Good

Tees,Esk & Wear Valley NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RX301	EIP North Yorkshire	YO12 7SN
Trust Headquarters	RX301	Scarborough CMHT	YO12 7SN
Trust Headquarters	RX301	CMHT H&R East	DL6 2NA
Trust Headquarters	RX301	CMHT H&R West	DL94GA
Trust Headquarters	RX301	Affective Disorders Service - Stockton	TS18 3TX

Summary of findings

Trust Headquarters	RX301	South Durham and Darlington Early Intervention Service	DL14 6SA
Trust Headquarters	RX301	Psychosis Service - Hartlepool	TS24 7DP
Trust Headquarters	RX301	North Durham Psychosis	DH3 3UR
Trust Headquarters	RX301	North Tees Liaison Psychiatry	TS19 8PE
Trust Headquarters	RX301	Affective Disorders service - Easington	SR8 3DY

This report describes our judgement of the quality of care provided within this core service by Tees Esk and Wear Valleys NHS Foundation trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Tees Esk and Wear Valleys NHS Foundation trust and these are brought together to inform our overall judgement of Tees Esk and Wear Valleys NHS Foundation trust.

Summary of findings

Ratings

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

Overall rating for Community-based mental health services for adults of working age.	Good
Are community-based mental health services for adults of working age safe?	Good
Are community-based mental health services for adults of working age effective?	Good
Are community-based mental health services for adults of working age caring?	Good
Are community-based mental health services for adults of working age> responsive?	Good
Are community-based mental health services for adults of working age> 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.

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as good because;

- Risks to patients using the service were assessed, monitored and managed on a daily basis and staff recognised and responded appropriately to changes in risks to patients.
- Staff understood their responsibilities to report on incidents and near misses and were supported when they do so.
- Adults and children were appropriately protected and staff took steps to report any incidents of safeguarding to the local authorities.
- Some teams had reported staffing vacancies; However, systems were in place to review staffing vacancies and community teams had implemented systems to keep patients safe.
- Staff received feedback from investigations and incidents. Actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.
- Patients receiving a service had comprehensive assessments of their needs which included consideration of their clinical needs, mental health, physical health and their well-being.
- Information about patients care and treatment and their outcomes were collected and monitored.
- The teams participated in local and national audits although front line staff were not always involved.
- Staff were qualified and skilled to deliver care and treatment to their patients but there were some gaps in their mandatory training.
- Patient care and treatment was planned and delivered in line with current best practice and evidenced based guidance.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005.
- Where patients were subject to the MHA community treatment orders (CTOs), some teams had effective procedures in place to ensure patients' rights were protected. However, the trust had identified in some community teams where improvements were needed.
- Feedback from patients who used the services was positive about the way staff treated them. Patients reported they were treated with respect, kindness and were involved in making decisions about their care and treatment
- Patients' social needs were understood and patients were assisted to maintain and develop their social networks and community support where needed.
- The trust had a clear vision and a set of values and staff were aware of these.
- The trust had a quality strategy, processes and systems were in place around governance.
- The teams had processes in place to manage team performance and the quality of care and treatment provided.
- Information about patient and carer experience was reported back to teams from information collated in relation to the friends and family test.
- There was an effective process in place to identify, monitor and address risk issues.
- The staff were open and transparent and were aware of their 'duty of candour' in relation to the NHS organisation they worked in.
- There was a strong focus on continued learning and improvements for staff within the teams they worked in.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Risks to patients using the service were assessed, monitored and managed on a daily basis.
- Staff recognised and responded appropriately to changes in risks to patients who use services.
- Staff understood their responsibilities to report on incidents and near misses and were supported when they did so.
- Most of the team bases where patients were seen were safe.
- Adults and children were appropriately protected and staff took steps to report any incidents of safeguarding to the local authorities.
- Some teams had reported staffing vacancies; However, systems were in place to review staffing vacancies and community teams had implemented systems to keep patients safe.
- There were effective handovers and meetings within teams to manage risks to patients who used their services.
- Staff received feedback from investigations and incidents. Actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.

