendations relating to adult mental health services but were still embedding many of the changes from the recommendations.

Following some internal patient safety assurance visits and identified governance shortfalls, Bedale and Cedar ward were subject to ward improvement plans to support the wards with senior care group members providing additional support. The wards were still working through the actions on these governance plans.

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

We found some shortfalls on the inspection which were not fully mitigated by the providers own systems. The trust's own audits showed significant shortfalls in ward governance expectations. For example, Danby ward scored 26% and Minster ward scored 48% on the trust's own quality assurance 4 audit for March 2023.

We found:

- Concerns around the management and recording of section 17 leave to ensure there was proper oversight of when patients left the ward, when they were due to return and when they were late to return.
- Seclusion safeguards were not always met due to the lack of a second available nurse to do nursing reviews.
- Some mandatory training uptake levels continued to be low. This was partly explained by staff shortages, but staff also reported having to travel significant distance to attend basic mandatory courses.
- Recorded clinical supervision uptake levels continued to be low.
- There were shortfalls in medicines management with a cumulative number of minor issues and ongoing medicines errors.
- We told the trust that they should improve in the areas around 'as required' medication recording, staff supervision and staff mandatory training at our last comprehensive inspection in October 2019 and we continued to find similar issues on this inspection.
- The written environmental risk assessment for Cedar ward did not reflect a specific risk in the courtyard
- The trust did not provide a timely response to some of our requests for information and evidence as a result of this inspection.
- The matrons and practice development leads carried out audits which identified some of these issues across the last few months prior to the inspection but we continued to see shortfalls occurring. With the continued short staffing for many wards, these shortfalls were likely to continue in some areas until staffing improved.

However:

- Leaders had worked to make sure that more ligature risks had been removed from the wards since the last inspection through a programme of work and mitigation of existing risks.
- There were embedded governance checks in place to audit and embed improvements to the recording and understanding of patient risks on safety overviews and safety summaries.
- There were now improved arrangements and oversight of mixed gender environments. This included the trust forming a sexual safety collaborative group to ensure data was also triangulated with complaints and patient experience.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the service's risk register. Staff were able to escalate concerns when required.

Managers kept a risk register which identified risks to people or staff within the hospitals. The current outstanding risks identified in April 2023 specifically relating to the trust's mental health acute wards and PICUs were:

- Defects in the design and construction of wards at Roseberry Park, particularly around the roof spaces and risk of fire spreading
- Continuing ligature risks across the estate
- Qualified nurse vacancy rates.
- Consultant psychiatry cover across North Yorkshire and York
- Clinical supervision rates
- Compliance with positive and safe training
- Delays in reviewing serious untoward incidents.

The risk register had details of how these risks could be mitigated and we saw that managers were making efforts to fully mitigate and improve in these areas.

The service had plans in place for emergencies. The trust had a written internal emergency plan which covered how staff should respond to emergencies such as major fire or flood, utility failure, severe weather conditions and security or health threats.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers monitored a range of performance indicators through the electronic management systems which provided information for incidents, care planning and risk assessments, and other key performance and safety data for the hospital. The trust was looking to implement a better system for overseeing the ward governance arrangements.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff on the acute wards liaised appropriately with external teams for patient care issues.

The trust also had an autism steering group which was a forum to share information and national guidance and provide feedback on outputs of the autism project team. This included representatives from external organisations.

Learning, continuous improvement and innovation

The trust were looking to develop services in line with their priorities and journey to change. There had been work and measurement against these priorities for 2022/23 which included improved care planning, compassionate care and measuring if patients feel safe. This included a commitment to ensure all clinical staff are trained in the new care planning system and record all patient-led care plans on a new patient record system.

Managers were introducing or embedding the ‘safe wards’ initiative which was a way of looking at every aspect of each hospital to ensure it was a positive experience for patients and help make it safer by reducing conflict and containment. Some of the ‘safe wards’ initiatives had been completed.

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

None of the trust's acute and PICU wards were accredited with the Royal College of Psychiatry quality network for inpatient mental health adult acute wards, known as AIMs accreditation.

This page is intentionally left blank

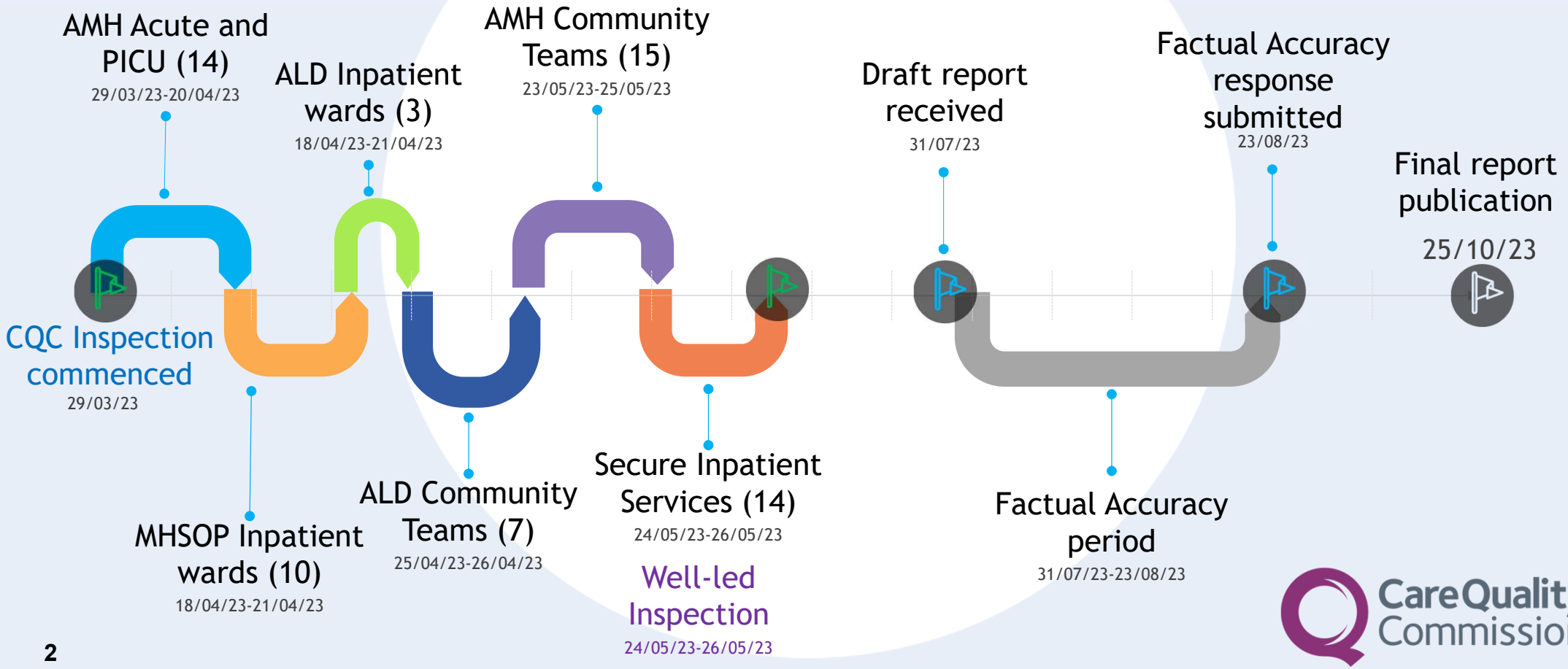
Adults Wellbeing and Health Overview and Scrutiny Committee

