Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Long Stay/Rehabilitation wards for adults of working age	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	Primrose Lodge	RX3AD
	163 Durham Road	RX3WE
Acute wards and Psychiatric Intensive Care Units for adults of working age	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	Sandwell Park	RX3NH
	Lanchester Road Hospital	RX3CL
	Friarage Hospital Mental Health Unit	RX3XX
	Cross Lane Hospital	RX3LK
	The Briary Unit	RX3YE
	Peppermill Court	RX34L
Community Learning Disabilities and Autism	Trust Headquarters	RX301
Wards for Older People	Roseberry Park	RX3FL
	West Park Hospital	RX3MM
	Sandwell Park	RX3NH
	Lanchester Road Hospital	RX3CL
	Friarage Hospital Mental Health Unit	RX3XX
	Cross Lane Hospital	RX3LK
	Springwood	RX3KW
	Auckland Park Hospital	RX3AT
	Worsley Court View for the Elderly	RX3W4

Summary of findings

The Briary Unit	RX3YE
Cherry Tree House Elderly Assessment Unit	RX3W6
Meadowfields Community Unit	RX33Y

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

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Overall summary

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

After the inspection in January 2017 the overall rating for the trust has not changed from good because:

- All ratings in the provider report and core service report key questions remained the same except; long stay/ rehabilitation mental health wards where there was a change of rating from requires improvement to good in safe; community services for people with learning disabilities or autism was not previously rated and following this inspection has a rating of good; wards for older people with mental health problems ratings have changed from good to requires improvement; the provider quality report ratings have changed in well led from outstanding to good.
- Staff engaged with patients in a caring, compassionate and respectful manner throughout our visits to the wards. Feedback received from patients and carers was positive in relation to the care and treatment they received and they felt involved in care planning. Patients had access to advocacy services. The trust actively sought the views and experiences of patients across all the services we visited.
- Staff had a good understanding of the Mental Health Act and applied this in practice. The trust had a system for monitoring and reducing restrictive physical interventions with a 'force reduction programme', this was trust wide. The trust was making a positive effort to reduce blanket restrictions on wards and had started to share effective findings with other parts of the trust. Patient's capacity and consent to treatment was recorded and staff regularly explained patient's rights to them.
- Staff managed medicines well on acute wards, psychiatric intensive care units and long stay rehabilitation wards. Staff completed the correct documentation when they administered covert medication to patients on older people's wards. Staff carried out a comprehensive assessments of patient's needs and reviewed patient's risks regularly.
- The trust worked actively to promote the wellbeing of staff. As a result, the overall sickness rate was low and staff morale was generally high. The trust was undertaking a 'staff engagement pilot' with the aim of increasing the engagement of staff working in the trust. It had also set up a residential retreat programme for staff which aided participant's wellbeing and helped staff to make the most of their lives.

However:

- The trust did not take all necessary action to ensure the safety of patients under its care. Staff on the wards did not always undertake annual environmental audits to reduce the risk of suicide nor were all staff aware of the risks in the ward environment. The Orchards had no nurse on call system for patients to summon staff in an emergency. Rowan ward and Wingfield ward did not comply with Department of Health guidance on eliminating mixed sex accommodation because they did not provide a seprate lounge-space for women. Few staff on the wards for older people with mental health problems had completed the training that the trust considered essential and only one-half of staff across the trust had completed training in resuscitation.
- The trust was not fully complying with the requirements of duty of candour. There were some omissions in the records showing when medication had been administered and recording physical observations when rapid tranquilisation had been used.
- The trust had not fully updated all of the policies and procedures listed in annex b of the Mental Health Act code of practice 2015. The mental health legislation committee, who was responsible for assuring the Mental Health Act code of practice was

implemented, had not adequately monitored annex b of the code. Seclusion recording in some parts of the trust was not fully available in the electronic record.

- The trust had not included external feedback in its equality delivery system 2 report as part of the workforce race equality system.
- The trust had not made significant progress in a number of patient safety areas detailed in the action plan for the York and Selby locality.

The full report of the inspection carried out in January 2015 can be found here at http://www.cqc.org.uk/provider/RX3?lk

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Annual suicide prevention environmental surveys were not up to date on nine wards. We found that on four of the wards, not all staff were aware of the risks in the environment.
- Rowan and Wingfield wards did not comply with Department of Health guidance on mixed sex accommodation. Male patients were allowed to use the female only lounge on Rowan ward; the room designated for use as a female only lounge was not being used as a female lounge on Wingfield ward.
- There was out of date stock and equipment in the clinic rooms of some wards. Clinic room temperatures on three of the rehabilitation wards were regularly exceeding recommended temperatures.
- There was no nurse call system for patients to summon staff in an emergency on The Orchards. Staff on The Orchards did not routinely carry personal alarms.
- On four older people's wards there were significant gaps where staff had not signed to state whether medication had been given to patients. Mental Health Act certificates were not always kept with medication cards for detained patients. On three older people's wards some medication records had gaps in the required information on the front of the card.
- The trust were not fully complying with all of the statutory requirements of duty of candour.
- Mandatory training compliance was low in some wards in the trust.

However:

- Seclusion rooms for patients complied with the requirements set out within the Mental Health Act code of practice.
- Staff reviewed patient's risk regularly.
- Staff had received safeguarding training and had a good understanding of safeguarding policy and procedures.
- A 'force reduction programme' was in place to monitor and review how patients challenging behaviour was managed in the trust.
- Staff managed medicines well on acute wards, psychiatric intensive care units and long stay rehabilitation wards. Staff completed the correct documentation when they administered covert medication to patients on older people's wards

Summary of findings

- Staff reported incidents and a process was in place to share learning and feedback from incidents.

Are services effective?

Good

We rated effective as good because:

- Staff undertook comprehensive assessments of the needs of the patients.
- Patients had good access to physical healthcare on all wards we visited.
- Pathways of care followed national best practice guidance.
- The trust participated in national audits and there was an annual clinical and non-clinical audit programme in place.
- Patients had access to a range of multidisciplinary staff and multidisciplinary teams worked well together across the services we visited.
- Staff received annual appraisals and specialist training to help them to do their jobs.
- Staff recorded patient's capacity and consent to treatment and regularly explained rights under section 132 to patients.
- The Mental Capacity Act was applied appropriately across the services we visited.

However:

- The trust had not fully updated all of the policies and procedures listed in annex b of the Mental Health Act code of practice 2015.
- Care plans on older peoples wards and on The Orchards rehabilitation ward were not always personalised or contained the patient's views.
- An unsecured box of confidential patient information was left in a room accessible by visitors on Worsley Court.
- Regular staff supervision was not evidenced or recorded on older people's wards.

Are services caring?

Good

At the last inspection in January 2015 caring was rated as good. Since that inspection we have received no information that would cause us to re-inspect a core service or change the rating.

- During the inspections between November 2016 and January 2017, staff engaged with patients in a caring, compassionate and respectful manner throughout our visit to the wards. Feedback received from patients and carers was positive in

Summary of findings

relation to the care and treatment they received and they felt involved in care planning. Patients had access to advocacy services. The trust actively sought the views and experiences of patients across all the services we visited.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Treatment commenced in services as part of the first appointment (initial assessment).
- The trust was exceeding the 50% target in early intervention in psychosis for treatment of people experiencing a first episode of psychosis with 69%.
- Patients and carers told us that staff within services responded quickly and appropriately when they called for advice and support.
- All wards supported the care and treatment of patients with a range of rooms, facilities and equipment. Patients had access to hot drinks and snacks 24 hours a day.
- Patients were often seen at locations that best suited their needs in community services.
- Patient's were informed how to complain and information was also on display . Staff knew how to handle a complaint and complaints were monitored at all levels of the trust.

However:

- On some wards the outside space was not well maintained and could only be accessed with support from staff.

Are services well-led?

Good

We rated well-led as good because:

- With the exception of older people's wards all services we visited were aware of the organisation's vision and values. Staff knew who their senior managers were and told us they visited the services.
- A 'staff engagement pilot' was taking place with the aim of increasing the engagement of staff working in the trust. A residential retreat programme was in place for staff which aided participant's wellbeing and helped staff to make the most of their lives.
- Overall sickness rate was low and staff morale was generally high.
- The trust complied with the fit and proper person requirements.

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- A quality improvement work plan was in place and improvements had been made across all services using the Virginia Mason Production System.

However:

- The trust had not included external feedback as part of the workforce race equality system in its equality delivery system 2 report.
- The trust had not made significant progress in a number of patient safety areas detailed in the action plan for the York and Selby locality.

Summary of findings

Our inspection team

Our inspection team was led by:

Inspection Lead: Jenny Wilkes, Head of Hospitals Inspection

Team Leader: Chris Watson, Inspection Manager, mental health services, CQC

The team included one other inspection manager, one CQC inspector and a variety of specialist advisors. As well as having a deputy chair of an NHS trust the specialist advisors were also experienced at a senior level within equality and diversity, clinical governance and nursing. The inspection team were also joined by a member of staff from another department of the CQC as an observer.

Why we carried out this inspection

We inspected Tees Esk and Wear Valleys NHS Foundation Trust as part of our on-going mental health inspection programme and to see if the trust had made improvements following our last comprehensive inspection in January 2015 in the following core services:

- Rehabilitation/long stay mental health wards for adults of working age.
- Community mental health services for people with a learning disability or autism.
- Inpatient wards for older people with mental health problems.
- Acute inpatient mental health wards and psychiatric intensive care unit for working age adults.

The trust had a comprehensive inspection in January 2015 which included a review of the leadership and governance of the trust; we rated the trust as good overall. We rated the trust as requires improvement for safe, good for effective, caring, responsive, and outstanding for well-led.

When we inspected the trust in January 2015 we rated the long stay/rehabilitation mental health wards for working age adults as good overall. We rated this service as requires improvement in safe and good for effective, caring, responsive and well led. Following that inspection we told the trust it must take the following actions to improve long stay/rehabilitation mental health wards for working age adults;

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

When we inspected the trust in January 2015, we were unable to give an overall rating for community services for people with learning disabilities or autism due to the adverse weather conditions. We were unable to meet with a sufficient number of people using the service and therefore, had insufficient evidence. Following that inspection we did not identify any regulatory breaches in community services for people with learning disabilities or autism.

When we inspected the trust in January 2015 we rated wards for older people with mental health problems as 'good' overall. We rated this service as requires improvement in safe and good for effective, caring, responsive and well led. Following that inspection in 2015 we told the trust that it must take the following actions to improve wards for older people with mental health problems:

- The trust must ensure that administration records for medication for patients on Hamsterley ward were signed as the medication was administered.
- The trust must ensure that medication is not administered to patients on both Ceddesfeld and Hamsterley wards covertly, without reference to a best interests meeting, or seeking advice from a pharmacist.

We also inspected the wards at Worsley Court View for the Elderly and Meadowfields Community Unit which Tees, Esk and Wear Valleys NHS Foundation Trust had taken over responsibility for in October 2015. When we last inspected these wards in October 2014, they had been managed by a different provider. At that time, we had rated the core service of which these wards were a part as 'inadequate'

Summary of findings

overall. Tees, Esk and Wear Valleys NHS Foundation Trust were aware of the findings of the October 2014 inspection when they took responsibility for Worsley Court View for the Elderly and Meadowfields Community Unit, and had developed an action plan to address them. We told the previous provider that it must take the following actions to improve Worsley Court View for the Elderly and Meadowfields Community Unit:

- The provider must ensure there are sufficient skilled staff at all times to meet the treatment and care needs of the patients.
- The provider must ensure it adheres to the guidelines for mixed sex wards under the Mental Health Act Code of Practice (Chapter 16).
- At Worsley Court the provider must ensure that there no delays to the administration of patients medication.