However,

- The South Durham and Darlington EIP team and the affective disorder team Easington had not fully ensured their premises were safe for staff and patients who visited the buildings.

Are services effective?

Good

We rated effective as good because:

- Patient receiving a service had comprehensive assessments of their needs which included consideration of their clinical, mental health, physical health and their well-being.
- Information about patients' care and treatment and their outcomes were collected and monitored.
- The teams participated in local and national audits although front line staff was not always involved.
- Staff were qualified and skilled to deliver care and treatment to their patients.
- Patient care and treatment was planned and delivered in line with current best practice and evidenced based guidance.
- Staff were supported to deliver effective care and treatment and received good support from their managers and peers.
- When patients moved between services the necessary teams involved were kept up to date.

Summary of findings

- Consent and care and treatment were obtained in line with legislation and guidance including the Mental Capacity Act 2005.
- Staff could access the information they needed to assess, plan and deliver care in a timely way.
- Where patients were subject to the MHA community treatment orders (CTOs) there was some good practice in place to ensure patients' rights were protected.

However,

- The trust had identified in some of the community teams where improvements were needed in relation to monitoring patients who were subject to CTOs.
- We found there were gaps in some of the mandatory training requirements for staff.
- South Durham and Darlington EIP service did not have adequate security to their offices where records were stored However records were kept in a locked filing cabinet.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients who used the services was positive about the way staff treated them.
- Patients reported they were treated with respect and, kindness by staff.
- Patients reported they were involved and encouraged in making decisions about their recovery pathways.
- Patients' privacy and confidentiality were respected.
- Patients' social needs were understood and patients were assisted to maintain and develop their social networks and community support where needed.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population.
- Care and treatment was coordinated with other services and providers.
- Services were responsive to any identified and increased risks to patients.
- Most of the facilities and premises were appropriate for the services being delivered and where patients visited.
- Patients could access the right care at the right time and access to care is managed taking account of their needs and risks.

Summary of findings

- Waiting times were monitored by local teams and the trust and patients were kept informed of any delays or cancellations.
- Complaints and concerns were monitored by the teams and the trust and information was readily available to inform patients of how they would make a complaint.
- Community teams in rural areas were flexible and responsive to patient need often arranging appointments in an area close to their homes.

Are services well-led?

Good

We rated well-led as good because:

- The trust had a clear vision and set of values,staff were aware of these.
- Structures, processes and systems were in place around governance and these fed upward from team to the trust board and were fed back down to teams.
- The teams had processes in place to manage team performance and the quality of care and treatment provided.
- Information about patient and carer experience was reported back to teams from information collated in relation to the friends and family test.
- There was an effective process in place to identify, monitor and address risk issues.
- The leadership at the trust had been visible and engaging at most of the teams we visited.
- The staff were open and transparent and were aware of their 'Duty of Candour' in relation to the NHS organisation they worked in.
- There was a strong focus on continued learning and improvements for staff within the teams they worked in.

Summary of findings

Background to the service

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and eating disorders services for the 1.6 million people living in County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire (H&R).

The trust has four operational directorates, one for each of their localities (County Durham and Darlington, Teesside, North Yorkshire)

Following their success in winning a tender to provide mental health and learning disability services in Harrogate, Hambleton and Richmondshire, these services transferred to TEWV in June 2011.

The trust provides a wide range of community based assessment and treatment services including primary care, liaison, crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders. The trust also provides community mental health and deafness services and adult attention deficit hyperactivity disorder (ADHD) across Teesside, County Durham and Darlington.

The trust works with their partner agencies in improving access to psychological therapy (IAPT) services in Durham, Darlington and Teesside.

We inspected 10 out of 30 community based teams at this trust.

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive for South West London and St Georges Trust.

Team Leader: Jenny Wilkes, head of hospital inspection (mental health), Care Quality Commission**.**

Inspection lead: Patti Bowden inspection manager, Care Quality Commission.