08 February 2024

Beverley Murphy, Chief Nurse

CQC Core Service and Well-led Inspection 2023

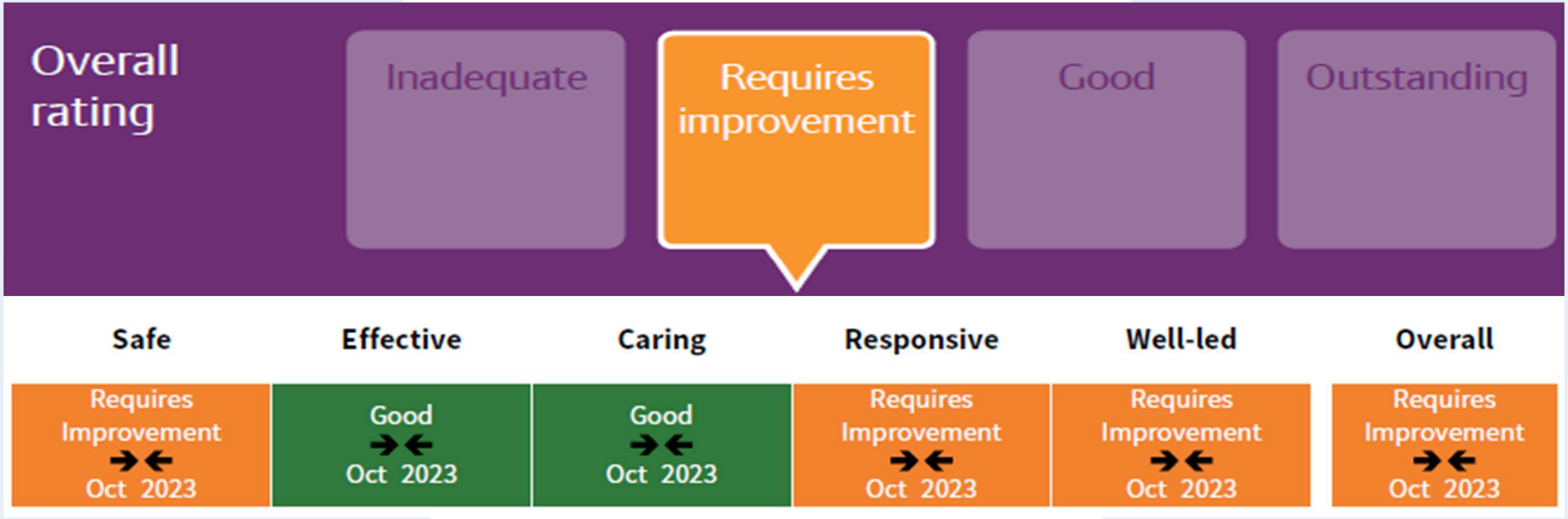
Tees, Esk and Wear Valleys NHS Foundation Trust



CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust



The overall Trust rating remains as: **Requires Improvement**

Care Quality Commission

CQC Core Services Inspected 2023

NHS
Tees, Esk and Wear Valleys

Core Service	Wards/ Teams			Dates of Inspections
Acute Adult Mental Health Wards and Psychiatric Intensive Care Wards	• Stockdale • Overdale • Farnham • Tunstall • Cedar PICU	• Bedale PICU • Bransdale Maple • Elm • Esk	• Danby • Bilsdale • Ebor • Minster	**29.03.23 – 20.04.23**
Mental Health Services for Older People Wards	• Rowan Lea • Ceddesfeld • Wold View • Moor Croft	• Westerdale North • Westerdale South • Springwood	• Hamsterley • Roseberry • Oak	**18.04.23 – 21.04.23**
Adult Learning Disability Wards/ Day Service	• Bankfields Court	• Talbot	• Aysgarth	**19.04.23 – 21.04.23**
Community Adult Learning Disability Teams	• LD York Community Team • LD Scarborough, Whitby, Ryedale • LD Harrogate and Craven	• Durham Integrated Learning Disabilities Team • The Orchard Day Service	• LD Darlington • North Tees LD Community	**25.04.23 – 27.04.23**
Community Adult Mental Health Teams	• AMH Central Community Team • AMH North Community Team • York and Selby Early Intervention in Psychosis • North Dales Community Mental Health Team • South Dales Community Mental Health Team	• Whitby and Ryedale Integrated Community Team • York Outreach Recovery Team • Easington South • Easington North • Whitby and Ryedale Early Intervention in Psychosis	• Scarborough Community Mental Health Team • West Community Mental Health Team • South Teesside Ryedale Early Intervention in Psychosis • Middlesbrough Access and Affective Disorders Team • Middlesbrough Psychosis	**23.05.23 – 26.05.23**
Secure Inpatient Services	• Brambling • Ivy/ Clover • Lark • Mallard • Mandarin	• Kestrel/ Kite • Linnet • Hawthorn/ Runswick • Merlin	• Newtondale • Swift • Sandpiper • Eagle/ Osprey	**24.05.23 – 26.05.23**

CQC Ratings - Comparison

Tees, Esk and Wear Valleys NHS Foundation Trust

Previous ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorders service	Requires Improvement	Outstanding ☆	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community mental health services with learning disabilities or autism	Good	Requires Improvement	Outstanding ☆	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Oct 2023 ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement →← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Requires Improvement →← Oct 2023	Good ↑ Oct 2023	Requires Improvement →← Oct 2023
Wards for older people with mental health problems	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement → ← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023
Wards for older people with mental health problems	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021

Of the 6 Core Services inspected:

- **3** Overall Core Service ratings have improved (MHSOP, ALD Inpatient, and Secure Inpatient Services)
- **3** Overall Core Service ratings have remained the same (AMH Acute and PICU, AMH Community and ALD Community)
- There have been **12** CQC domains across the core services inspected that have improved, **15** which have remained the same, **3** where the rating has decreased.

CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Must and Should Do Actions

Core Service	Must Do	Should Do	Total
ALD Community	1	3	4
ALD Inpatient	6	7	13
AMH Acute and PICU	5	7	12
AMH Community	2	3	5
MHSOP Inpatient	1	6	7
Secure Inpatient Services	6	16	22
Trust wide	17	14	31
Total	**38**	**56**	**94**

CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Positives

- ✓ Cultural changes
- ✓ Innovative practice
- ✓ Person-centred care
- ✓ Multi-disciplinary working
- ✓ Environmental changes
- ✓ Medication Management
- ✓ Risk Management
- ✓ Governance
- ✓ Clear Vision and Strategic Direction

Learning Themes

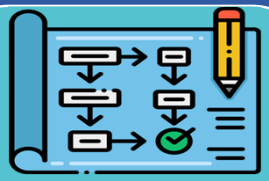
- Staffing
- Mandatory/Statutory Training
- Complaints/PALs
- Supervision
- Waiting times
- Physical health monitoring
- Serious Incident processes (including Duty of Candour)

CQC Improvement Plan Reporting Framework

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

25 October 2023

- Formal publication of the Trust's CQC Inspection Report 2023



31 October, 01 November

Improvement Planning Events

03 November 2023

- Presentation to, and consideration of, Improvement Actions by the Strategic Fundamental Standards Group

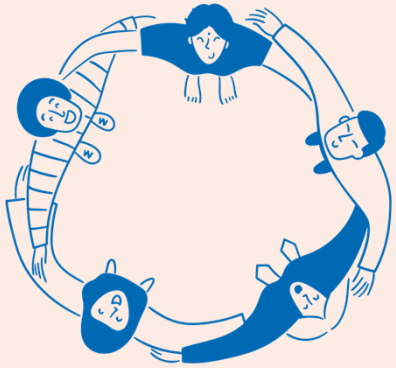
22 November 2023

- Extraordinary QuAC received the Improvement Plan

27 November 2023

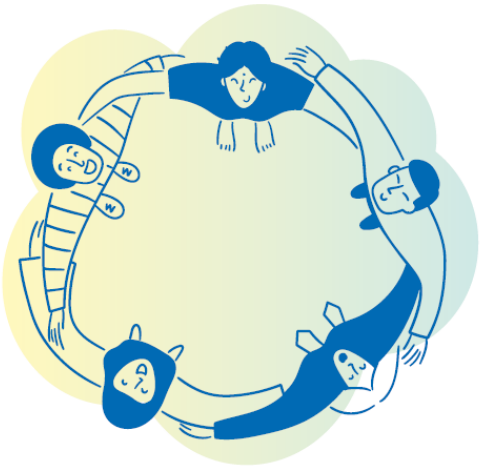
- Submission of Improvement Plan to the CQC

Improvement Plan Governance



- Co-produced with operational, clinical and subject matter leaders
- Approved at Extraordinary Quality Assurance Meeting, 22 November 2023
- Submitted to the CQC 27 November 2023
- Reporting to ERoQ, QuAC, NHSE Quality Board
- Regular progress and impact reporting to the Board of Directors
- May 2024 Quality Assurance Committee (QuAC) workshop planned to consider progress and impact