When we inspected the trust in January 2015 we rated the acute wards for adults of working age and psychiatric intensive care units as good overall. We rated this service as requires improvement in safe and good for effective, caring, responsive and well led. Following that inspection in 2015 the we told the trust that it must take the following actions to improve the acute wards for adults of working age and psychiatric intensive care units:

- The provider must ensure that current risks have an associated intervention plan which clearly outlines measures to manage the risk with the input of the patient.
- The provider must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels.
- The provider must ensure an effective quality monitoring system is in place for joint working with partner NHS trusts where services are provided from.

We also inspected Forensic inpatient/secure wards at Roseberry Park hospital in February 2016. We inspected this core service as part of a focused inspection into the use of restrictive practices. Roseberry Park was inspected in March 2014 and we found the provider to be in breach of regulation 9 and 11 of the health and Social care Act 2008 (regulated activities) Regulations 2010. When we inspected in January 2015 the trust was still implementing its action plans around the use of restrictive practice. This was a focused inspection to ensure the action plan had been implemented. Therefore only aspects relating to the restrictive practice were inspected during this focused inspection. We found no regulatory breaches during the inspection visit in February 2016 but informed the provider that it should ensure it progresses action to reduce the restrictive practice around mobile phones and personal laptops.

We also made a number of recommendations following the inspection in January 2015, where we think the trust should take actions to improve services. We reviewed a sample of these recommendations across the services that we inspected and in the well-led review we completed in relation to the leadership and governance of the trust.

At this inspection we inspected the following key questions in the core services:

- Rehabilitation/long stay mental health wards for adults of working age - all key questions.
- Community mental health services for people with a learning disability or autism – all key questions.
- Inpatient wards for older people with mental health problems – safe; effective; well-led.
- Acute inpatient mental health wards and psychiatric intensive care unit for working age adults – safe.

How we carried out this inspection

To get to the heart of people who use services experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

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- Is it well-led?

Before the inspection visit the inspection team reviewed a range of information we hold about Tees Esk and Wear Valleys NHS Foundation Trust. We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit. This also included receiving feedback from external stakeholders including commissioners.

During the inspection visits the inspection teams:

- Visited all six inpatient rehabilitation/long stay mental health wards for adults of working age
- Visited all 14 inpatient wards for older people with mental health problems across eight sites.
- Visited all 17 acute inpatient mental health wards and psychiatric intensive care unit for working age adults across eight sites.
- Visited a sample of five community mental health services for people with a learning disability or autism bases from a total of 13.
- Observed how staff were caring for patients on all wards and services we visited.
- Spoke with 171 patients who use the services and their relatives and carers.
- Spoke with 207 staff including doctors, nurses, psychologists, occupational therapists, pharmacy staff, physiotherapy staff, healthcare assistants and other health care professionals.
- Spoke with 42 managers including ward managers, acting ward managers and clinical leads.
- Reviewed 212 patient records, five seclusion records on acute mental health wards and psychiatric intensive care units, eight enhanced observation records and seven do not attempt cardiopulmonary resuscitation records.
- Reviewed most of the patient medication records on inpatient wards we visited and reviewed the medication management across the trust.
- Observed 17 meetings including report out morning meetings and team meetings.
- Interviewed over 28 senior staff, board members and representatives of the council of governors. These included the chief executive, the chair, medical director, and director of nursing.
- Facilitated two focus groups with black and minority ethnic staff.
- Facilitated interviews with staff representing staff side and their unions, the freedom to speak up guardian and the Mental Health Legislation managers.
- Attended a meeting of the board of directors and a quality assurance committee.
- Looked at policies, procedures and other documents relating to the running of the wards, services and the trust.

Information about the provider

Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health and learning disability services to the people of County Durham and Darlington, Teesside, Hambleton and Richmondshire, Scarborough Whitby and Rydale, Harrogate and Craven, and the Vale of York. The trust serves a population of 1.6 million people and covers 3,600 square miles, 8% of England. It employs more than 6,500 staff and has an annual income of £300 million. Its services are commissioned by eight clinical commissioning groups and NHS England. It also works with seven local authorities.

The trust formed in 2006 following the merger of two mental health and learning disability trusts and was authorised as a foundation trust in 2008. In 2011 it was awarded the contract to be provider of mental health and learning disability services in Harrogate, Hambleton and Richmondshire. In 2015 it was awarded the contract to be provider of mental health and learning disability services in York and Selby.

The trust provides the following core services:

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

Summary of findings

- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards.
- Child and adolescent mental health wards.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.
- Community-based mental health services for adults of working age.
- Community-based mental health services for older people.
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community mental health services for people with learning disabilities or autism.
- Substance misuse services.
- Adult social care services.

Tees, Esk and Wear Valleys NHS Foundation Trust was first registered with CQC on 1 April 2010. It has 27 locations registered with CQC.

There have been 57 inspections at registered locations of Tees, Esk and Wear Valleys NHS Foundation Trust since 2016. These inspections have occurred at 18 locations.

What people who use the provider's services say

During these inspections, we spoke with 171 patients who use the services and their relatives and carers.

Patients and carers we spoke with expressed positive comments about the staff, the care they received and the environments in which care was delivered. In community mental health services for people with learning disabilities or autism patients and carers commented that they had never received such thorough and helpful service before and staff went the extra mile and over and above their expectations.

A carers group said when they had experienced care that they felt was inadequate they were impressed with the way the trust responded. They felt very well supported and involved by the trust at all levels and said the trust was fully committed to all CQC key questions. They described the trust leadership as strong with a commitment to joint working and developing services.

An advocacy provider told us that there were sometimes difficulties for people accessing services and not always being involved in their care planning. They also highlighted that there was good handling of complaints with lots of contact from investigators and the complaints team to ensure clear communication and patients kept informed. However, deadlines were not always adhered to.

Good practice

In the community services for people with learning disabilities or autism the South Teesside service worked with GPs and the local community to highlight issues around learning disabilities. It also ran an autism group, which had received positive feedback from carers. The service had also created an annual health check template for its patients, ran training sessions within GP practices and had hosted events attended by GPs, advocacy services, therapists and local authorities. The Hambleton and Richmondshire service provided training to external care providers to give them a greater understanding of the needs and issues relating to people with learning disabilities. The consultant psychiatrist at this service initiated a GP liaison group to raise awareness of the service and reinforce the need for annual health checks to improve the formulation of health action plans.

In acute wards for adults of working age and psychiatric intensive care units the trust operated a psychiatric intensive care unit pathway called a 'PICU pyramid'. There was an admission flow chart in place based around the principles of a care planning approach to engage patients in the management of their behaviours. This aimed to

ensure admission to the psychiatric intensive care unit was a last resort. The plans incorporated measures to proactively encourage patients to move back to the acute ward.

Areas for improvement

Action the provider MUST take to improve

Trust Wide

- The trust must ensure when exercising their responsibilities under the duty of candour that a notification be given in writing to the person or their representative or a written record of attempts to contact or speak to the relevant person.
- The trust must ensure it complies with the Department of Health guidance on mixed sex accommodation with the provision of female lounges. Male patients were allowed to use the female only lounge on Rowan ward; the room designated for use as a female only lounge was not being used as a female lounge on Wingfield ward.

Inpatient wards for older people with mental health problems.

- The trust must ensure that staff complete mandatory training.
- The trust must ensure that all wards participate in the annual audit programme when requested to do so.
- The trust must ensure that all wards are included in the audit programme to ensure quality and oversight. In addition to annual clinical audits, staff must complete checks on each ward in a timely manner. This includes daily checks of medication cards, storage of medication and emergency equipment, and that drugs fridges are secure. Staff must follow up checks, which evidence a problem (such as the clinic room temperature at Worsley Court) to ensure repairs are made in a timely manner.
- The trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with trust's policy.
- The trust must ensure that they improve the environment to ensure patient dignity and privacy at Cherry Tree house.
- The trust must ensure that they train staff in the use of the safety summary tool and that staff regularly update patient risk assessments to reflect current risk.
- The trust must ensure that staff are, appraised and supervised according to their own policy and that managers adequately record this.
- The trust must ensure that the service regularly reviews staffing levels to ensure the observation of patients takes place and that staffing levels meet with the level of patient need and complexity.
- The trust must ensure that the environment at Worsley Court is clean, safe and fit for purpose.
- The trust must ensure that clinic rooms are clean, tidy and allow staff quick access to equipment and medication that is stored correctly and safely.

Acute inpatient mental health wards and psychiatric intensive care unit for working age adults.

- The trust must ensure that each ward has a suicide prevention environmental survey reviewed annually in line with their policy. Staff must be aware of ligature risks and blind spots on the wards and be able to identify how they mitigate for these.
- The trust must ensure that all staff are up to date with their mandatory training in immediate life support as a minimum standard for staff that deliver, or are involved in, rapid tranquilisation, physical restraint, and seclusion.
- The trust must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with the trust's policy. The trust must ensure staff are trained in rapid tranquilisation.
- The trust must ensure that staff recognise when patients are being secluded in rooms other than a seclusion room in line with their policy. Staff must record this as seclusion and ensure patients are

afforded the procedural safeguards of the Mental Health Act code of practice in these instances. The provider should ensure that the recording of any episodes of seclusion is in line with trust policy and complies with the Mental Health Act code of practice.

Long stay/rehabilitation mental health wards for working age adults

- The trust must ensure patients and staff at The Orchards have an alarm call system that can be easily accessed to summon assistance.

Action the provider SHOULD take to improve

Trust Wide

- The trust should review the operation of its mental health legislation committee and its assurance processes to ensure it robustly monitors action plans.
- The trust should ensure it has a robust system for continually checking staff against convictions and / or cautions.
- The trust should continue to monitor and improve its compliance rate for staff attending resuscitation training.
- The trust should ensure it includes external feedback in its equality delivery system report and have this approved by the board of directors.

Rehabilitation/long stay mental health wards for adults of working age.

- The trust should ensure that clinic room temperatures at Primrose Lodge, Lustrum Vale and Willow ward are within acceptable limits.
- The trust should ensure that monitoring of blood collection tubes and blood spillage kits takes place to ensure out of date equipment is replaced.
- The trust should ensure there are no trip hazards in the courtyard at Fulmar ward.
- The trust should ensure that patient care plans at The Orchards are personalised.
- The trust should ensure that expired section 17 leave forms on The Orchards are archived.
- The trust should ensure clear plans are in place to support patients discharge planning.

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

- The trust should ensure fire drills are carried out as required at the York service so staff and people who use the services know what to do in the event of a fire occurring.
- The trust should ensure there are effective systems in place at the York service to allow staff to call for help in the event of an emergency.
- The trust should ensure that all patient risk assessments are continually updated.
- The trust should ensure that all patients and their carers are involved in their care planning and treatment.
- The trust should ensure that the views and opinions of all patients are taken into account and recorded in care records.
- The trust should ensure team meetings at the South Durham service incorporate all relevant staff.
- The trust should give consideration to running patient activities within all its services.
- The trust should ensure that all staff at the service are aware of their risk register so that any risks identified can be centrally recorded and managed.

Inpatient wards for older people with mental health problems.

- The trust should ensure that the falls procedure is embedded on all wards and that staff follow the trust's policy. The trust should ensure it undertakes regular review of wards with significant number of falls.
- The trust should ensure there is a clear review process in place to review blanket restrictions such as doors and areas on wards which staff lock to prevent access to all patients.
- The trust should ensure that the review of the use of bed bays at The Friarage and Rowan (Briary Unit) is completed and practice changed in a timely manner to reduce patient distress and ensure they uphold patient's privacy and dignity.