The team included a CQC inspector and a variety of specialists: The inspection took place over a two week period from 19 January 2015 – 30 January 2015

Week one of the inspections we inspected four community adult teams in North Yorkshire and had a CQC inspector and a consultant psychiatrist on the inspection team.

Week two had a CQC inspector, a consultant psychiatrist, an assistant director of nursing for clinical governance and safety, two nurses and and an occupational therapist. We inspected six teams and divided the above specialists into a team of three inspecting each service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 20, 21,27,28,29 January 2015.

Summary of findings

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with patients who use services. We observed how patients were being cared for and talked with carers and/or family members and reviewed care and treatment records of patients who use services. We met with patients who use services and carers, who shared their views and experiences of the core service. We looked at a range of policies, procedures and other documents relating to the services we inspected.

During our visits we:

- Visited 10 out of 30 community adult mental health teams in the TEWV trust area and looked at the quality of the services and environment where patients visited. These included community mental health teams (CMHTs) and assertive outreach, affective disorder teams, psychiatric liaison team, psychosis teams including early intervention in psychosis teams.
- Spoke with 18 patients who used the services.
- Spoke with one carer.
- Visited two patients in their own homes.
- Spoke with 33 members of staff from a range of disciplines including consultant psychiatrists, psychologists, nurses specialists, primary health care workers, and social workers,
- Interviewed the ten team managers with responsibility for these services.
- Attended and observed multi-disciplinary meetings, clinical supervision/support meetings peer supervision, leadership and management meetings, daily team meetings and recovery meetings as well as listening in to telephone conferencing with the ward staff and crisis teams and observed team allocation meetings.
- Attended a psychological therapy group and observed patient contacts in A&E as well as attending a clozapine clinic.
- Looked at 26 care records of patients.

What people who use the provider's services say

We spoke with 18 patients. All patients we spoke with were positive about their experience of care and treatment in the community mental health adult teams we visited.

- They told us that they found staff to be very caring and supportive, and patients were involved in decisions about their care.
- They told us they were positive about the way staff treated them and were treated with respect and, kindness by staff.
- Patients reported they were involved and encouraged in making decisions about their own recovery and their privacy and confidentiality were respected.
- Patients' reported that staff understood their social needs and assisted them to maintain and develop their social networks and community support where needed.

At the end of the inspection we collected comment cards from the community teams. These gave mixed feedback stating staff are very caring and flexible, CMHT (community mental health teams) did not engage with patient or parents; they had neither a care plan nor a follow up plan.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should ensure the premises at South Durham & Darlington early intervention psychosis team and the

affective disorder team Easington are safe and secure for patients and staff. These include; securing access to staff areas where records are maintained and implementation of their policies and procedures to ensure staff and visitors are safe when visiting the premises.

Tees,Esk & Wear Valley NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
EIP NY	Trust Headquarters
Scarborough CMHT	Trust Headquarters
CMHT H&R East	Trust Headquarters
CMHT H&R West	Trust Headquarters
Affective Disorders Service - Stockton	Trust Headquarters
South Durham & Darlington Early Intervention Service	Trust Headquarters
Psychosis Service - Hartlepool	Trust Headquarters
North Durham Psychosis Service	Trust Headquarters
North Tees Liaison Psychiatry	Trust Headquarters
Affective Disorders service - Easington	Trust Headquarters

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.

Teams had access to Mental Health Act (MHA) training but this was not mandatory. Some managers at the teams we visited told us care coordinators were expected to attend.

Detailed findings

We observed a team meeting at Hartlepool psychosis service and saw training dates were provided to staff to make them aware of MHA training as well as Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Tees psychiatric liaison team had arranged bespoke training for staff about the MHA, MCA and DoLS.