Tees, Esk and Wear Valleys
NHS Foundation Trust



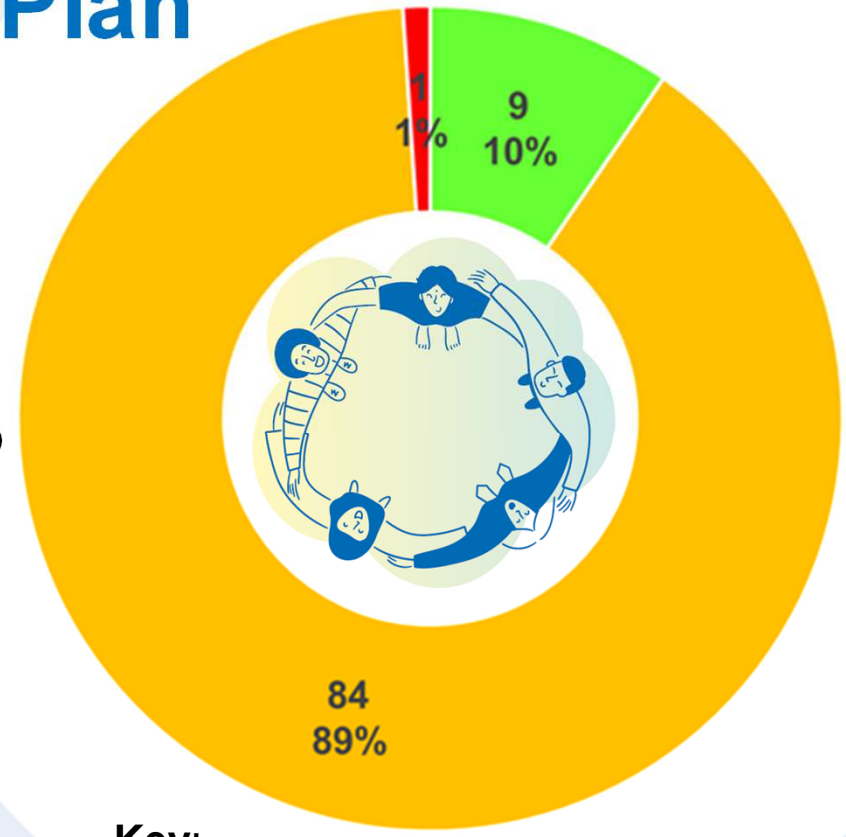
Delivering the Trust's CQC Improvement Plan

Care Quality Commission

Delivering the Trust's CQC Improvement Plan

Tees, Esk and Wear Valleys NHS Foundation Trust

Following the Core Service and Well-led CQC inspection (published 25 October 2023), the CQC Improvement Plan was co-created in collaboration with Care Group colleagues, Specialty/ Directorate Leads and subject matter experts in response to the Must and Should Do recommendations. This forms a component of the Integrated Oversight Plan.



Key:
- Complete
- In Progress (within target date)
- In Progress (behind target date)

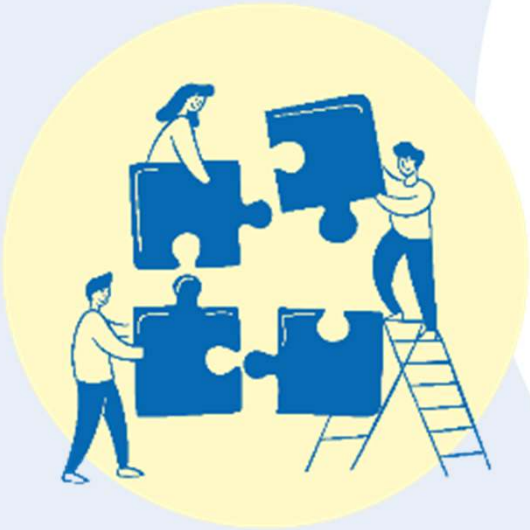
Progress of the CQC Improvement Plan by Must and Should Do Recommendation as of **19 January 2024**.

Care Quality Commission

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust

Service	Action No.	Must/ Should Do	CQC Action Required
Trust wide	**15**	**Must Do**	The trust must ensure that it acts in accordance with the duty of candour regulation.



- ✓ The Duty of Candour Policy has been revised in line with National Standards.
- ✓ There is weekly reporting of Duty of Candour to Executive Directors Group and the Quality Assurance Committee to confirm compliance with the policy standards.

CareQuality Commission

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust

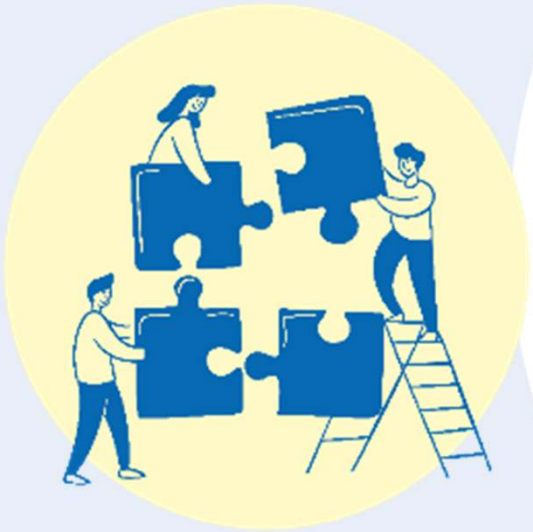
Service	Action No.	Must/ Should Do	CQC Action Required
AMH Acute and PICU	**26**	**Must Do**	The trust must ensure that staff manage and mitigate the risks to service users when they are detained and are permitted to go on section 17 leave.

- ✓ We have reviewed, updated and implemented the Section 17 Leave Policy.
- ✓ The Mental Health Legislation Team have undertaken formal monitoring and checks in relation to completion of Section 17 leave documentation, ensuring that it is fully completed, and that staff are using the correct form. Feedback from these reviews has demonstrated improvements and has been reported to the Trust's Mental Health Legislation Committee.
- ✓ We have included monitoring of leave documentation in our Quality Assurance Schedule.
- ✓ We are continuing to quality assure until we are confident of embedded improvements.

CareQuality Commission

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust

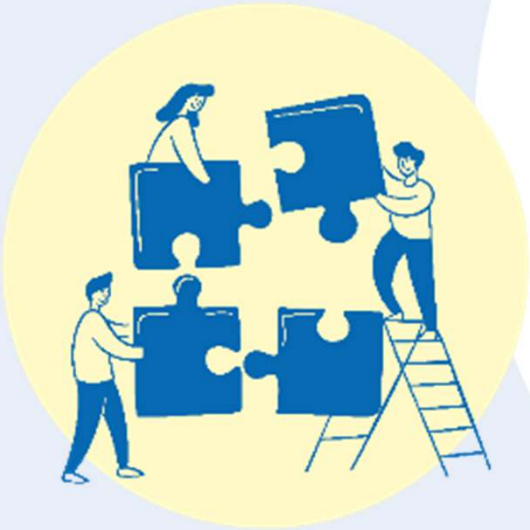


Service	Action No.	Must/ Should Do	CQC Action Required
Secure Inpatient Services	**18**	**Should Do**	The trust should ensure that the blanket restrictions on Kestrel and Kite wards are individually assessed.

- ✓ We have reviewed all blanket restrictions on Kestrel/ Kite Ward to ensure that these are now individually assessed.
- ✓ These have been presented at the Reducing Restrictive Interventions Group.

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust



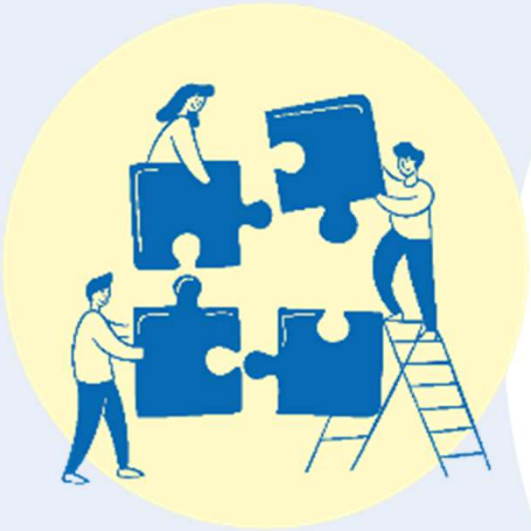
Service	Action No.	Must/ Should Do	CQC Action Required
Secure Inpatient Services	**20**	**Should Do**	The trust should ensure that appropriate food options are available for patients and food is stored in line with food safety requirements.

- ✓ We have reviewed the contract for the provision of patient food and a new Provider is now well established.
- ✓ We have held focus groups with patients to support the development of new ward menus.
- ✓ We have incorporated fridge checks by Ward Housekeepers into the daily workplan.

Care Quality Commission

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust



Service	Action No.	Must/ Should Do	CQC Action Required
Secure Inpatient Services	**23**	**Should Do**	The trust should ensure that actions from community meetings are actioned, and the outcome and update shared with patients.