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- The trust should ensure that patient's nutritional and hydration needs are monitored at Worsley Court and that patients have access to snacks and drinks.
- The trust should ensure that all patient belongings, including personal confidential information, are stored securely at Worsley Court.
- The trust should ensure that staff attach leave risk assessments to leave forms to record that staff have considered risks when they authorise leave.
- The trust should ensure that staff attach certificates authorising medication for mental disorder to all medication cards of detained patients. The trust should ensure that female patients at Rowan ward have access to the female only lounge, and that they provide adequate communal facilities for male patients to prevent male patients using the female only lounge.
- The trust should ensure that patients of both sexes are able to use the assisted bathroom at Ward 14 at the Friarage unit safely and in line with same sex accommodation guidance.
- The trust should ensure that where wards have no space available for examination couches, that patients have a choice of areas for examination, which are not their bedroom.
- The trust should ensure that it improves the privacy and cleanliness of the visitors room at Cherry Tree House.
- The trust should ensure that they deep clean equipment at Worsley Court.
- The trust should ensure that staff record all physical health observations on one system where they can be easily located.

Acute inpatient mental health wards and psychiatric intensive care unit for working age adults.

- The trust should ensure that all equipment in the resuscitation bags is in date and ready to use in an emergency.
- The trust should ensure that staffing establishment levels on the psychiatric intensive care units comply with national guidance.
- The trust should ensure that the wards meet their agreed staffing establishment levels of qualified staff.
- The trust should ensure that staff are trained in the use of the safety summary tool and that it reflects current patient risk. Staff should ensure intervention plans are in place and fully documented to manage identified risks and are individual to each patient.
- The trust should ensure there is a clear process in place to review blanket restrictions.
- The trust should ensure they maximise the privacy and dignity of patients on Ward 15 at The Friarage Hospital mental health unit.
- The trust should ensure they are able to control the temperature in the de-escalation room on Cedar Ward at The Briary Unit.

Tees, Esk and Wear Valleys NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust had not yet made Mental Health Act training mandatory for staff but had a varied training programme in place and the trust had decided to make Mental Health Act training mandatory in April 2017. There was good support for staff in relation to the Act across the trust and staff generally had a good understanding of what this meant for patients and their rights. People had access to independent mental health advocates in inpatient areas and had information relating to the service displayed in ward areas. Independent mental health advocacy providers we contacted gave a positive view of their relationship with the trust.

The trust developed an action plan to address the changes to the Mental Health Act code of practice 2015 in January 2015 when the first draft of the revised code was published. This addressed policy, procedures and clinical aspects that the changes to the code had brought about. This was monitored through the mental health legislation committee and we saw evidence of updates to the trust action plan. At the time of our inspection, not all of the policies and procedures listed in annex b of the Mental Health Act code of practice had been updated. This was brought to the attention of the trust and they completed most of the outstanding updates to the policies and procedures during the inspection period and these were ratified by the executive management team on 1 February 2017. Some policies, controlling access to and exit from in-patient areas policy and use of mobile phones were updated and ratified on 15 February 2017.

Significant work had been undertaken in forensic services to reduce blanket restrictions and the trust had developed a wider application of the principles to produce a 'framework on the use of restrictive practices in in-patient units'. This was approved by the executive management team on 18 January 2017 and a draft policy 'Blanket restrictions: policy on the use of global restrictive practices (blanket restrictions) in in-patient units' was distributed for consultation across the trust.

The trust include Mental Health Act and code of practice compliance in its audit programme, these include seclusion and restrictive practices. Monitoring of compliance with the Mental Health Act is also carried out by the mental health legislation office centrally with exception reporting to the mental health legislation committee. Compliance with providing patients with an explanation of their rights, use of holding powers (section 5) and consent to treatment under the Mental Health Act are included in this monitoring and reporting.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a rolling training programme in the Mental Capacity Act and Deprivation of liberty safeguards. Training

was not mandatory, the trust informed us that from April 2017 all Mental Capacity Act training would be mandatory and recorded and monitored against compliance. The training was delivered alongside the Mental Health Act and formed part of the overall mental health legislation training for the trust. Staff knowledge of the Mental Capacity Act was generally good across the core services with the exception of some areas in mental health services for older people. Since our last inspection in January 2015 the trust had made improvements in its application of the Mental Capacity Act in older peoples services.

The trust had detailed policy and guidance to inform staff and this was supported by a central team and Mental Capacity Act lead who were available for advice.

We saw evidence of the application of the Mental Capacity Act across the core services with documented mental capacity assessments and records of best interest considerations which met with the requirements of the Mental Capacity Act and its code of practice.

Requires improvement

Are services safe?

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

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

Summary of findings

The summary can be located on page 7.

Our findings

Safe and clean environment

The trust had an estates strategy 'Estates and Facilities Management Framework' covering the periods from September 2014 to March 2017. The trust framework aimed to achieve the following:

- Identify where we are now, assess the business environment, identify where we want to be in 3 years and how we will get there.
- Support the Trust Business Plan 2014 – 2017 and the clinical service developments approved by the Board of Directors.
- Act as an enabling development plan for the directorate to ensure we continue to improve, maintain and deliver an appropriate quality estate and facilities management service to provide a safe, sound and supportive environment for patients and staff.
- Support the delivery of the planned capital investments over the next 3 years as set out in the Trust Capital Plan.
- Deliver and improve upon our assurance of compliance with Care Quality Commission.
- Commission essential standards of quality and safety.
- Continue to rationalise the estate as services change and the trust adopts new ways of working to ensure we maximise the efficient use of physical space.
- Act as a baseline for measurement of key performance indicators and service improvement.

The strategy covered all the trust services except the Vale of York an area of the trust, which had been acquired after the strategy was published. The trust had made changes to the accommodation for patients at Bootham Park hospital and reprovided acute inpatient beds at Peppermill Court in York. There had also been changes to older peoples mental health inpatient services at Worsley Court which had closed and been reprovided in Acomb Garth. Plans were being consulted on regarding the provision of a new purpose built hospital in York.

At the time of inspection, ligature points and blind spots were present on all wards for older people, all acute wards, both psychiatric intensive care units and all long stay rehabilitation wards. The majority of staff could identify what mitigating factors the wards had in place to ensure the safety of patients. These included the use of individual risk assessments, staff engagement with, and observation of patients and the position of staff on the wards. The trust completed annual suicide prevention environmental surveys, although these were not up to date on nine wards. We found that on four of the wards, not all staff could identify the risks in the environment.

When we last visited in January 2015, we found one mixed sex ward did not comply with Department of Health guidance. This ward had since closed. Of the 37 wards we visited, 22 provided mixed sex accommodation. Most of these complied with the guidance on same sex accommodation. However, Rowan ward allowed male patients to use the female only lounge as this room had the only working television and on Wingfield ward the room designated as a female lounge had a table and chairs in and was used as a meeting room. Although this did not comply with the Department of Health guidance on single sex accommodation we failed to identify this as such when we inspected in November 2016. We have therefore represented a breach of regulation in the provider report so the trust can take appropriate action. On Ward 14 at The Friarage Hospital Mental Health Unit, both male and female patients used the assisted bathroom. Some of the mixed gender wards had 'swing beds' which allowed gender segregated areas to be opened up if there were more males or females admitted. These were managed well and allowed an effective system for managing admissions.

We inspected the clinic room on each ward and found all of them to be fully equipped. Staff had access to equipment

for physical health monitoring, including weight scales and blood pressure machines. On all acute wards, psychiatric intensive care units and long stay rehabilitation wards, clinic rooms were clean and in good order. However, we found out of date stock on Kirkdale ward and Lustrum Vale and Peppermill Court. On three of the rehabilitation wards, the clinic rooms were exceeding the recommended temperature and on one acute ward fridge temperatures had not been recorded daily in line with trust policy. At Worsley Court the clinic room was disorganised and untidy.

There were no seclusion rooms on any of the older people's wards or long stay rehabilitation wards. The trust had a seclusion room on Bedale Ward at Roseberry Park, Ward 15 at the Friarage Hospital mental health unit in Northallerton, and one shared by Danby Ward and Esk Ward at Cross Lane Hospital. All three seclusion rooms complied with the requirements set out within the Mental Health Act code of practice. Between 1 July 2016 and 31 December 2016, seclusion was used on 93 occasions with Bedale PICU at Roseberry Park Hospital having the most incidents of 26. Between 1 July 2016 and 31 December 2016 there was 1 reported incident of longer term segregation on Westwood Children & Young Peoples low secure unit at Westlane Hospital. The trust were undertaking a review of the seclusion facilities at the time of inspection and a proposal had been made for seclusion facilities at West Park Hospital. The paper also recommended the trust consider the development of a formal extra care area on each inpatient site.

The trust had a de-escalation room at four of their registered locations. These low stimulus rooms were used to enable a patient to enter an area where they could de-escalate from their current emotional state, in a safe place to reduce the chance of physical injury to both themselves and others around them.

We observed good hand washing by staff and visitors on each ward. Hand gel dispensers were in place in toilets and clinical areas. In the community teams, hand washing facilities such as hand sanitiser gel were visible throughout our inspection of each site.

Thirty six of the 37 wards we visited had alarm systems in place. Staff wore personal alarms that sounded if assistance was needed and reported no concerns about the alarm system. The majority of wards also had nurse call systems in non-communal areas, such as patient bedrooms and shared bathrooms. However, an alarm system was not in place at The Orchards. Staff had access to personal alarms but did not always carry them; we raised our concerns about this to the manager during the inspection.

In the community adult learning disability and autism service, staff mainly saw patients in their own homes or at another location of their choice. With the exception of the York and Selby Community learning disability team, all locations had alarms installed in one to one rooms. Patients and carers using this community service were seen at their own home or location of their choice and rarely visited the service, which meant the risk of aggressive behaviour in the team's base was low.

Safe Staffing

The total number of substantive staff employed by the trust at the time of inspection was 6,551. In the last 12 months 749 substantive members of staff had left the trust (11% substantive staff turnover). In the 12 months ending December 2016 the overall trust sickness rate was 4.89% which is just below the national average of 4.97% for mental health and learning disability trusts. The trust vacancy rate was 6%.

The trust did not use a tool to establish staffing levels on the wards. Staffing levels varied due to the number of patients and the acuity of their illness. All of the ward managers we spoke with told us they were able to adjust staffing levels if the needs of the patients required it. At Lustrum Vale we saw this in practice as there were patients on enhanced observations.

All acute wards had an expected staffing establishment level of two registered nurses and two healthcare assistants during the day, and two registered nurses and one healthcare assistant during the night. In mental health services for older people, staffing varied between wards and was not based on bed numbers. Although wards met establishment levels on most shifts by using bank and agency staff, the complexity of the patient needs on some wards compromised the safety of the ward. At Worsley Court we observed three patients who were unsafe and the CQC team needed to call for staff to assist the patients because they were busy with other patients and had not witnessed the incidents. Staff reported agency staff were fully inducted to the ward and they aimed for consistency in using the same people. The wards rarely used agency staff but did use bank staff and overtime to respond to

planned and unplanned staff absence with the exception of Cherry Tree House and Worsley Court. On these wards the trust data showed that sickness levels were high and there was a significant amount of bank and agency staff used. Patients admitted to these wards told us that they felt that bank and agency staff affected the continuity of their care. Managers told us that low staffing levels had an impact on staff ability to carry out other tasks such as training, meetings, audits and supervision.