Scarborough community mental health team (CMHT) had completed their own audit of patients who were subject to community treatment orders (CTOs). The manager found from the audit that improvements were needed. Records in South Durham & Darlington early intervention psychosis service indicated there were processes in place for monitoring CTOs. However, there was no evidence of patients' rights being repeated. Other teams we visited had good systems in place to monitor patients subject to CTOs, for example the CMHT H&R East. Records reviewed informed us that patients had their rights explained to them routinely and these had been documented by the patient and the care coordinator.

We also found examples of risk assessments and care plans in relation to patients subject to CTOs. These were important as a breach of the patients' conditions as stipulated within their CTO, could mean that patients could be recalled back to hospital. It is therefore important that staff that provided care and treatment to patients who are subject to a CTO are aware of their conditions stipulated in the order when providing care and treatment. We found patient records were stored appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had not received training in the MCA and DoLS as this was not part of the trusts mandatory training requirements.

Staff were able to articulate the principles of the MCA and discussed how they assumed capacity of their patients unless this was identified during their care and treatment. Staff were aware of where to go for support and advice about the MCA and DoLS within the trust. The trust had a policy in place and this was accessible via their intranet.

In the patient records we reviewed we looked at capacity and found capacity was considered during the assessment process and had been recorded.

The affective disorder service Easington showed good examples of using the MCA, where concerns over patient financial vulnerabilities had been assessed appropriately. Tees psychiatric liaison team had devised an amended capacity assessment for patients attending A&E where patients may present intoxicated.

Good

Are services safe?

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

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

Summary of findings

We rated safe as good because:

- Risks to patients using the service were assessed, monitored and managed on a daily basis.
- Staff recognised and responded appropriately to changes in risks to patients who use services.
- Staff understand their responsibilities to report on incidents and near misses and are supported when they do so.
- Most of the team bases where patients were seen were safe.
- Adults and children were appropriately protected and staff took steps to report any incidents of safeguarding to the local authorities.
- Some teams had reported staffing vacancies. However, systems were in place to review staffing vacancies and community teams had implemented systems to keep patients safe.
- There were effective handovers and meetings within teams to manage risks to patients who used their services.
- Staff received feedback from investigations and incidents. Actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.

However,

- The South Durham & Darlington EIP team and the affective disorder team Easington had not fully ensured their premises were safe for staff and patients who visited their bases.

Our findings

Safe environment

Patients were seen by staff in eight of the ten community bases we visited. Interview rooms were available and personal alarms were also accessible when seeing patients at most of the teams visited. Responders had been identified either by a buddy system or where the whole team responded. Generally local policies and environmental risk assessments were in place to inform staff about the use of consulting rooms.

Staff told us they would also see patients within their own homes or an alternative community setting. However, South Durham & Darlington EIP team and the affective disorder service at Easington had not implemented their local policy and the use of alarms when patients visited their base. Environmental risk assessments had not been reviewed at South Durham & Darlington early intervention psychosis team. We found no alarms were fitted in the visiting rooms although alarms had been identified in their environmental risk assessment.

We checked the clinic rooms at the team bases we visited and all were well equipped and had the necessary equipment needed to see patients within community teams.

Safe staffing

We looked at the staffing levels at each team we visited to ensure they met the needs of the patients. We reviewed the staffing levels and saw that these were in line with the teams' staffing establishment.

Of the ten teams we inspected most had the number and grade of staff required. Scarborough community mental health team (CMHT) and CMHT H&R East had the most reported vacant posts which were in the process of being recruited into. South Durham and Darlington early intervention psychosis service had some vacant posts had been identified were as a result of long term sickness, staff leaving the trust and staff being seconded into other positions.

Locality review meetings were held monthly for the working age adult teams. These meetings showed that the trust had reviewed and discussed vacant staffing issues within the teams. Minutes reviewed from the CMHT H&R East from 23 October 2014 highlighted the concerns raised by staff about the current staffing and this had been escalated to the locality managers.

The trust had carried out a review of the service provided by Scarborough CMHT due to identified performance

Good

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shortcomings. This was addressed in the trust's schedule of risk actions and mitigation plan. This resulted in an implementation action plan being produced to improve the service of which the trust signed off in November 2014.