- ✓ Ward managers have coproduce a system with service users for dissemination and storage of community meeting minutes which will document the outcomes of actions taken

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust

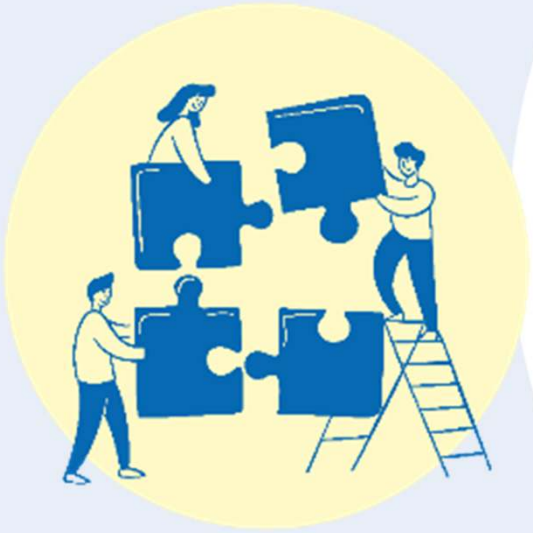
Service	Action No.	Must/ Should Do	CQC Action Required
Secure Inpatient Services	**25**	**Should Do**	The trust should ensure that staff consider how they access the ward spaces and not use wards as a cut through.

✓ We have decommissioned the seclusion facility where this issue was observed.

CareQuality Commission

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust



Service	Action No.	Must/ Should Do	CQC Action Required
Secure Inpatient Services	**29**	**Should Do**	The trust should ensure that all lockable safes for patient use are in working order.

✓ Lockable safes will be checked on admission of new patients and at discharge to ensure that they are in good working order.

Improvement Action delivery

Tees, Esk and Wear Valleys NHS Foundation Trust

Service	Action No.	Must/ Should Do	CQC Action Required
MHSOP Inpatient	**33**	**Should Do**	The trust should ensure that the storage of gas cylinders is carried out in line with their own policy.
AMH Acute and PICU	**41**	**Should Do**	The trust should ensure that appropriate action is taken when medicine fridge temperatures are out of range and that oxygen is stored correctly.

- ✓ We have developed and undertaken an oxygen assessment against the policy assurance statements for the storage of oxygen.
- ✓ This was reported to the Care Group Quality Assurance and Improvement Group and the Executive Review of Quality Group.
- ✓ We have developed and implemented Fridge Temperature Assessments which covered a 30-day period and assessed practice against the policy assurance statements. Where improvements were required, action plans were agreed and followed up to provide assurance of completion. This was reported to the Care Group Governance Forums.
- ✓ We are continuing to quality assure until we are confident of embedded improvements.

CareQuality Commission

Thank You

This page is intentionally left blank

Evaluating the Community Mental Health Transformation in County Durham

December 2023

Working together to help keep the people of County Durham happy, healthy and at home

What were we trying to achieve?

County Durham Care Partnership

Huddles – no wrong door and can do attitude, replaces traditional "referral" processes

NOW YOU'RE TALKING...

Getting Early Help

- Local community support
- County Durham Together Hubs
- Libraries/ leisure centres
- Parks/ recreation
- Education
- Places of worship
- Work/Colleagues
- Social Media
- Family/Friends
- **Primary Care**
- Online support/ self help
- Social Prescribing
- Local Early Help Services (eg VCSE)

Getting Help

PCN Community Mental Health Hub

NO WRONG DOOR; NEEDS-LED SUPPORT

- 4 week max wait
- System huddles mean no referrals – transfer between members of the hub based on need

Needs led interventions:
Brief treatment & longer term care;
Psychologically & trauma informed approaches;
Governed Psychological Therapies; Social Care interventions; peer support; named workers follow through journey

Step up/down

Getting More Help

Integrated Treatment and Intervention Services

Working together to help keep th
County Durham happy, healthy a

Co-Production

- 2 strategic leads (peer support and lived experience)
- 5 locality LE leads
- 13 Peer Support workers (joint TEWV/VCSE)
- Strong engagement in County and local Steering Groups – definite culture shift in attitudes of 'professionals'

👍	Great support from local organizations
👍	Through building relationships with people and listening to their stories the voice of lived experience become more apparent within CMHT work.
👍	Open and positive attitude from people who are experiencing difficulties with/when accessing services.
👎	Co-production still to be embedded. 'Lived Experience' workshops are the step towards co-production, however looking at co-production ladder we are at the engaging / consulting level.
⚠	Support needed to develop consistent approaches to holding/sharing/safeguarding personal information
	Consistent approaches to incentivisation/reimbursement/appreciation ideas across the system are needed
	Talking to various groups, individuals bring complex stories, issues, and we need to create the environment which allows addressing these in a co-production approach.
	Terms and references needed for local Steering Groups within which the mechanism for co-production to be considered.

How did we use transformation resources?

INVESTMENT OVER 3 YEAR PROGRAMME

£300,250 *Complex Emotional Needs*

Structured Clinical Management (previously funded); Substance Misuse Peer Mentors; Distress Brief Intervention; Animation

£1,666,326 *Community Rehabilitation*

TEWV and VCSE investment to expand community rehabilitation team

£78,090 *Adult Eating Disorders*

FREED Champion; Provider Collaborative supported VCSE capacity

£5,194,065 *Core Model*

- Population Health Management
- Lived Experience and Peer Support roles
- Pharmacist capacity
- Referral Co-ordination and Community Navigation
- Community Resilience Team
- Older People's Social Isolation project
- MH Housing and Accommodation Strategy
- Programme support and Workforce Project post
- Destination Fund (non recurrent)
- ARRS workers (ICB contribution)

54% VCSE

44% NHS

2% other (inc DCC)

Working together to help keep the people of County Durham happy, healthy and at home

What's in place now?

County Durham Care Partnership

Core model

- System branding – "Now You're Talking…."
- Single point of access for additional support – Durham Mental Wellbeing Alliance or Gateway in Sedgefield
  - Rapid contact (24-48 hours)
  - Single assessment of need
  - Daily decision making
  - Supported by multi agency huddles for step up/down/across
  - "Business Card" to support self-navigation

- Community Navigation and local link worker networks
- Enhanced capacity within practices (GP Aligned plus First Contact Practitioners)
- Increased joint working between AMH and OP services (based on need, rather than age)

Durham County Council

NHS

Dedicated Focus Areas

What's in place now?

County Durham Care Partnership

- Significantly enhanced offer for people with complex emotional needs:
  - Structured Clinical Management
  - Distress Brief Intervention
  - Family/Carer Psychoeducation Model
  - Peer Mentors
  - Animation
- Still more to do to ensure the whole systems works in a trauma-informed way
- Community Rehab
  - Multi agency enhanced model
  - Significantly increased activity
  - Social Rehab model
- Eating Disorders:
  - FREED embedded
  - VCSE offer enhanced and strong lived experience involvement (working with Provider Collaborative

What's in place now?

County Durham Care Partnership

Other areas of focus

CYP

- 14-25 Preparing for Adulthood Group re-established and initial mapping work completed
- CYP MH Early Intervention Hub (11-25 yrs) bid submitted
- Alignment with CYP Integration work, including Family Hubs and Consett Pilot

Older People

- Joint Age UK/TEWV social isolation offer
- Better access to GP Aligned, First Contact Practitioners, NHS Talking Therapies and wider community services

Physical Health

- Improving joint working with adult teams
- Achieved national targets for SMI Physical Health Checks
- Focused work within primary care based on PHM profiles (eg type 2 diabetes weight management and SMI, smoking cessation and SMI)

Durham County Council

NHS

HEADLINE ACTIVITY AND PERFORMANCE CHANGES (Countywide)

Average 26% monthly increase in referrals to Durham MWB Alliance with contact remaining within 48 hours

Number of people signposted to system services rather than referred to secondary care increased 8 fold

GP Aligned – 5222 referrals in 2023/24 (to Q3) with only 14.8% stepping up to secondary care

22,560 people seen in past 12 months by First Contact Practitioners with majority (95+%) having needs met in primary care or through signposting to community offers

Community Navigation met 72.5% of people's needs when referred to them, with 94% receiving support within 1 week

Access "waiting" caseload (excl. neuro) has halved and waiting times for assessment reduced from approx. 6 weeks to approx. 2 weeks on average

SMI physical health checks exceeding 60%

More men accessing help – access up from 32% referrals for males to 47%

FREED and EIP exceeding targets for young people presenting with first episode eating disorders or psychosis/at risk mental states

423 people 2+ contacts from Community Rehab in past 12 months = 480 referrals (projected) in 23/24 and 4521 contacts (256% increase)

More under 70s accessing support (22% access now over 50 yrs) and significant increase in those accessing early support through Age UK

Almost 35% increase in the number of over 65s accessing NHS Talking Therapies

Over 100 staff accessed 2 day SCM training and over 250 accessed DBI level 1 training

SCM:

- 30 people (40%) had hospital admissions prior to SCM vs to 2 (3%) after SCM
- ALoS pre SCM 20 days vs 13.5 days after SCM

Community Peer Mentors

- 91% increase in MH referrals now skill set available
- 155 people High Impact Users of police: 87.6% demand reduction saving 20,260 staff hours

TOPIC: SYSTEM FEEDBACK TO HEALTHWATCH ON PROGRESS TO DATE

NOW YOU'RE TALKING...