The trust had undertaken a trust wide review of psychiatric intensive care units and seclusion facilities in August 2016. This recommended that staffing establishments in both trust psychiatric intensive care units should be increased to meet national guidance. Although this was not in place at the time of inspection, staff on the psychiatric intensive care units stated that they always operated at above establishment levels. We reviewed the previous three weeks rota and found that all shifts were above staffing establishment levels.

The trust described its mandatory training as the 'core 7' subjects and the target for mandatory training was set by the trust at 95%. The overall mandatory training compliance at the trust for the last 12 months to December 2016 was 89%.The core 7 included;

- Equality and diversity 93%.
- Fire 84%.
- Infection control 83%.
- Safeguarding children level 1 96%.
- Safeguarding adults 95%.
- Health & safety 93%.
- Information governance 88%.

Other essential training monitored by the trust had 70.9% overall average compliance for the last 12 months to December 2016. These subjects included:

- dual diagnosis- 89%;
- clinical supervision - 90%;
- care programme approach & care coordination - 90%;
- clinical risk assessment and management - 88%;
- manual handling – objects - 88%;
- manual handling – patients - 88%;
- manual handling - patients part 1 - 59%;
- manual handling - patients part 1 update - 35%;
- manual handling - patients part 2 - 59%;
- manual handling - patients part 2 update- 40%;
- medicines management - 82%;
- management of violence and aggression - 79%;
- resuscitation - 51%;
- safeguarding children level 2 - 89%;
- safeguarding children Level 3 - 63%;
- safeguarding children level 3 update - 51%;
- safeguarding adults level 2 - 85%;
- rapid tranquilisation 1- 74% ;
- rapid tranquilisation 2 - 41%;
- rapid tranquilisation 3 - 42%;
- safe prescribing - 86%;
- Dual diagnosis – medics - 86%.

When we inspected in November 2016 the trust were implementing a resuscitation training programme following issues with their previous training provider. The training at that time was averaged at 44% across the trust. When we inspected in January this had improved slightly to 51%.

When we inspected in January 2017 the trust were implementing an 'integrated information centre'. We saw how this could be used to identify training compliance at different levels of the organisation using live data in the trust's system. This will enable managers to monitor training compliance with a view to improving attendance.

The trust did not include mental health legislation in its mandatory training subjects but had made the decision to make this mandatory from April 2017. In December 2016 the trust had introduced new mandatory training reporting arrangements including weekly reports to directors and heads of service. These 'integrated information centre' reports identified those teams whose compliance rates were less than 75% and those teams whose compliance rates will fall to less than 75% within the next three months should mandatory training not be completed. Ward managers were also able to view their own team's

mandatory training compliance using the integrated information centre. The trust monitored and reviewed its compliance with mandatory training in quarterly board of director meetings as part of its workforce report against key performance indicators.

All wards had a multi-disciplinary team who worked closely together and operated a 'report out' system. The report out system consisted of a daily meeting on a morning with the whole multidisciplinary team where all patient's current presentation, risks, medication, management and care plans would be reviewed. The team also considered any outstanding investigations, tests or procedural tasks that needed to be completed and allocated these. The process was assisted with the use of a white board containing information about that patient.

Assessing and managing risks to patients and staff

Tees, Esk and Wear Valleys NHS Foundation Trust used a two stage narrative risk assessment tool that was developed within the trust, called a safety summary. The safety summary tool had recently been updated and staff were unsure of which parts they were required to complete and when. The majority of staff we spoke to in November 2016 had not yet received training in the completion of the updated document; however guidance was available for staff on the trust internal system. Staff informed us that risk was reviewed at key times such as medication changes, before and after leave and following incidents. All records on all wards we visited had a safety summary in place, with evidence of reviews taking place. Some of the reviews in the safety summary were not dated, making it difficult to ascertain whether the frequency of reviews was in line with the trust policy. In long/stay rehabilitation wards for working age adults we found staff regularly conducted risk assessments. The service used a 'safety management plan' to record risks, triggers and actions to reduce harm.

Risk was reviewed at key events and we observed risk being discussed during report out meetings and multidisciplinary team meetings in all of the areas we visited in the trust. However, staff did not always complete the safety summary in a consistent format across the acute, psychiatric intensive care units and older people's wards. Although all patients had intervention plans, these were often generic and did not always reflect the individual risk and need of the patient.

In the community teams, staff undertook an initial risk assessment of every client and regularly updated these. However, in the York and Selby Community learning disability team, five out of seven client risk assessments were not being regularly updated. Staff in all community teams had a good understanding of potential risks associated with their patients and discussed these at regular multi-disciplinary and team meetings.

All wards had access to rooms off the main ward area that could enable children to visit patients. Staff were required to attend mandatory training in safeguarding children level one and safeguarding adults. Compliance rates with this training 96% and 95% respectively.

A safeguarding policy was available on the trust intranet for staff to follow if they had a safeguarding concern. Staff had a good knowledge of what constitutes abuse and how they would raise a safeguarding alert. We saw evidence that staff raised safeguarding concerns in response to identified risks. Staff reported good links with the trust safeguarding team and the local authorities. The trust's 'Thematic Quality Assurance Group for Safeguarding' provided assurance and the oversight of safeguarding in the trust. This group reported to the board via the quality assurance committee. Staff report all safeguarding referrals made through the electronic trust reporting system, datix.

Between 1 July 2016 and 31 December 2016 the trust reported 3006 incidents of restraint involving 488 different service users. Of these restraints, 395 were in the prone position and 228 resulted in the use of rapid tranquilisation. Prone restraint means that the patient is laid in the face-down position. Sandpiper Ward at Roseberry Park had the most incidents of restraint with 367, followed by Evergreen West Lane Hospital with 365 and West Wood Centre at West Lane Hospital with 339. The highest use of prone restraint was used in Sandpiper Ward at Roseberry Park Hospital with 130 incidents followed by Evergreen Centre (46) and Westwood centre (40) both at West lane Hospital. The trust had a 'Safe Use of Physical Restraint Techniques Procedure' which aimed to provide guidance in relation to the nature, circumstances and use of restraint techniques currently adopted by the Trust.

The trust had implemented the Department of Health Guidance 'Positive and Proactive Care: reducing the need for restrictive interventions' (April 2014) and had a policy 'positive approaches to supporting people whose behaviour is described as challenging'. The trust had a

restraint reduction plan which used their force reduction programme to monitor and review how behaviour was managed in the trust. This had been in operation since June 2014. The Force Reduction Project aimed to:

- Review and understand the usage and impact of control and restraint within the Trust.
- Understand the systems by which usage of control and restraint are recorded and monitored and devise a system for transparent reporting.
- Deliver a framework for the reduced usage of control and restraint within the Trust.
- Recommend methods for increasing the frequency of positive "front-end" preventative and proactive care planned interventions and suggest measures for this, including links to patient experience.
- Recommend ways of increasing service user involvement.
- Make recommendations on the suitability of the existing management of violence and aggression training programme and to consider procuring a different training organisation.

This was led by a force reduction project lead and reported quarterly to the trust quality assurance committee. The trust told us that the project had made significant forward steps in developing their management of violence training with a focus on no-physical interventions.

Appropriate arrangements were in place for the management of medicines on all of the acute wards, psychiatric intensive care units and long stay rehabilitation wards we visited. Some patients on the rehabilitation wards managed their own medications and care plans were in place for this. However, on five of the older people's wards we found significant gaps where staff had not signed to state whether they had given medication to patients. We also found patient's medication record cards had gaps in the required information at the front of the card, such as the patient's capacity to consent to medication on three of the older people's wards. On four older people's wards, we found that staff did not keep Mental Health Act certificates with medication cards for all patients when detained patients received treatment for a mental disorder. We found that on all these wards, the correct documentation was in place to support the administration of covert medication.

Reporting incidents and learning from when things go wrong

The trust had a central electronic incident reporting system used across the trust. All staff we spoke with knew how to recognise and report incidents on the system. All incidents were reviewed by the trust's patient safety team, who maintained oversight. Since October 2015, staff across the trust had received a monthly learning lessons bulletin. This included learning from other trusts or national reviews. The trust also provided staff with a patient safety bulletin that highlighted themes from recent serious incident reviews across the trust. In addition, there was a draft learning lessons framework in place, which was being refined through the learning lessons project. This was focused on learning lessons from serious incidents, safeguarding and medicines management.

Staff were involved in reviewing incidents using the format of situation, background, assessment, recommendation, and decision. These completed reports were then shared with staff across the trust. Staff reported they had access to debrief sessions and were provided with feedback on the investigation of incidents. Staff had access to counselling through the employee assist scheme if required.

Staff told us that the trust share learning from incidents across the service with staff. Staff were able to give examples of incidents outside of their own ward or service where they had received information about lessons learned. Staff told us that the trust shared learning from incidents via safety bulletins on the trust intranet. Managers also shared bulletins at 'report out' meetings and in supervision and team meetings. We saw that staff changed practice following an incident

Staff told us debriefing from serious incidents took place and we heard past examples relating to staff assaults by patients. We also saw debriefing as a focus for the trusts 'force reduction project'.

Duty of Candour

Since November 2014 trusts had a responsibility to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. This is called duty of candour. The trust provided the 40 completed incident reports for which duty of candour applied during 2016.

Requires improvement

Are services safe?

The trust had a duty of candour policy and staff knew where to access this. All managers and most of the staff that we spoke to could explain their responsibilities under the duty of candour. Staff were able to give examples of when they or colleagues had used this. Senior managers described being open and honest with patients and their families when things go wrong. They told us about providing information about incidents to patients and their families in the most appropriate way and at the most appropriate time. This meant that at times this was done face to face and not in writing. We reviewed four comprehensive and one concise serious incident report and found little mention of duty of candour and only one of these had a letter of apology on file. Duty of candour necessitates a notification is given in writing to the person or their representative or to keep a written record of why this was not done.

Good

Are services effective?

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

Summary of findings

The summary can be located on page 8.

Our findings

Assessment of needs and planning of care

All of the records we viewed on inpatient wards and in the community contained a comprehensive assessment of the patient's needs. On inpatient wards, staff completed these within 72 hours of admission. In the community teams, staff completed these within the first month of the patient accessing the service.

Staff on the older people's wards completed intervention plans, which contained standard statements regarding patient needs, care and treatment. Of the 70 intervention plans we reviewed, 29 were not personalised and lacked the patient's views. We also found 15 intervention plans had not been updated in line with trust policy and 37 did not contain a crisis plan. On the long stay rehabilitation wards, care plans were up to date, personalised, holistic and recovery oriented with the exception of The Orchards. We saw the team reviewed care plans with the patient and we observed patients discussing their care and treatment plans with staff.

In the community adult learning disability and autism teams the majority of care records and recovery plans were being regularly reviewed and updated. They covered the client's physical, emotional, mental and social needs. However, nine of the 37 recovery plans contained little or no evidence that the client's views and wishes had been considered.

All information was stored securely on the electronic records system which ensured that confidentiality of patient information was maintained. Paper documentation was locked in metal filing cabinets and only authorised staff held the keys. However, on visiting Worsley Court, we observed a box of confidential patient information which belonged to one patient. Staff had not secured this and had left it in a room accessed by our team and other visitors throughout our visit. We asked the ward manager to rectify this during our visit.

Best practice in treatment and care

The trust used a variety of methods to embed best practice throughout the service. The trust's overarching prescribing of medicines framework linked to National Institute for Health and Care Excellence guidance. The trust's electronic system supported staff by embedding this guidance into care plans on the electronic system.