Records reviewed for Scarborough CMHT indicated a reduction in sickness levels over a four year period from 2011 and these were being monitored by the trust. Staff at this service had access to support services including occupational health, counselling, staff retreats, mindfulness training and individual stress assessments.

Teams had buddying arrangements in place and caseload management tools had been implemented. These were being piloted in some of the community teams with plans to introduce these across the trust community adult services. The tools were used to determine the number of patients each staff member should have on their caseloads. These tools were reviewed by the managers at the teams with the staff involvement. The Department of Health 'Policy implementation guide' for CMHT's (2002) recommended caseloads of no more than 35.

Psychology waiting times were monitored locally by the team and locality managers. There were contingency plans for long term or planned absence, where backfill of posts would be explored. Short term absences would not be backfilled as psychologists would be expected to cover urgent work.

North Durham psychosis team reported feeling under pressure to manage their workloads. There were 22 patients on their waiting list. These patients were being managed by the duty workers and all patients had been sent information advising them who to contact in an emergency.

New staff were orientated to the team by attending the trust corporate induction and team based inductions with buddying arrangements in place for new staff. TEWV supervision policy outlines guidance for the supervision of employees and details requirements for managerial, clinical, educational/training and professional supervision of clinical and non-clinical employees.

Staff and managers spoken with during the inspection told us there were some vacancies and staff sickness in the teams visited. There were plans in place to manage patient safety when staff were absent. These included hand over team meetings, cell meetings, buddying arrangements, daily telephone conferences with acute inpatient services. Crisis teams and other community teams provided a duty system that managed patients when their worker was off sick or vacant posts were unfilled.

There was adequate medical cover within the teams we visited. We found Scarborough CMHT had advertised for a permanent psychiatrist and a locum psychiatrist was in post. Consultant psychiatrists were fully integrated into the teams we visited and teams reported they were accessible.

Assessing and managing risk to patients and staff

The teams visited used various tools in the assessment of patient risk. Most used the functional assessments of care environments (FACE) risk profile assessment tool to identify patient risks. This assessment tool is nationally accredited by the Department of Health (best practice in managing risk - principles and evidence for best practice in the assessment and management of risk to self and others in mental health services 2007).

The South Durham and Darlington EIP used an initial risk assessment tool for all new referrals into the service before completing the trust wide risk assessment tool when the patient was accepted onto their caseloads. The psychiatric liaison team used a situation background assessment recommendation risk assessment tool.

Risks to individuals were effectively assessed and managed on referral to the community teams. Referrals into services were either to a duty team or to a single point of access. We observed 'report out' meetings, 'peer pod' meetings and handover meetings. These were held frequently to discuss and manage patients and their risks.

Of the 26 records we reviewed there was a process for identifying and managing risks to the patient and others to minimise any risk of harm. Risk assessments had been reviewed and updated where necessary and or where risks had changed.

Community teams used an electronic patient recording system. This was used to store and update current and historical information about patients including risk information. This system was accessible to all teams we visited. North Tees psychiatric liaison team were able to access the system within the acute hospital wards and in A&E department. This meant that current and updated risk information was readily available at the acute hospital location.

Good

Are services safe?

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The system used provided risk alerts about patients who had previously been in receipt of services as well as current patients. This meant staff were immediately alerted to serious risk information they may need to consider when a patient was re-referred or was already receiving a service from the community teams.

Records had accessible and updated patient risk information and community teams were able to review the content of information provided by other professionals within the trust. An example of this was where the crisis team, community teams and the psychiatric liaison team had provided input into a patient record. When a crisis occurred or when patients presented at A&E they had access to updated and current information.

The community teams were all aware of local safeguarding adults and children procedures and how to report any concerns.

Medicines were stored securely at the services we visited and fridge temperature were monitored daily and recorded.