People using services before and since transformation have said:

What's working well?

- 89% felt support offered in the last 4 months met all or some of their needs
- 68% said it was easy to get the support they needed
- 64% knew where to go to get the support they needed
- 80% felt able to explain what they wanted
- 73% felt their needs were listened to

What do we need to do more work on?

- 50% found it wasn't as quick a process as they would want to get the help they needed
- 48% felt they didn't have choice over the services that could support them
- 48% had to explain their story more than once to get the support they needed
- 42% had to speak to more than 1 person to get referred to all the services needed to support them

Staff and teams have said:

What's working well?

Service provider response

50% of providers had used the Single Point of Access	39% found it was quicker	50% felt it helped meet the needs of the service user
Communication between services	80% said communication had improved	19% felt there was no improvement
Knowledge of other services	95% said knowledge had improved	Knowledge increased a great deal for 19%

Huddles

- 64% taken a referral to a huddle
- 79% found referring within a huddle easy
- 71% received a referral in a huddle
- 92% found huddles to be as expected
- 85% felt they received the right information
- 86% able to refer to the right services to meet the needs of the client

What do we need to do more work on?

- Time to attend huddles consistently
- Making sure the right people are attending the huddles
- Promotion and communication of new models/process needs more work
- Lack of capacity in community mental health teams is a barrier to stepping up
- In some places, still feels like there is a divide in the system
- Complex, long referral forms still being used in some places mean people have to repeat their story
- Need to continue to ensure that there is a person centred approach with the service user at the heart of all decisions

ACHIEVEMENTS, CHALLENGES AND RISKS

What are we most proud of?

- Its making a difference – to people needing support and to staff
- Cross sector collaboration and understanding of each other's roles
- increasingly influential role of people with lived experience – which is demonstrably changing culture and approach across system
- Achieving a single point of access in each local area
- The role the VCSE have played and our ability to embrace their passion to change, adapt and help
- Tangible movement towards needs-led, multi disciplinary and multi agency services
- Person centred approach – coming together of all providers to really put the person at the centre of support
- Delivering such a complex system change within a relatively short timescale
- Visible change to how services are working together, and how people are talking differently
- Significant successes of some of the smaller projects – huge impact for relatively modest resource

What are the biggest challenges, gaps and risks?

- Getting the communication of a simplified, new pathway/model right across so many services, partners and communities
- Increased psychological interventions and other wider system workforce developments
- Data sharing and interoperability
- Commissioning and contracting supporting model capacity/sustainability and continued future growth, including admin support for hubs
- Loss of momentum when the "formal" national programme ends
- Capacity and data to support ongoing evaluation of the overall impact in the medium and longer term
- In shifting our focus to more of a preventative/early intervention approach, ensuring we are still able to meet the needs of those with more complex needs
- Embedding a single pathway in each local area to replace multiple access points/teams
- Continuing to reshape the system to remove duplication
- System estates approach to enable model to be delivered through physical bases within local communities

Patient stories

GP Aligned Service:

A 25 year old single male with a history of homelessness and rough sleeping, socially isolated with features of anxiety, depression, poor self-esteem and lacking confidence. He was a regular attender at the GP surgery and was very focused on prescription led solutions often presenting with associated physical complaints. Following assessment we agreed a PsychoSocial approach engaging specialist counselling after he disclosed historic sexual abuse we also engaged one to one support from a local support and recovery agency who enabled him to find secure accommodation and introduced him to the local community resources improving his confidence whist developing positive social networks. As a result he was able to reunite with his children and his quality of life improved. As the counselling progressed his confidence grew and
he was able to secure full time employment, his attendance at the surgery has reduced and he is no longer using anti-depressant medication

"This was my first time ever getting professional help for my mental health and Richard, you were incredible. I had a preconceived opinion – thinking the system was in shambles being the reason I never sought help before – and you quickly proved me wrong. From the very first session you were very sympathetic, patient, understanding and in every way amazing. You didn't hesitate to help with anything I brought to you, pointing me in the right directions if you couldn't help yourself and helped me every step of the way you possibly could, putting a lot of my worries at ease. You never left me wondering what was going to happen, always explained and planned my next steps with me and made sure I was always comfortable. You've helped me in many ways I never thought I'd be able to be helped, and I can't thank you enough for it all. An extremely amazing person that I probably wouldn't be here without. Thank you so, so, much for everything."

Patient stories

Age UK/TEWV Social Isolation Offer:

Man referred by MH Access clinician suffering from anxiety and depression, finding the return to work after COVID very difficult. Chatting to him, it was revealed that he would really like to do something meaningful and helpful. He had considered voluntary work but had been put off by the long application process. He was interested in doing some volunteering as a handyman and after a chat with our Volunteer Coordinator, we put him in touch with her and he was happy to fill in the simplified version of our application form and to receive help with his DBS application.

The client has been able to do something which is useful and valuable. Our organisation has gained a valuable handyman and our clients on the Help at Home waiting list will be able to get help much earlier than expected

Patient stories

Community Navigator:

Client was struggling with symptoms of depression and anxiety and had not left the house in 2 years following a relationship breakdown and loss of business. He wanted to access mental health support but was unsure of who to reach out to. He had lived off savings for the past 2 years and needed support to apply for PIP and UC.

He was discussed in the CLS Huddle and a step across to the GP Aligned Mental Health Team was agreed. The Community Navigator worked with the client over a period of time to apply for Universal Credit and PIP. On advice from the GP Aligned Team, the Community Navigator used an approach similar to graded exposure, to help the client leave the house and access his local community. Client agreed to speak to the Lived Experience Lead of the CLS Transformation – 'He mentioned that he benefits a lot from a support you give him (his words: "Rosie is fantastic"), which was great to hear.'

Patient stories

PCCVO Peer Mentor Service:

Feedback from Male Client Alcohol Misuse: I writing this to say thank you for all your help and support, you came into my life at just the right time. I lost everyone I could actually could turn to for advice, no one ever gave me the answers, help or support I really needed. Look were we started to were we are now yes I fell twice on the way but you were the one I could pick the phone up anytime which actually means a lot. I always thought I was one of the strongest minded people on the planet until I need a shoulder to cry on . I'm so grateful for having you come into my life and I now want to give back to as all I've ever done is try my best to make people happy and also thanks for offering me a bike that meant a lot. You've actually done more than you know mate.

NHS
North East
Ambulance Service
NHS Foundation Trust

2023/24 Quality Report

Tracy Gilchrist
Deputy Director of Quality & Safety
(Lead Nurse)

Mission: Safe, effective, responsive care for all | **Vision:** Unmatched quality of care

Introduction

- Overview of Quality Report requirements
- Current position and performance
- Update on 2023/24 quality priorities

Overview of quality report requirements

- NHS Improvement provide detailed guidance on the requirements of the report
- Report must be shared with commissioners, governors, staff, Healthwatch, Overview and Scrutiny Committees or the Health and Wellbeing Board
- Providers must upload their final Quality Report onto their website by 30th June
- No requirement to obtain external auditor assurance this year

NHS
North East
Ambulance Service
NHS Foundation Trust

2023/24 performance
1st April- 31st December 2023*

Mission: Safe, effective, responsive care for all | **Vision:** Unmatched quality of care

Patient Safety Incidents

2,209
Patient Safety Incidents
2.2% per 1,000 calls answered

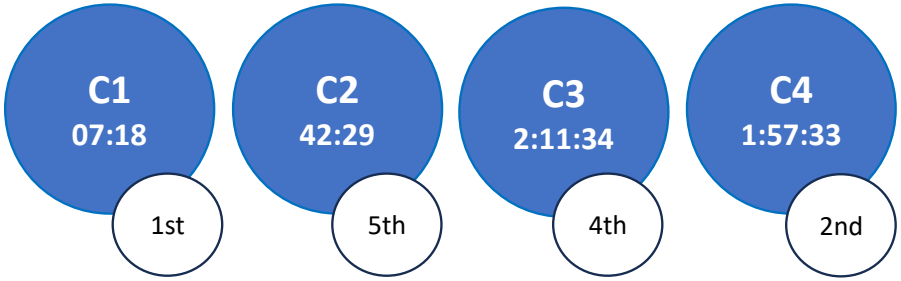
140
Serious incidents

Patient Experience/ Feedback

273
Complaints

812
Appreciations

Ambulance Response Times



Taken from Ambulance Quality Indicators: Systems Indicators December 2023

Friends & Family % of satisfaction good/very good

93.4%
Unscheduled Care (999) see & convey

91.7%
Unscheduled Care (999) see & treat

95.8%
Patient Transport Service

78.4%
111 service

Update 2023/24 quality priorities

Patient safety

- To continue working with system partners to reduce handover delays
- Respond to patient safety incidents in a way that leads to service improvements and safer care for all our patients