On the long stay rehabilitation wards, patients were able to access psychological therapies including cognitive behavioural therapy, group therapy and family therapy. These therapies were recommended by the National Institute for Health and Care Excellence for the treatment of psychosis and schizophrenia. Staff used health of the nation outcome scores and the recovery star outcome measures. A variety of evidence-based tools to assess and record severity were also used. These included national early warning scores, hospital anxiety and depression scale and Lester tool.

In the community adult learning disability and autism services, the trust had developed a number of pathways to support people using the service in line with best practice guidance. The pathways included positive behaviour support and stress management.

On the older people's wards, the occupational therapy teams based their practice model on guidance provided by the Royal College of Occupational Therapy (mental wellbeing and independence in older people). All patients had a falls assessment within six hours of admission, which was supported if required by the use of a specialist falls pathway reviewed by physiotherapists.

Patients had good access to physical healthcare across all services inspected. In the community, care records contained details of physical health checks for patients and evidence of liaison with other healthcare professionals, such as their GP. Patients received a full physical assessment on admission to inpatient wards. Nurses and

health care assistants used early warning scores to determine any issues with physical health. All patient records we reviewed showed on-going physical health monitoring and referrals to specialists when needed. Care plans for specific physical health conditions were in place, for example diabetes.

The trust had a quality assurance committee which met monthly and an audit committee which met quarterly. These committees had the overarching responsibility for the provision of assurance to the board of directors on the establishment and maintenance of an effective system of integrated governance, risk management and internal control of clinical and non-clinical audit activity. The audit committee had oversight of external and internal audits with provision of assurance to the council of governors on the engagement and performance of external auditors. The trust continued to participate in national audits, including prescribing observatory for mental health audits and the national audit for schizophrenia. The trust had an annual clinical and non-clinical audit programme in place and this was reviewed at the audit committee. Staff engaged in clinical audits on the wards and in the community teams, including infection control, medication and care records. On three of the 14 wards for older people the trust had not carried out their full audit programme.

Skilled staff to deliver care

Patients in the community and on inpatient wards had access to a multi-disciplinary staff team, including occupational therapists, physiotherapists, psychologists, psychiatrists, pharmacists, nurses, dieticians and speech and language therapists.

We examined personnel files and found appraisal documentation, clinical supervision contracts, individual action plans for development, contracts of employment, employment references and identity checks present in files. We also saw annual self-declarations of any convictions or cautions from the police completed by the employee. This was in place of any on-going disclosure and barring service (DBS) checks. We raised this with the trust who confirmed they rely on appraisal, annual self-declaration and a possible approach from the police as assurance that staff have not received any cautions or convictions. The executive management team had discussed the issue of regular checks in January 2017 and they had agreed to move to the sign up system of regular checks and would be identifying funding through their workforce report to meet this need.

Staff (including bank staff) attended a trust induction at commencement of employment. Agency staff did not complete a trust induction before working on the wards. However, the ward managers that used agency staff told us that they inducted any new staff to the ward and that managers would not ask them to complete complex tasks or work one to one with complex patients. In acute wards for adults of working age and psychiatric intensive care units all bank staff underwent a trust induction checklist on the ward and a shadow shift before they were allocated shifts.

Staff across the trust were supported to undertake specialist training that would enhance the skills within the team and lead to professional development. In wards for older people with mental health problems, staff undertook training in; person centred care in dementia, dementia training, meaningful engagement training, positive approaches to care and the challenging behaviour pathway. The trust offered staff training in functional disorders such as depression, schizophrenia and personality disorders de-escalation training, self-harm and suicide awareness and delirium.

The School of Medicine at the University of Leeds works with the trust to provide 4th Year Psychiatry placement to undergraduate medical students. The school of medicine described the team as 'very well led with a clear patient-centred focus, the quality of the placement is excellent and the working relationship with the trust's Undergraduate Medical Education team very strong'. They meet regularly to review the quality of the placements. The placement is innovative in terms of medicines management and the team recently won a Clinical Teaching Excellence Certificate of Merit (2016) for their work.

At the time of our inspection the total number of permanent non-medical staff who had had an appraisal in the last 12 months was 5178 (82%) against a trust target of 95%. The trust had recently reviewed and revised its appraisal system and had reported improved quality and volume with positive feedback. In wards for older people with mental health problems managers across all wards did not record staff supervision. Staff told us that supervision was ad hoc and took place in team meetings

and in reflective practice sessions. This was not in line with trust policy. However, the amount of staff who had received an appraisal was above 80% across all wards with the exception of Worsley Court (19%) and Meadowfields (73%). In long stay/rehabilitation mental health wards for working age adults all staff had received regular supervision including clinical supervision for qualified staff.

The total number of doctors who had been revalidated was 214 (96%). The trust told us they have 14 doctors that are yet to go through the revalidation process. Six of these will go through revalidation in the next 12 months, the further eight doctors were from overseas and had not yet reached their revalidation date.

Multi-disciplinary working

At our last inspection in January 2015 we saw good evidence of multi-disciplinary working across the trust and we found this has continued. We saw that the teams worked closely together completing report out meetings daily and formulation meetings as a team. In Community mental health services for people with learning disabilities or autism, multi-disciplinary meetings were held regularly at each service either on a weekly, fortnightly or monthly basis. Meetings could also be held outside of these times if any client cases needed urgent consideration. These meetings were well attended by staff from a variety of different backgrounds and areas of expertise.

Assessment and treatment in line with Mental Health Act

Administrative support and legal advice on implementation of the Mental Health Act and its code of practice was available from a central mental health legislation office based at the Roseberry Park Hospital site. Smaller offices were based at Lanchester Road Hospital and West Park Hospital. Support for the Mental Health Act at the other areas of the trust was provided locally by a member of staff supported by the central team. These were based at Harrogate, York and Scarborough.

Detention documentation was stored in the mental health legislation office and a copy of this was kept locally in the patient record. We were told by the trust that there were plans to scan Mental Health Act documents and link them to the electronic records.

Training was provided in the Mental Health Act across the trust but his was not categorised as mandatory. However, the trust had decided that from April 2017, training would become mandatory. At the time of inspection there was a programme of training based on six half day sessions:

- Introduction to the Mental Health Act and Mental Capacity Act
- Leave, absent without leave and Missing Patients (Non-Mandatory)
- Renewal, challenges to detention, discharge and aftercare (Non-Mandatory)
- Consent, Capacity and Treatment (Non-Mandatory)
- Community Treatment Orders (Non-Mandatory)
- Mental Health Act and Mental Capacity Act Interface and The Deprivation of liberty (Non-Mandatory).

These sessions were offered at a number of locations within the trust.

Bespoke training was available if a particular team had requested something specific to their speciality or because they want to be trained as a team during a planned training day.

Targeted training was also available if there was a recurring issue within a particular team or a training need was identified for a specific team or service. The existing face to face learning is to be enhanced with E-Learning with effect from April 2017.

Mental Health Act training was not measured against compliance targets as it was not considered mandatory by the trust. The trust informed us that from April 2017 all Mental Health Act training would be mandatory and recorded and monitored against compliance. Training numbers for the period from January 2016 to February 2017 showed 105 sessions delivered with 739 attendees and 35 bespoke sessions delivered. However, attendance records were not routinely kept for bespoke sessions. On long stay/rehabilitation mental health wards for working age adults staff had a good understanding of the Mental Health Act, the code of practice and the guiding principles. In community mental health services for people with learning disabilities or autism the staff we spoke with were unable to recall how long ago they had received training in the Mental Health Act. However, they received updates from the trust by e-mail or newsletters which kept their knowledge up to date. These updates included changes to the Mental Health Act Code of Practice.

Good

Are services effective?

The trust developed an action plan to address the changes to the Mental Health Act code of practice 2015. This had been initially discussed in the trust's mental health legislation committee in January 2015 when the first draft of the revised code was published. An action plan had been developed by the trust to address, policy, procedures and clinical aspects that the changes to the code had brought about. This was monitored through the mental health legislation committee and we saw evidence of updates to the trust action plan. At the time of our inspection not all of the policies and procedures listed in annex b of the Mental Health Act code of practice had been updated, this was brought to the attention of the trust. The trust completed most of the outstanding updates to the policies and procedures during the inspection period and these were ratified by the executive management team on 1 February 2017. Some policies, controlling access to and exit from in-patient areas policy and use of mobile phones were updated and ratified on 15 February 2017. We were concerned that the mental health legislation committee responsible for monitoring the action plan around the code implementation had not realised the implementation plan had not been completed.

When we inspected in November 2016 there were some blanket restrictions in place across the acute wards and psychiatric intensive care units and wards for older people with mental health problems. A blanket restriction is a rule laid down by mental health services, which applies to everybody, or to all detained patients, regardless of their particular needs and circumstances. In the previous inspection in 2015, we reported that blanket restrictions were in place about mobile phones and internet access. At the time of this inspection, access to mobile phone and the internet was risk assessed on an individual basis.

Some wards had rooms that were only to be accessed with staff supervision and were therefore locked to patients at all other times, regardless of individual risk. These varied across each ward and hospital site. On Maple Ward at West Park, this included the assisted bathroom and the activities of daily living kitchen. The laundry room remained open on Maple Ward, however on Tunstall Ward at Lanchester Road Hospital the laundry room remained locked. This was also the case on a number of other wards across the hospital locations. Staff we spoke with were unaware of any trust review process for blanket restrictions. They were therefore not undertaking regular reviews of blanket restrictions in place on their wards. This did not comply with the MHA code of practice which says any restrictions should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures.

In long stay/rehabilitation mental health wards for working age adults we found that risks were individually assessed and the use of blanket restrictions was appropriate for the risks identified for that patient. Fulmar ward was part of the forensic governance structure and directorate whilst the other wards were part of the acute mental health directorate. Kirkdale was situated in the Ridgeway forensic part of Rosberry Park hospital; the ward had carried out significant work to reduce the amount of blanket restrictions in place.

Our Mental Health Act reviewer visit reported that significant work had been undertaken in forensic services to reduce blanket restrictions. At the time of our inspection visit the trust had developed a wider application of the principles used in the forensic service and produced a 'framework on the use of restrictive practices in in-patient units'. This proposal was taken and approved by the executive management team on 18 January 2017 and a draft policy 'Blanket restrictions: policy on the use of global restrictive practices (blanket restrictions) in in-patient units' was distributed for consultation across the trust.

Reminders were sent to responsible clinicians from the mental health legislation office to prompt action when consent to treatment authorisations needed to be reviewed. On all wards visited during the inspection, except for some older people's wards, detained patients received treatment authorised by the appropriate certificates and copies of the certificates were kept with the patient's prescription cards. Staff clearly recorded capacity and consent to treatment in all patient records. The exceptions were Meadowfields where five authorisation certificates (T3 forms) were not kept with the patient medication record cards; one at Rowan ward, one at Rowan Lea, and two at Westerdale North. This meant that on these wards nurses administering medications could not be sure that the correct legal authorisation was in place when staff gave detained patients medication for mental disorder.

The trust had a policy to guide staff in explaining the rights to patients and their relatives, 'Section 132/132A MHA – providing information to patients and patient's nearest relatives'. This gave details of how, when and what information needed to be explained. In community mental

health services for people with learning disabilities or autism, patients subject to community treatment orders under the Mental Health Act were informed of their rights regularly. They were also informed of any implication the community treatment order may place on them. In long stay/rehabilitation mental health wards for working age adults and wards for older people with mental health problems staff regularly explained to patients their rights under section 132 and recorded their understanding in patient records these were repeated when patients lacked understanding. All acute wards ensured informal patients were aware of their rights to leave. Staff would assess the presentation of patients prior to them leaving the ward for their own safety and some patients had leave intervention plans. Notices were in place at exit doors and the informal patients we spoke to were aware of their rights. The explanation of the patient's rights, the patient's reaction to this information and assessment of the patient's comprehension was recorded on a form and filed in the patient's record. The compliance with the process was monitored by the mental health legislation office.

The trust had a mental health legislation committee which provided assurance to the board of directors on compliance with the Mental Health Act and associated code of practice. The committee also ensured appropriate arrangements were in place for the appointment of associate managers and the administration of manager's hearings. We were concerned that the mental health legislation committee responsible for monitoring the action plan around the code implementation had not realised the implementation plan had not been completed.

The trust include Mental Health Act and code of practice compliance in its audit programme, these include seclusion and restrictive practices. Monitoring of compliance with the Mental Health Act is also carried out by the mental health legislation office centrally with exception reporting to the mental health legislation committee. Compliance with providing patients with an explanation of their rights, use of holding powers (section 5) and consent to treatment under the Mental Health Act are included in this monitoring and reporting.

People had access to independent mental health advocates in inpatient areas and had information relating to the service displayed in ward areas. Independent mental capacity advocacy providers we contacted gave a positive view of their relationship with the trust.

Good practice in applying the Mental Capacity Act

A rolling training programme in the Mental Capacity Act and Deprivation of liberty safeguards was available for staff. Training was not measured against compliance targets as it wasn't considered mandatory by the trust. The trust informed us that from April 2017 all Mental Capacity Act training would be mandatory and recorded and monitored against compliance. The training was delivered alongside the Mental Health Act and formed part of the overall mental health legislation training for the trust. Staff knowledge of the Mental Capacity Act was generally good across the core services with the exception of some areas in mental health services for older people.

We saw evidence of the application of the Mental Capacity Act across the core service with documented mental capacity assessments and records of best interest considerations which met with the requirements of the Mental Capacity Act and its code of practice.

In our last inspection in January 2015 we identified an issue on Ceddesfeld and Hamsterley wards where medication was covertly administered without reference to the pharmacist or through best interest decision. During this inspection we found that where patients had plans for covert medication, staff had followed all processes and had documented this correctly.

The trust had a policy for the Mental Capacity Act and the Deprivation of liberty safeguards which was available to staff and provided guidance on how to comply with the Act and its code of practice. The policies described how staff should assess capacity and determine best interests and how these should be recorded in practice.

Advice and guidance and monitoring of the Mental Capacity Act was supported by the mental health legislation office in a similar way to the Mental Health Act. The trust also employed a Mental Capacity Act lead. The mental health legislation committee provided assurance to the board of directors.

The trust had carried out an audit to provide a baseline of compliance with the Mental Capacity Act. The finding in the report dated November 2016 showed areas of good practice as 98% (46/47) of patients records it is clear who the actual decision maker is; 96% (44/46) shows that there is evidence of a completed capacity assessment and the functional test is clearly evidenced; although there was a lack of consultation with patient/carers (38%,(15/40)), there

Good

Are services effective?

was some attempt to consult patient and carers and there was some evidence of recording. The report highlights issues the trust needed to progress, the issues raised in the York and Selby CQC inspection (in November 2016) were evident across the trust; there is a lack of evidence to support that the assessment was carried out at the right time only 44% (20/45); only 11% (5/47) identified attempts to compensate for cognitive/communication/emotional disabilities or use support tools, comments suggest this was due to a lack of evidencing patient support in case notes and patient records.

There were 45 Deprivation of liberty safeguards applications made in the last 6 months. These were highest in wards Bankfields Court, an adult learning disability respite service in Middlesbrough with 17 applications. The trust kept accurate records and tracked the application and outcomes of applications to the local authority. The trust provided comprehensive and up to date guidance in relation the application of the Deprivation of liberty safeguards in clinical areas.

Good

Are services caring?

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

Summary of findings

The summary can be located on page 8.

Our findings

At the last inspection in January 2015 caring was rated as good. Since that inspection we have received no information that would cause us to re-inspect a core service or change the rating.

Kindness, Dignity, respect and support

At these inspection visits we observed positive interactions between staff and patients in both the community services and on inpatient wards. All patients and their carers provided positive feedback about the way staff treated them. On long stay rehabilitation wards, patients told us staff were caring and supportive. They were complimentary about staff attitude and engagement. In the community learning disability and autism teams, patients and carers said staff were friendly, helpful, polite, caring and professional at all times. They commented that they had never received such a thorough and helpful service before, they liked visiting the service and staff went over and above their expectations. On the long stay rehabilitation wards, we observed staff discussing patients during report out meetings. Staff understood the individual needs of patients and had a clear vision of the patient's pathway. We saw staff being discreet and respectful towards patients ensuring their confidentiality was maintained.

The involvement of people in the care they receive

At this inspection we saw involvement of patients and their families in most of the cores services.

In the community learning disability and autism services, staff encouraged patients to be actively involved in planning their care and treatment. Staff routinely offered copies of care plans to patients, their families and their care teams.

On inpatient wards, staff used intervention plans to document care and treatment. On some older people's wards and acute wards, we found these to be often standardised and generic, with little evidence of patient involvement. On long stay rehabilitation wards, most records showed that patients had been involved in care planning. Not all patients were aware of their care plan, but said they discussed their care with staff. During a multi-disciplinary team review at Primrose Lodge, we observed staff giving time and encouragement to the patient and their family member to express their views and wishes.

Patients could access advocacy services and a number of patients on the wards told us they had access to independent mental health advocates. Staff informed patients about the availability of advocates and enabled them to understand what assistance the independent mental health advocate could provide.

In the community teams, staff involved families and carers in assessment, care planning and patient review meetings. Family members we spoke with said they felt supported and if they needed to contact the service, staff responded quickly.

The trust actively sought feedback from patients and their families.

Good

Are services responsive to people's needs?

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

Summary of findings

The summary can be located on page 9

Our findings

Access and Discharge

The trust had a target of 90% of patients being seen within four weeks of external referral, the trust was only meeting this target in its forensic services. The actual percentage between April and December 2016 was;

- Children and Young People 70%
- Adults 85%
- Older Persons 88%
- Learning Disabilities 86%
- Forensic Services 99%

The trust reported that treatment commenced in all these services as part of the first appointment (initial assessment).

In 'achieving better access to mental health services by 2020' from NHS England and the Department of Health a national target of 50% in early intervention in psychosis had been set. The trust was reaching this target with 68%. The standard states that more than 50% of people experiencing a first episode of psychosis will be treated with a national institute for health and care excellence approved care package within two weeks of referral. The trust was monitoring but had not yet achieved the target in children and young people with eating disorders. The national target in these services was 95% by 2020. The trust compliance was;

- Percentage of children and young people with eating disorders (urgent cases) seen within 1 week of referral for national institute for health and care excellence approved treatment, trust compliance 14%.
- Percentage of children and young people with eating disorders (routine cases) seen within 4 weeks of referral for national institute for health and care excellence approved treatment trust compliance 41%.

The community learning disability and autism service had a target of 28 days from referral to comprehensive assessment. The majority of patients in all five teams were seen within 2 weeks and fully assessed before the 28 day target. There were waiting lists at the South Durham and Hambleton and Richmondshire to see allied health professionals. Allied health professionals included dieticians, medical technologists, occupational therapists and speech and language therapists. The other services did not have any waiting lists.

Patients and carers told us that staff within the services responded quickly and appropriately when they called for advice and support. Staff saw patients in their homes and other venues of their choice, such as GP surgeries or restaurants. Staff offered patients flexibility in their appointments time; appointments were rarely cancelled and generally ran on time.

There had been 20 out of area placements from acute wards in the six months prior to inspection, because there were no available beds on the rehabilitation wards. This was in the trust's York and Selby locality. Expected length of stay on these wards varied from nine months to three years. Fulmar ward catered for patients stepping down from forensic services or who had significant risks. Kirkdale ward was a trust wide adult mental health locked rehabilitation ward. Patients anticipated length of stay on these wards was 12 months.

Between 1 July 2016 and 31 December 2016 the trust had average bed occupancy of 88% across its services with long stay rehabilitation having the highest percentage of 93% and learning disability inpatient services having the lowest average of 76%. Four of the 82 wards had average occupancy over 100%; 11 wards averaged 100% and 56 wards had average occupancy over 85%. Research undertaken by the Royal College of Psychiatrists indicated that where wards were running at over 85% bed occupancy, this could have a negative impact on patient care.

Average bed occupancy across the specialities was as follows;

Mental Health Services for Older People 92%

Good

Are services responsive to people's needs?

Long Stay Rehabilitation 93%

Acute wards for adults of working age and psychiatric intensive care units 90%

Learning Disability Inpatient 76%

Forensic 90%

Children and Young People Services 77%

Adult Mental Health - Eating Disorders 97%.

The trust told us that bed pressures had reduced following the reopening of the acute wards in York.

In the six months prior to inspection, there had been 33 discharges and four delayed discharges, with reasons recorded as lack of community options and placements. The trust informed us that they were working with commissioners to identify reasons for delayed discharges and develop solutions, especially with the transforming care agenda in learning disability services.

The facilities promote recovery, comfort, dignity and confidentiality

Across the inpatient wards, there was a range of rooms and equipment to support the care and treatment of patients. Quiet areas or rooms were available for one to one time with staff. Each ward provided access to outside space, although on some wards these outside areas were not well maintained and could only be accessed with the support of staff. On Fulmar ward and Kirkdale ward, the outside space appeared neglected. Patients only had access to the outside area on Ward 15 at the The Friarage Hospital Mental Health Unit and Cedar Ward at the Briary unit with staff supervision, as it was away from the ward itself.

On all long stay rehabilitation wards, patients had access to facilities to make hot drinks and snacks 24 hours per day. Patients on these wards had somewhere secure to store their possessions. There was a range of daily activities for patients to engage in, including arts and crafts and a gym. Activities in the community included swimming, voluntary work and dog walking. Activities were available seven days a week; however some patients said they would like more activities to be available.

In the community services, patients were often seen at locations that best suited their needs. Information was available in a variety of different formats to meet patient's needs. Packs were available to patients and carers that gave details of their rights, what the service offered, the importance of annual health checks and how to complain or submit a compliment.

Following our inspection in November 2016 the trust decided to close one of the wards for older people with mental health problems, Worsley Court. The trust highlighted that the location of the unit was not ideal; plans were already in place to move these services back to York in February 2017. As a result of concerns raised by the CQC about staffing on the unit, they felt the best and safest option for patients was to work towards closing the unit. Worsley Court was closed at the end of December.

Meeting the needs of all people who use the service

The trust covered a large geographical area and managed the clinical services through five directorate localities. Each of these localities were led by a director of operations, a head of nursing and a deputy medical director who were responsible for the delivery of operational services locally.

In the community learning disability and autism services, accessible rooms were available which took into account the needs of people requiring disabled access, such as wheelchair access. Information packs for patients and carers were available in easy read, braille and different languages.

All long stay rehabilitation wards had facilities for disabled access including disabled toilets and bathrooms. Specific bedrooms could accommodate wheelchair users. Information and leaflets were available for patients which could be translated into a range of different languages and accessible styles to meet patient's needs. Staff could also access interpreter services for patients and their families. Access to faith rooms was available on most wards or staff would enable patients to be able to use their own bedrooms.

Most patients were working towards being able to self-cater and could budget and shop for their own food. Patients at Primrose lodge had a weekly allowance of £23 to cater for food. Those that did not cook for themselves received trust catering services. Patient's assessments identified individual dietary requirements, which the service ensured were met.

Listening to and learning from concerns and complaints

Good

Are services responsive to people's needs?