Clinical effectiveness

- Implementation of clinical supervision

Patient experience

- To increase service user and colleagues involvement in our patient safety and patient satisfaction activities

To continue working with system partners to reduce handover delays

What we achieved

- Thematic analysis of handover delays
- Partnership working to improve data sharing, standardise reporting to drive improvements
- Partnership working to improve effectiveness across the system
- Reviewed our risk management and escalation arrangements during times of demand

What we need to do

- Understand the impact on patients
- Understand the impact on staff

Respond to patient safety incidents in a way that leads to service improvements and safer care for all our patients

What we achieved

- 5 year review of quality & safety profile to inform local safety priorities
- Development of governance procedures
- PSIRF training provided by NHS accredited provider (including oversight training and patient safety specialist training)
- Transition to LFPSE 1st June 2023
- Transition to PSIRF 1st January 2024
- Introduction of x3 patient safety partners

What we need to do

- Closure of all serious incidents & actions by 31st March 2024
- Embed PSIRF governance and organisational learning

Implementation of clinical supervision

What we achieved

- Policies and procedures for clinical supervision developed
- Clinical supervision launched across unscheduled care in August 2022
- Audit roadmap for Clinical Team Leaders (CTLs) introduced to managers understand individual clinical performance
- CTLs complete clinical supervision shifts with individuals including protected time for discussions
- Clinical staff are also provided with 5 hours to support with any CPD needs identified through clinical supervision

What we need to do

- Development of electronic audit tool and dashboards
- Development and roll out of a bespoke university module to help ensure that our CTLs have the appropriate skills, knowledge and experience (to be completed in 2024)

To increase service user and colleagues involvement in our patient safety and patient satisfaction activities

What we achieved

- Multidisciplinary working groups established for PSIRF implementation and patient safety improvement activities
- Introduction of patient safety partners
- Board level lead identified for patient safety partners
- Stakeholder involvement in patient safety meetings
- Collaborative working with stakeholders and partners
- Stakeholder involvement in recruitment for patient safety roles

What we need to do

- To establish patient feedback group
- Implement a patient and carer feedback survey (post investigations)
- Wider patient and colleague involvement in recruitment activities

NHS
North East
Ambulance Service
NHS Foundation Trust

North East Ambulance Service
Bernicia House
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

T: 0191 4302099

E: publicrelations@neas.nhs.uk

Mission: Safe, effective, responsive care for all | **Vision:** Unmatched quality of care

This page is intentionally left blank

NHS
North East and North Cumbria

NHS Primary Care Dental Services
&
Dental Access Recovery

Place Directors Information Pack

Update as at 15 January 2024

Summary Overview of NHS Dentistry

- NHS England have delegated responsibility to NENC ICB for commissioning dental services from 1 April 2023
- NHS Dentistry services MUST operate in accordance with **Nationally set Government Regulation (2006)**
- Under NHS Dentistry national regulation there is **no 'formal registration' of patients** with dental practices as part of their NHS Dentistry offer, patients can therefore approach any dental practice offering NHS care for access.
- Dental contracts and provision is **activity and demand led** with the expectation practices deliver courses of treatment with **recall intervals appropriate to clinical need** and manage their available commissioned capacity to best meet both local demand and the clinical needs of patients presenting to their practice.
- The contract regulations set out the contract currency which is measured in **units of dental activity (UDAs)** that are attributable to a **'banded' course of treatment prescribed under the regulations**.
- **North East and North Cumbria ICB do not commission private dental services,** however, NHS dental regulations do not prohibit the provision of private dentistry by NHS Dental Practices.
- The prolonged **COVID- 19 pandemic period** required NHS Dental Practices to follow strict Infection Prevention and Control (IPC) guidance which significantly restricted levels of access to dental care. As a result, **backlog demand for dental care remains high with the urgency and increased complexity of patient clinical presentations** further impacting the ability for the NHS Dental Care system to return back to pre-COVID operational norms.

Out of hours Urgent Care Services

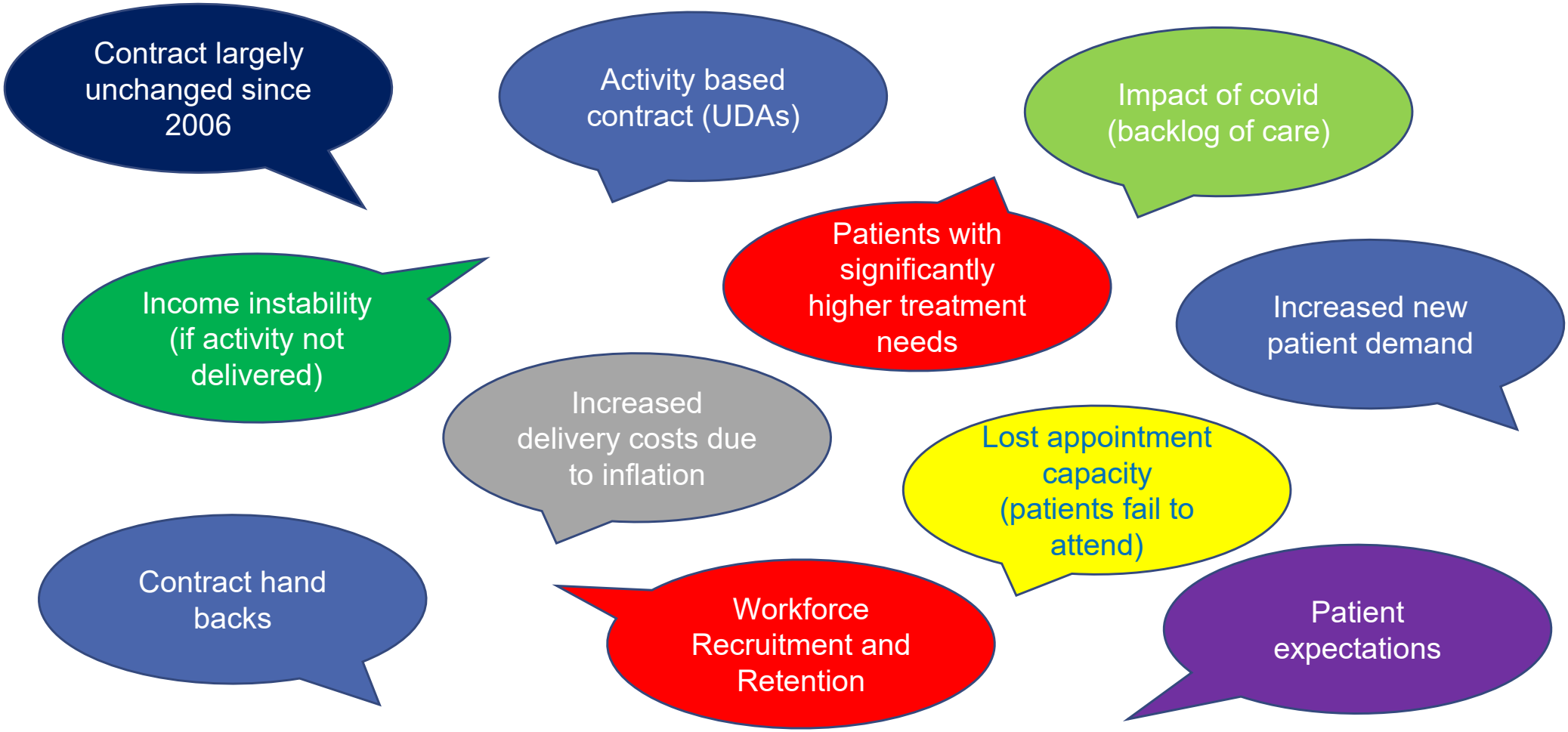
Service Tyne	Geographical Coverage	Provider and site Locations
NHS 111 Integrated Dental Clinical Assessment Service (DCAS)	NENC Wide	NEAS & Dencall – NHS 111 Call Centre 'Newburn' (PDS) Operates Mon through to Thurs 18:00 to 09:00, weekends (Friday 18:00 through to Monday 09:00) and all bank/public holidays
NHS 111 Dedicated 'Out of Hours' Direct Booking Treatment Centres	North Cumbria	NCIC FT – Cumberland Infirmary (Carlisle) / West Cumberland Hospital (Whitehaven)
	North of Tyne	NUTH FT – Molineux (Byker) and Wansbeck Hospital
	South of Tyne	Dencall – Sunderland Royal Hospital/ Palmer Community Hospital in Jarrow
	Durham & Darlington	Dencall – Durham, Darlington/Tees Valley - delivery sites UHND & DMH (To note service temp suspended from DMH due to hospital re-development – additional sessions being delivered at UHND)
	Teesside	DDS – Middlesbrough (North Ormesby Health Village)