The trust has a central patient advocacy liaison and complaints team consisting of three patient advocacy liaison officers and three locality complaints managers the trust reported they receive approximately 1,400 contacts each year into the patient advocacy liaison team. There were 210 formal complaints made to the trust in the last twelve months, 72 of these were upheld and one complaint was referred to the ombudsman. Complaints are recorded on the trust's electronic incident reporting system and were scored for risk using a matrix. We found the scoring was not always recorded clearly in the paper records. We were told the chief executive sees every complaint letter and approves each report. Complaints were monitored through the patient experience group with trend analysis; they also went to service and locality quality assurance groups and to quality assurance committee where they are monitored by the board of directors. Complaints were recorded on the visual display boards in ward offices to monitor the progress of the complaint and allocate tasks.

Patients told us they knew how to complain and would talk to staff, the patient advice and liaison service or their advocate. Patients felt confident to raise any complaints. Information was available to people who used the services about how to make a complaint or raise concerns. Staff knew how to handle a complaint appropriately and received individual feedback during supervision sessions. Lessons learned from complaints were also discussed in team meetings.

The trust had a 'concerns or complaints about our services' leaflet detailing the process of complaints in the trust and who to contact should they have concerns. This included internal and external contacts and local advocacy services. The leaflet stated it could be provided in another language, large print, audio or Braille on request.

Good

Are services well-led?

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

Summary of findings

The summary can be located on page 9.

Our findings

Vision, values and strategy

Tees, Esk and Wear Valleys NHS Foundation Trust had a mission, a vision and a set of five values. The mission is to improve people's lives by minimising the impact of mental ill health or a learning disability. The vision is to be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. This is to be achieved through five values which were a commitment to quality, respect, involvement, wellbeing and teamwork.

The Trust has five strategic goals:

- To provide excellent services, working with individual users of our services and their families to promote recovery and wellbeing.
- To continuously improve the quality and value of our work.
- To recruit, develop and retain a skilled, compassionate and motivated workforce.
- To have effective partnerships with local, national and international organisations for the benefit of the communities we serve.
- To be recognised as an excellent and well-governed foundation trust that makes best use of its resources for the benefit of the communities we serve.

To achieve their vision, the trust believed that services must aim to provide a perfect patient experience each and every time. They believed services must be appropriate, effective, safe, reduce waste and build upon standards set by the CQC, other regulators and their commissioners.

The trust refreshed their Quality Strategy in 2016 and identified three quality goals to be achieved by 2020:-

- Patients, carers and staff will feel listened to and heard, engaged and empowered and treated with kindness, respect and dignity.
- We will enhance safety and minimise harm.
- We will support people to achieve personal recovery as reported by patients, carers and clinicians.

The quality assurance committee monitored progress against these quality goals through the use of strategic measures and provided assurance on this to the trust board. The locality management and governance boards and the directorate quality assurance groups fed into this monitoring process through the trust's quality improvement system. The trust aimed to ensure that quality was monitored from ward to board.

Commissioners of the trust services said it was a very good provider and they had effective relationships with stakeholders. They described the trust as outward facing with a good strategic overview but also said they needed to work on closing action plans from serious incident investigations sooner and increasing dialogue with clinical commissioning groups.

In long stay/rehabilitation mental health wards for working age adults and community mental health services for people with learning disabilities or autism staff displayed a good understanding of the vision and values and we observed these in the behaviours of staff during our visit. Each ward had an operational policy. The Orchards and Lustrum Vale policies reflected the values of the organisation. Staff knew who the senior managers in the organisation were and we heard they had visited the ward.

In community mental health services for people with learning disabilities or autism the values were displayed on noticeboards throughout each service site. Team objectives were based around these values. Staff knew who the senior managers were within the trust. Senior staff had visited some of the teams. For example, the medical director had visited the Hambleton and Richmondshire service and service leads had visited the South Durham service

During our inspection of inpatient mental health services for older people, we found staff had not displayed the

vision and values of the trust on the wards and the staff had limited awareness of them. Staff told us that they were on the trust intranet and on all computers but could not remember them. Staff were unable to tell us what objectives individual wards worked towards but thought that ward managers mentioned them in their appraisal meetings.

However, we saw staff were respectful, compassionate and treated patients with kindness. We saw evidence that teams worked closely together to provide the best outcomes for patients, often in difficult situations with regard to staffing levels and the environments in which they worked. When we reminded staff of the values, staff told us that they felt they embedded the values into their work and that they came naturally to them.

Good governance

The trust covered a large geographical area and managed the clinical services through five directorate localities; Tees; York and Selby; County Durham and Darlington; North Yorkshire and Forensic localities. Each of the directorates was led by a director of operations, a head of nursing and a deputy medical director. These were managed by the chief operating officer who held overall accountability and responsibility for the delivery of operational services through the localities. The chief operating officer also managed the director of operations estates and facilities management; head of psychology; senior clinical directors and chief pharmacist and provided leadership and assurance for services improvement.

The clinical directorates provided leadership, management and delivery of clinical services with their localities. The clinical directors in each locality are aligned to each quality assurance group and speciality development group.

The trust had a Kaizen promotion office and clinical pathways team who worked to the chief operating officer. Kaizen is a shortened version of a rapid process improvement workshop (RPIW) and is used to make improvements in existing services. This team was established in 2007 and reflected the experience of Virginia Mason hospital Seattle which developed the Virginia Mason Production System, a lean management methodology. The team provided support including training, coaching and direct facilitation of improvement activity as well as the hosting of a number of programmes and projects. We saw evidence of the positive contribution this had made to practice in the core services. For example, acute wards and psychiatric intensive care units followed the principles of the 'Virginia Mason Production System' and part of this included a meeting on each ward called a 'report out'. This was attended by staff in the morning on a daily basis where each patient was discussed using a visual control board looking at current care and risk factors and tasks were set for staff for the day. We attended five 'report out' meetings and found these to be an effective system for ensuring care was patient focussed, therapeutic and informed by risk.

The trust had an equality and diversity lead and the trust's policies included appropriate consideration of disability and equality and diversity issues. We held two focus groups for black and minority ethnic staff and received positive feedback about the trust. Staff stated the trust worked hard to support black and minority ethnic staff at all levels.

The NHS Equality and Diversity Council implemented two measures to improve equality across the NHS into the Standard Contract, which commenced in April 2015: the Workforce Race Equality Standard and Equality Delivery System 2. The main purpose of the Equality Delivery System 2 is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the Equality Delivery System 2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

The Workforce Race Equality Standard requires NHS organisations to produce a detailed action plan, agreed by its board. The plan should identify the next steps to be taken and expected progress against the nine indicators. It should also identify links with other work streams agreed at board level, such as the Equality Delivery System 2. The trust confirmed the report was presented to the board; however this was after its publication.

The trust had published their Workforce Race Equality Standards report; however, this lacked a detailed action plan as required. The trust confirmed the action plan was still a work in progress at the time of inspection and therefore had not been published. The report identified that four of the nine indicators were unconscious bias related and would be addressed with training. A further three of the indicators were to be addressed with the use of external staff surveys and one was to be addressed by way

of focus groups with black and minority ethnic staff. There was no plan identified to address indicator nine, which referred to the under-representation of black and minority ethnic people on the board.

Following the inspection, on 2 February 2017, the trust submitted a workforce report to the quality assurance committee, outlining additional actions for each of the indicators. These included the development of a black and minority ethnic staff leadership and development programme and a rolling annual review of recruitment decisions and disciplinary hearings involving black and minority ethnic staff. The trust also planned to deliver equality and diversity presentations to the senior medical staff committee meetings in March 2017 and June 2017, as part of efforts to increase awareness and receive feedback about staff experiences and potential future actions. A presentation from the British Institute of Human Rights about board responsibilities and the Human Rights Act was also planned to be delivered at the next board of directors seminar in March 2017.

The trust published its Equality Delivery System 2 report in September 2016 and it showed an overall rating of excelling. This report requires organisations to consult with their communities and collect data which demonstrates that it meets the needs of all of its community protected characteristics, in order to rate themselves as excelling. This report had been based upon self-assessment, not on external feedback and had not been approved by the board as required. The trust had sought external feedback at the time of compiling the report, but none had been received. Following the inspection, the trust decided to remove the report from their website and replace it with the previous Equality Delivery System 2 report, which had included external feedback. The trust planned to make further efforts to seek external feedback and re-publish their more recent report.

The trust has not published its Public Sector Equality Duty report for 2015-2016. Their previous report 2014-2015 stated that the data completeness available to the trust to measure its public sector equality duty had remained static or slightly deteriorated. The trust acknowledged further work was required to achieve higher levels of data completeness and plans to publish its Public Sector Equality Duty report for 2015-2016 in May 2017, following approval by the board of directors.

During our inspection we looked at policies and procedures in relation to the revised Mental Health Act code of practice 2015 and specifically annex b. We found that the trust had developed a comprehensive action plan in relation to the implementation of the revised code in January 2015 when the draft code was first published. We found that most policies and procedures had been updated but some had not. The trust reviewed these remaining policies and procedures to ensure they complied with the code during the inspection. We were provided with evidence to say these had been updated during the two weeks following the inspection visit and these were ratified by executive management team with the exception of two policies. The remaining two were updated and ratified by 16 February 2017. We saw evidence of compliance with the Mental Health Act in the core services and the staff knowledge of the Act was generally good, some of the practice described in the revised code was being implemented in core services despite the policies being in draft, for example community treatment order policy. We were concerned that the mental health legislation committee responsible for monitoring the action plan around the code implementation had not realised the implementation plan had not been completed.

The trust developed an action plan when it took over responsibility for services in York and Selby in October 2015. The action plan was designed to address the issues which had been identified by the CQC during the inspection of the previous provider. Although the trust had made some progress they had not addressed the issues identified in the action plan in wards for older people with mental health problems when we inspected in November 2016. We expected the trust to have completed or made significant progress in the areas of training for staff, medicines management, risk management and patient involvement in care planning as these areas related to patient safety.

Leadership and culture

We attended both the public and private board meeting that took place during our inspection period. The public part of the board was also attended by student nurses who were required to produce a report on their experience as part of their learning. Both the public and private parts of

the board were well attended and with good input from members who were well informed and had relevant, succinct and respectful contributions. The meetings were conducted efficiently and largely without challenge.

The trust was undergoing a 'staff engagement pilot' with an aim of increasing the engagement of staff working in the trust. This involved the staff engagement team leading an away day with four randomly selected teams from around the trust to create a vision of their service in a year's time. Using the staff engagement survey questions they introduced 'engagement agents', a small group led by the manager and other team members without leadership responsibilities, and use the information to develop an action plan. This was taken back to the team for verification of content. The trust planned to evaluate the pilot and if successful planned to hold a 'pass it on' event where teams involved will share their journey with other teams in the trust who might like to take part in this process.

The trust wide turnover rates had slightly risen to 11% from our last inspection in January 2015 when they were 10%. Staff sickness rates had slightly decreased to 4% in our January inspection from 5% reported in our inspection in January 2015.

The trust provided a residential retreat facility for all staff. These were 48-hour events, led by the trust's staff engagement lead. Participants thought about the purpose of their lives and how to make the most of every minute. They also learned basic meditation techniques and had the opportunity for a one to one session. The majority of attendees described the event as worthwhile. The trust's website indicated that 89% of staff who had attended retreats reported positive changes to their lives.

The trust had made arrangements for all staff to access the trust's mindfulness programme. Mindfulness-based cognitive therapy has been shown to significantly reduce relapse rates in individuals with recurrent depression, has benefits in relation to wellbeing, stress and resilience and is recommended by the National Institute for Health and Care Excellence for this purpose.

In the core services we inspected staff morale was generally high and staff felt valued and positive about their jobs. Staff were aware of how to raise concerns and most told us that they would do this through their line manager or service manager. Staff told us they were actively encouraged to provide feedback and input into service development. They also told us that they felt they could raise any issues or concerns with senior colleagues without fear of victimisation.

The trust provided overall results for its most recent staff survey. All of the questions highlighted below had seen an improvement in the last year and all scores were above the national average for mental health trusts in England.

- Care of patients / service users is my organisation's top priority (81%).
- My organisation acts on concerns raised by patients / service users (87%).
- I would recommend my organisation as a place to work (69%).
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (75%).
- Staff recommendation of the organisation as a place to work or receive treatment (3.9).

Tees, Esk and Wear Valleys NHS Foundation Trust used the staff survey to measure staff engagement. The trust's score was 3.9 out of five, which is above the average for similar trusts. This was also an increase on the previous year's score of 3.8. Staff told us that they felt engaged in changes within the trust and that the trust kept them updated on practice and research issues. Staff said that they were encouraged to give input and ideas in team meetings and at 'report out' meetings.

Staff did not report feeling bullied or suffering harassment and told us that they would feel comfortable raising complaints, concerns and whistleblowing if they needed to ensure the safety of patients. Staff could describe whistleblowing procedures and told us that they felt comfortable contacting senior managers if required. However, the staff survey reported that the percentage of staff / colleagues reporting their most recent experience of harassment, bullying or abuse had reduced from 49% last year to 17% in the most recent staff survey.

The Sir Robert Francis QC review of whistleblowing in the NHS 'Freedom to Speak Up:

An independent review into creating an open and honest reporting culture in the NHS' 2015 recommends that each trust appoint a freedom to speak up guardian responsible

Good

Are services well-led?

for supporting staff to raise concerns. The trust had appointed a freedom to speak up guardian in October 2016 working one day a week. The guardian was linked into the national and local network. We were told the role will be developed in the trust, promoted through the intranet, use of posters on wards and staff engagement sessions. There were also plans to develop a network of staff who will be better informed in raising concerns across the trust. The guardian was able to describe a number of instances where the role had already been able to make a positive difference for staff. The role is supported by senior management and will be evaluated in April 2017.

When we inspected the trust in January 2015 we saw the trust had developed a 'Staff Compact'. The staff compact was 'the gives and gets' between the trust and its staff and is displayed on one sheet of paper outlining the trust and the staffs commitment. For example the trust ' will recognise staff who have achieved excellence and show commitment to value adding work; in return the staff are expected to respond to the changing needs of patients and people who use services. During the inspection in January 2017 we saw that the trust continues to support the 'psychological or cultural relationship that exists between staff and the trust' using the 'compact'.

Fit and Proper Person Requirement

From 27 November 2014, the fit and proper person's requirement has applied to all NHS trusts, NHS foundation trusts and special health authorities. This regulation applies to individuals who have authority in organisations that deliver care and are responsible for the overall quality and safety of that care, including board directors or equivalents. This purpose of this regulation is to ensure that those individuals are fit and proper to carry out this important role. Directors, or equivalent, must be of good character, have the necessary competence, skills and experience and be physically and mentally fit enough to fulfil the role. They must also be able to supply information including a Disclosure and Barring Service check and a full employment history.

Tees, Esk and Wear Valleys NHS Foundation Trust had a fit and proper person's policy in place that was available to staff. The policy included a definition of what would make someone unfit and set out the requirements for demonstrating directors were fit and proper. The policy was last amended in January 2016 and due to be reviewed in September 2017.

We inspected the files of two non-executive directors and one executive director, all of whom had been appointed since the previous inspection in January 2015. All other files had been checked during the previous inspection and found to be satisfactory. The majority of the required information was present in all three files as outlined in the trust policy, including insolvency checks, references and evidence of competency based interviews. However, in one file the occupational health clearance was missing and in another the induction and mandatory training information was not present. This was raised with the trust at the time of inspection and addressed.

Engaging with the public and with people who use services

At our previous inspection in January 2015 we saw that the trust engaged with patients and carers very well and the feedback from these was positive. This has continued we received feedback from people who use the services and their carers to say that the trust made a great effort to listen to their views and take action to improve services.

Quality improvement, innovation and sustainability

The trust were committed to quality improvement and staff told us of a variety of programmes, groups and networks which ran across all wards to consider methods of quality improvement. The trust had an on-going plan that they regularly reviewed which included large projects such as the renovation of wards and relocation of some services to enhance oversight and patient outcomes.

The trust had a quality improvement work plan which included areas of innovation and change for older people with mental health problems. They held 'Kaizen' events which were short duration projects with a specific aim for improvement. For example; these had led to 'report out', recovery based services and enhanced clinical strategy. We spoke with staff that were aware of and had attended these events.

In long stay/rehabilitation wards for working age adults the service had used improvement methodologies for several years to improve services, for example, Willow ward had had a rapid improvement workshop which examined the ward layout and had resulted in improvements. A recent project to redesign some rehabilitation and recovery services was currently taking place.

Good

Are services well-led?

Fulmer ward was working on introducing 'safe wards'. This was a model of care which aimed to reduce levels of potentially harmful events on inpatient wards, for example; restraint, aggression and self-harm. Three ward managers had been trained in the boundary see saw model which works on relational boundaries.

Willow ward and Primrose Lodge had achieved the Royal College of Psychiatrists' accreditation for inpatient mental health rehabilitation services.

In community services for people with learning disability or autism the South Teesside service worked with GPs and the local community to highlight issues around learning disabilities. It also ran an autism group, which had received positive feedback from carers. The service had also created an annual health check template for its patients, ran training sessions within GP practices and had hosted events attended by GPs, advocacy services, therapists and local authorities.

The Hambleton and Richmondshire service provided training to external care providers to give them a greater understanding of the needs and issues relating to people with learning disabilities.

The Darlington service had offered a considerable amount of training around dysphagia to external care providers within the locality.

In wards for older people with mental health problems ward managers also told us that they were working on introducing 'safe wards'. This was a model of care which aimed to reduce levels of potentially harmful events on inpatient wards, for example; restraint, aggression and self-harm. Rowan Lea ward had achieved inpatient accreditation from the Royal College of Psychiatrists, and other wards were working towards this. Ward staff told us that they used the 'triangle of care' approach to provide a therapeutic engagement between carers and staff. Partnership working in this way can improve outcomes for patients and their families.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met** **Wards for older people with mental health problems** Staff did not create care plans which evidenced that care was collaborative and they did not include patient choices and preferences, at Rowan (Briary Unit), Rowan Lea, Westerdale North and South, Friarage ward 14 and Hamsterley we found that 32 records did not contain person centred care plans. **This was a breach of regulation 9 (1) (c) and (3) (a) (b).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met** Rowan and Wingfield wards did not comply with Department of Health guidance on mixed sex accommodation. Male patients were allowed to use the female only lounge on Rowan ward; the room designated for use as a female only lounge was not being used as a female lounge on Wingfield ward. **Wards for older people with mental health problems.** The trust did not ensure that patient privacy and dignity was upheld for all patients because there was still clear glass in the viewing panels in the bedroom doors at

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Requirement notices

Cherry Tree House. The trust advised in its last action plan that this would be rectified by replacing these doors and adding privacy film in the interim, but this was not in place during our visit.

At Worsley Court, lack of patient observation by staff led to patient dignity being compromised because patient needs could not be quickly responded to.

This is a breach of regulation 10 (1), (2) (a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** **Wards for older people with mental health problems** The provider must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation on Rowan Ward in line with trust policy. The provider must ensure that staff are trained in rapid tranquilisation. **This is a breach of Regulation 12 (1).** **Wards for adults of working age and psychiatric intensive care units** The provider must ensure that each ward has a suicide prevention environmental survey reviewed annually in line with their policy. Staff must be aware of ligature risks and blind spots on the wards and be able to identify how they mitigate for these.

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This is a breach of Regulation 12 (2) (d).

The provider must ensure that all staff are up to date with their mandatory training in immediate life support as a minimum standard for staff that deliver or are involved in rapid tranquilisation, physical restraint, and seclusion.

This is a breach of Regulation 12 (2) (c).

The provider must ensure that staff monitor and record physical observations following the administration of rapid tranquilisation in line with trust policy. The provider must ensure that staff are trained in rapid tranquilisation.

This is a breach of Regulation 12 (1).

Long stay/rehabilitation mental health wards for working age adults

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

There was no nurse call system or alarm system in place on the unit. This meant patients had no means of summoning staff help or support in an emergency.

This was a breach of regulation 12 (1) and (2) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met**

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Requirement notices

Wards for older people with mental health problems

The trust did not have effective systems or processes to ensure that all staff complied with the medicines management policies and procedures. Medicines management was a concern at the previous inspection of Ceddesfeld, Worsley Court and Meadowfields. Since the last inspection practice is now also a concern at Westerdale North and South and Ceddesfeld wards. On these wards, staff had not correctly documented medication administration and this placed patients at risk. The trust did not monitor and improve the quality and safety of the services adequately. Ward managers had not ensured that checks of medication charts, emergency equipment and safety took place on a regular basis. Three of the fourteen wards had not been included in the trust's full 2015-2016 audit programme because they were new to this provider. This meant that the trust had reduced ability to have oversight of the quality of service provided by these wards.

The trust did not adequately assess, monitor, and mitigate the risks relating to patients health, safety, and welfare. Staff did not consistently complete and update risk assessments at Springwood, Friarage ward 14, Meadowfields, Cherry Tree House, Worsley Court, Rowan

Ward and Rowan Lea. 37 patients did not have a specific plan relating to how they needed support in a crisis in place at Rowan Lea, Meadowfields, Oak, Westerdale North and South, Springwood, Friarage and Ceddesfeld.

The suicide prevention environmental survey and risk assessment was out of date at Meadowfields and Wingfield.

This was a breach of regulation 17(1)(2)(a)(b)(c).

Wards for adults of working age and psychiatric intensive care units

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The provider must ensure that there is an effective system in place to record and monitor when patients are being secluded in rooms other than a seclusion room, in line with their policy. Staff must record this as seclusion and ensure patients are afforded the procedural safeguards of the Mental Health Act Code of Practice in these instances. The provider should ensure that the recording of any episodes of seclusion is in line with trust policy and complies with the Mental Health Act Code of Practice.

This is a breach of Regulation 17 (2) (c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **Wards for older people with mental health problems** The trust were not ensuring that all staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The trust did not record staff supervision in line with the trust policy and not all staff had an annual appraisal. The trust did not ensure that staff had received mandatory training. Mandatory training compliance was below 75% in several areas and the trust had not ensured that training directly linked to safe patient care (such as resuscitation, medicines management, moving and handling, management of aggression and violence, risk assessment and rapid tranquilisation) training was accessible to all staff. The trust were not ensuring sufficient numbers of suitably qualified, competent and skilled and experienced persons were deployed. They had not ensured at Worsley Court that staff were suitably

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Requirement notices

deployed to ensure patient safety by observation. Patients were at risk of falls, and choking, and staff were not observing them closely enough to mitigate these risks.

Staff were not correctly deployed at Worsley Court to monitor hydration and nutrition of patients at mealtimes and patients who needed support to eat were not always supported.

This was a breach of regulation 18 (1) (2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met**: We found that the trust did not routinely send a notification in writing to the person or their representative; or keep a written record of attempts to contact or speak to the relevant person, when exercising their responsibilities under the duty of candour. **This is a breach of Regulation 20 (4) (a) (b) (c) (d); (5) (b).**