Notes:

- Treatment services operate between 18:00 to 23:00 Monday to Friday (on-call basis) 09:00 to 23:00 Weekends and all bank holidays as a combination of fixed clinics on-call).
- Additional OOHrs dental treatment capacity commissioned from all providers for 2023-24 with exception of NCIC (due to staffing capacity).
- In hours urgent capacity across the County

Challenges

NHS
North East and North Cumbria



There are significant challenges to people accessing dentistry in North East & North Cumbria

(NB: see further supporting information at end of slide deck by way of background/ awareness)

- Dental services have struggled to recover from the impact of covid
- There are significant challenges with recruitment and retention of dentists
- As a result, some providers unable to deliver full commissioned capacity.
- There is widespread recognition that the national dental contract requires reform (see link to House of Commons Health and Social Care Committee report published July 2023 for further details - https://committees.parliament.uk/publications/40901/documents/199172/default/)
- The number of contracts handed back in NENC has increased from 3 in all of 2020 calendar year to 14 in 2023-24 to date.
- This means local people across the NENC are experiencing problems accessing NHS dentists – areas of particular challenge include N Cumbria, North Northumberland, Darlington, parts of Co Durham and Sunderland.

NHS Contracts handed back since 1 April 2023
(position as at 15 January 2025)

Contract/activity handbacks (2023-24)	Locality		End Date
Plumfield Dental Practice	Carlisle	5,500	30/04/2023
Novident Willington (Mr Aggarwal)	Durham	3,500	30/04/2023
Oasis Dental Care Ltd (Hylton Road, Pennywell)	Sunderland	23,665	30/06/2023
Bishop Auckland Partnership	Durham	13,273	30/06/2023
Oasis Dental Care Limited	Durham	18,847	30/06/2023
Yarm Road Dental Practice	N Tees	1,213	30/06/2023
Lismore House Dental Care Partneship	Carlisle	1,300	30/06/2023
Mr and Mrs Stephenson (The Villa Dental Practice)	N Tyneside	8,954	31/07/2023
Davison, Sadler and Tannahill Partnership	Newcastle	3,017	31/11/2023
Kelvin Lodge (Elmfield Road)	Newcastle	1,218	31/01/2024
Miss S L Goodman (Shakespeare Street Dental practice NE1 6AQ)	Newcastle	2,425	31/03/2024
Dr N Suggett and Dr B Suggett (Seaham Smiles)	Durham	18,907	31/03/2024
Mr N Plahe (High Street, Loftus, Cleveland TS13 4HG	Redcar & Cleveland	7,723	31/03/2024
Mr A A Waugh (Lowfell Caring Dental Practice)	Gateshead	24,250	31/03/2024
Total		**133,792**	

We will tackle the challenges in three phases

Improving access to dentistry will not be a quick fix

We are tackling this in three streams:

Immediate actions to stabilise services

A more strategic approach to workforce and service delivery

Developing an oral health strategy to improve oral health and reduce the pressure on dentistry

Immediate actions undertaken (1)

c£3.8m non-recurrent investment agreed to date for 2023-24 to:

- Increase NHS 111 dental clinical assessment capacity
- Increase out of hours dental treatment services
- Extend access arrangements to provide where possible an additional 27.5k patient treatment slots between July 2023 and end of March 2024 (to supplement the circ 4.3k slots funded in Q1).

Funding made available to allow practices who have the NHS workforce to deliver additional UDAs up to 110% of their NHS contracted levels.

Implemented a local commissioning process to re-provide (where possible) activity when contracts are handed back

We have a flexible commissioning scheme to provide a training grant to support employment of overseas dentists – 24 months tie in period.

Recovering Access – Immediate actions Progress so far

NHS
North East and North Cumbria

Circa 19.3k additional patient treatment slots have been commissioned to date,
plus
Circa 57.4k patient treatment slots secured from existing practice capacity for patients in greatest clinical need.

908.5 hours of additional dental clinical triage call handling capacity is now available in 2023-24.

836 additional sessions of dental out of hours treatment capacity until the end of March 2024. (D&D = 68)

NB: Extension of short-term initiatives into 2024-25 currently being considered

Access Scheme breakdown by Locality Commissioned capacity (2023-24)

(additional payment and UDA substitution)

	No of Appts Commissioned
Darlington	2079
Durham	11315
Gateshead	6258
Newcastle	6818
North Cumbria	2604
North Tyneside	4452
Northumberland	7105
South Tyneside	10500
Sunderland	6727
Teesside	18704

Dental Access Re-commissioning (UDAs)

Locality	UDAs commissioned 2023-24 (recurrent)	UDAs commissioned 2023-24 (Non-recurrent)	UDAs commissioned 2024-25 (Non-recurrent)*
Durham		14,600	20,100
North Tyneside		1,500	2,000
Stockton on Tees		4,000	11,000
Newcastle		3088	5,730
South Tyneside		4185	10,000
Darlington		4707	4,707
N Cumbria (Carlisle)		3720	3,720
N Cumbria (Eden)	7,000		
TOTAL	**7,000**	**32,080**	**53,537**

*** Commissioned capacity to be made recurrent if providers demonstrates they can deliver this additional activity**

Further actions/next steps (1)

- £7.5m funding earmarked to progress formal procurements to secure new market interest/NHS dental practices to address gaps in provision where is has not been possible to re-commission UDAs from existing NHS practices (new contracts planned for N Cumbria x 4, Berwick x 2, Sunderland x 2, Durham x 2, Darlington) (NB: reflects position agreed by ICB in August 2023)

- Further advert to be placed in BDJ to attract overseas dentists and to support them through National Dental Performer List process (required to deliver NHS dental care).

- Work on-going to identify options to address variation/inequity of funding into practices.

- Work with dental profession to identify further opportunities to ‘protect, retain and stabilize local dental practices and improve dental access.

- Work with Healthwatch to update patient and stakeholder comms.

Further actions/next steps (2)

- Work with local system partners to progress development of an oral health strategy to improve oral health and reduce the pressure on dentistry.

- Engage with NHS England Regional Workforce, Training and Education Directorate to support where required the work they are doing to improve workforce recruitment and the local implementation of the National Dental Workforce Plan.

- Engage with NHS England regional and national teams to influence national Dental System Reform.

Advice/signposting for patients

- Patients are not registered with a dentist in the same way as GP practices – you can therefore contact any NHS dental practice to seek access to dental care.

- As independent contractors, dental practice are responsible for managing their appointment books and are best placed to advise on the capacity they have available to take on new patients.

- Practices providing NHS treatment are listed on www.nhs.uk. Practices are responsible for keeping the website updated and whilst it may currently indicate they are not taking on new patients, we would advise that patients do contact them to check the latest position on availability of routine appointments.

- Dental practices are being **encouraged to prioritise patients for treatment based on clinical need and urgency,** therefore appointments for some **routine treatments**, such as dental check-ups, may therefore still be delayed. Some practices are operating waiting lists to manage those patients requesting routine NHS dental care).

- If your teeth and gums are healthy – a **check-up, or scale and polish may not be needed every 6 months.**

Advice for patients with an urgent dental treatment need

- If you develop an **urgent dental issue** telephone your regular dental practice (or any NHS practice if you don't have a regular dentist).
- It is important that when you ring the practice, you fully explain the nature of your dental problem so that the urgency of your dental treatment need can be determined.
- If the practice is unable to offer an appointment because their NHS urgent access slots have already been taken up, they will advise you to ring another NHS dental practice, or alternatively you can visit www.111.nhs or call 111.
- The NHS111 health advisor will undertake a clinical triage and where the dental need is deemed to be clinically urgent, an appointment will be made at the nearest in-hours urgent dental care hub, or alternatively depending on the time of the call, into the dental out of hours treatment services.
- If the issue is not deemed urgent, patients will be signposted to another NHS dental practice and/or given self-care advice until an appointment can be offered.
- You should be advised to make contact again if your situation changes/worsens.

Oral Health Promotion Strategy 2023-2028

NHS North East and North Cumbria

https://www.durham.gov.uk/media/42407/Oral-Health-Strategy/pdf/OralHealthStrategy

- The strategy evidence based and reflects local need.
- The strategy promotes:
  - tooth brushing with fluoride toothpaste at least twice per day for 2 minutes each time
  - a healthy diet, low in sugars
  - stop smoking and limiting alcohol consumption to reduce the risk of oral cancer
  - sustained support and encouragement for mothers to breastfeed
  - regular dental check-ups
- It will be delivered through a multi-agency workplan that promotes good oral health and prevention across the life course with particular focus on higher risk groups to reduce inequalities
- The workplan builds on existing work for example supervised toothbrushing in early years settings in high need areas

NHS
North East and
North Cumbria

Water Fluoridation

- At a population level, it is the most effective way of reducing inequalities, as it ensures that people in the most deprived areas receive fluoridated water.
- Water fluoridation should be part of an overall oral health strategy.
- The Health and Care Act 2022 has moved the responsibilities for initiating and varying schemes for water fluoridation from local authorities to the Secretary of State.
- Information about water fluoridation has been referenced in the strategy although any actions for the local authority will be directed from the Secretary of State.

FURTHER SUPPORTING

BACKGROUND INFORMATION

Challenges and Pressures
&
Summary of recently published ICB Commissioning Framework

1. COVID-19 Impacts

- During the **first wave of the pandemic** in the interest of patient and dental staff safety, **routine dental services were paused in March 2020** and urgent dental care centres (UDCs) were established to provide access only to clinically confirmed urgent dental care.

- In **July 2020 all practices gradually re-opened for limited face to face care** in strict accordance with Nationally mandated COVID-19 NHS Dentistry Standard Operating Procedures and IPC constraints.

- As part of those arrangements, practices were required to **prioritise patients based on clinical need and urgency into their significantly reduced safe operating capacity**, creating inevitable delays and backlogs over time for patients seeking non-clinically urgent and more routine dental care at that time.

- As part of those nationally mandated COVID-19 response arrangements practices were provided with **income protection** but also **mandated to operate at significantly reduced and safe levels of face to face access levels** throughout the prolonged COVID-19 Pandemic period as follows:

○ **0% between March – July 2020 (remote triage only unless designated UDC)** ○ **20% between July - December 2020** ○ **45% between January - March 2021** ○ **60% between April - September 2021**	○ **65% between September - December 2021** ○ **85% between January - March 2022** ○ **95% between April 2022 – June 2022** ○ **100% from July 2022**

- All dental practices are now able to safely provide a full range of treatment however **demand for care remains extremely** high with dental practices having to **balance addressing the backlog of care with managing new patient demand**, whilst also facing **workforce recruitment and retention issues** which continues to mean a delay in meeting demand for more routine and non-urgent care.

2. Dental Workforce Recruitment and Retention

There are a number of factors relating to workforce recruitment and retention that are affecting the ability of NHS dental practices to deliver the full level of commissioned access, these include:

- **Younger generation and newly qualifying dentists** more often choosing not to pursue an NHS Dentistry career or where they do, they are seeking a work life balance that limits their working commitment to part time NHS Dentistry
- **More experienced dentists and increasing dental nurses** are choosing to retire early, move into private dentistry or pursue a different career path.
- General recruitment issues **attracting new dentists into NHS Dentistry from private dentistry and from overseas** due to a range of issues including but not limited to; securing GDC and Performers List registration for overseas dentists, Dental Student and Foundation Dentistry Places being limited nationally and private dentists not perceiving working within the current NHS Regulatory arrangements as being attractive in terms of pay, conditions, work life balance etc.

This creates difficulties for NHS Dental Practices locally and nationally to **maintain and/or replace the level of clinical workforce** they need in order to reliably deliver their full NHS Dentistry capacity as they continue to try to fully recover from COVID-19 Pandemic impacts.

3. NHS Dental Contract & System Reform

- Current **NHS Dental Regulation/contract was introduced in 2006**
- **March 2021** the Department of Health requested that **NHS England lead on and develop national dental system reforms for England.**
- In **July 2022**, NHS England published a **national package of 'initial reforms'** to the NHS dental regulatory contract. This included:
  - Prioritising patients with high care needs by **increasing the funding that practices receive for more complex care.**
  - Setting a **National minimum UDA value of £23**, which hadn't existed previously (variable UDA rates across NENC – equivalent at 2023-24 prices is £25.33)
  - Greater flexibilities within national regulations to **locally release funding and unused dental access locked into practices** who are unable to deliver their commissioned activity so that it can be offered to those who can deliver activity above their contracted levels.
  - Emphasis on **recall intervals that are clinically appropriate to a patient's oral health status** (NICE Best Practice Guidance – adults up to 24 month, children 12 months). The intention being to release treatment capacity and reduce inequality of access to dental care.
  - **Making it easier for practices to introduce skill mix** by utilising the skills of the wider dental care professionals (dental therapists and hygienists) to work within their full scope of practise thereby freeing up capacity and dentist time to focus on more complex treatments.
- **National Dental Plan -** no clear timescale for publication.

Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners (1)

(Published 9.10.23)

- **Summary of Opportunities outlined in Framework:**
  - Additional investment into new or existing contracts to address areas of need including:
    - Increased contracting of mandatory services (must be commissioned as UDAs – monitoring supported nationally)
    - Commissioning additional capacity for Advanced Mandatory Services, Sedation and Domiciliary Services and Orthodontics
    - Commissioning additional capacity for Dental Public Health Service and/or Further Services (commissioner determines own remuneration approaches – requires local resource for monitoring etc)
  - Reallocation of existing contractual funding away from Mandatory Service into new priorities (must be commissioned as Additional or Further Services) – see next slide
  - Local negotiation of indicative rates for Units of Dental Activity (UDAs) or Units of Orthodontic Activity (UOAs)
    - Increase can be achieved through either a reduction to contractors commissioned UDAs or an increase in the overall contract value.
    - Key things to consider in deciding whether to make adjustments to a contract:
      - Average value of UDAs commissioned in ICB area.
      - Seek further information from contractor such as practice income and expenses including provider drawings to compare to local and national averages.
      - Is the decision supported by local needs .
      - VFM and impact assessment.
      - Risk of legal challenge at a local level and potential wider regional or national implications.
      - May wish to consider a short-term change, offered as a trial period subject to agreement by both parties to allow time for the impact of the change to be monitored to inform decision on whether to make a permanent change.

Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners (2)

- **Key points to note:**
  - ICB should continue to give **due regard to national procurement guidance and organisational standing orders and standing financial instructions** should be observed.
  - *Commissioning of Additional and Further Services:*
    - Must comply with the definitions in the Regulation and **go beyond the reasonable expectations of Mandatory Services**
    - Performance management of **Dental Public Health and locally defined Further Services** and any associated financial recovery are **not governed by the Regulations/SFEs** – commissioners need to **determine their own mechanisms** to monitor and measure performance, including management of under-performance, including provision for financial recovery.
    - Local contract arrangements are not supported through national processes – ICBs will need to **ensure they have sufficient resources to manage/monitoring local schemes including mechanisms for financial recovery**
    - Statutory duty to **involve the public when making commissioning decision** that will affect services for NHS patients.
    - Responsibility to ensure that any services represent **good value for money** and are **clinically effective**.
    - Should be based on **local need assessment**.
    - Can be funded through **additional investment** or **offsetting of existing UDAs (**where latter approach adopted must consider **impact on wider access to Mandatory Services).**
    - No longer advising 10% UDA flex as a max threshold – nationally monitoring of the total quantum of additional and further commissioning – do **not expect this to routinely exceed 10-20%** if the additional to Mandatory Services test is being suitably applied.
    - Must **consider risk of legal challenge** at a local level and the **impact** that local programmes may have on **wider national arrangements and contract reform packages.**
    - Opportunities to be **available to all contractors in an ICB area who meet the eligibility criteria** to **ensure fairness and transparency**.
    - Robust process to support all decision making should be in place
    - Recommended that Additional or Further Services are **commissioned on a time limited basis** to give flexibility to ensure service continues to meet local need and that local contracts do not replicate any future nationally agreed changes to the GDS/PDS regulations, SFE and GDS contract/PDS Agreement.

This page is intentionally left blank