The North Durham psychosis service had piloted physical health monitoring of patients within their locality by completing physical health checks within the drug monitoring clinics held at the CMHT. They had developed a tool that enabled the teams to compare patients' physical health monitoring over time. This resulted in better data collection, accessibility and usability to improve patient care and safety.

Crisis plans were in place for patients. Care plans we reviewed contained information which informed patients of who to contact in a crisis. Advance decisions made by some patients were accessible on their computerised systems. Their system also had prompts to remind staff to ask the question to, ensure patients had been asked about this during their assessment. This meant where patients had made a decision about what treatment they did or did not want in the future then this was recorded and trust staff were aware of this.

Teams we visited were able to respond to sudden deterioration in patients' health. Teams had staff identified to respond via a duty system or by a single point of access team. We saw close working links with the crisis teams and where reports about patients' deterioration were highlighted then these were discussed within teams and appropriate action taken.

Some teams did not have a waiting list of patients waiting to be allocated. When teams had a waiting list they had various ways in which people were monitored. These included reviewing patient referral information and monitoring patients who did not attend planned appointments.

Some teams used clinical reporting systems to monitor patient risks, managing urgent and routine risks to patients. This meant patient risks were being monitored and managed. Where levels of risk had escalated, for patients on the waiting list then these were discussed and managed by the individual teams with duty workers arranging assessments of these patients. Duty teams gathered further information from professionals involved and the referrers into the service. Teams also had access the crisis teams, enhanced liaison teams and in the Scarborough area they had access to a street triage team.

Patients told us they were aware of whom to contact in an emergency and most had the crisis team contact information. They were also aware of who their care staff coordinators were and how to contact them

Staff knew how to recognise safeguarding concerns and were aware of the trust's safeguarding policy. Safeguarding leads had been identified within the trust and staff knew who to contact. Safeguarding concerns were discussed within the teams meetings we visited.

Trust lone working policies were in place. Most teams had developed local procedures to ensure staff were safe when visiting patients in the community. All staff were able to tell us about the processes and checks in place.

Track record on safety

The trust reported 40 serious incidents in the community teams from 1 December 2013 to 30 November 2014 via the strategic executive information system (STEIS). Three of these incidents were reported at Stockton affective disorder team, one at South Durham psychosis team and one at Easington affective disorder team. This indicated that the trust have appropriately reported incidents to external agencies as required.

Information reviewed identified the trust had completed post incident reviews into serious incidents. We looked at action plans produced following one serious incident. This made recommendations and actions for community teams to implement to improve their practice.

Good

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Reporting incidents and learning from when things go wrong

There was an electronic incident reporting system in place. This was completed following any incident. Incidents were graded by severity 1-5. Levels 4 and 5 were reviewed by the serious untoward incident (SUI) team and managers. This enabled team managers and senior managers to review and grade the severity of incidents.

Staff were aware of how to report and complete an incident reporting form and were aware of their responsibilities in relation to reporting incidents. Incidents were analysed by the service manager to identify any trends and appropriate action was taken in response to these. An example of this was at Scarborough CMHT. Reported incidents had identified increased concerns of violence and verbal abuse when patients visited the base. This led to a security audit being completed and funding was sought to improve the safety to patients and staff when patients visited.

Staff had a general awareness of the duty of candour requirements and they had received information from the trust to inform them of these new regulations which came into force in November 2014 for all NHS organisations. Team managers reported they had received awareness training regarding 'duty of candour'. And this was included in the chief executive's reflections found on the trust's website in September 2014. Duty of candour requires NHS and foundation trusts to notify the relevant person of a suspected or actual reportable patient incident, it focuses on transparency and openness.

Staff received feedback from investigations and incidents. Actions from incidents and patient alerts were regularly discussed in team meetings and at individual supervision if needed to ensure lessons were learnt. SUIs from other teams were shared via the locality team managers meetings and the trust communicated with staff via the trust email bulletin.

The trust had a policy in place to ensure staff were supported and debriefed after a serious untoward incident and access to counselling was available should staff want to access this.

Are services effective?

Good

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

Summary of findings

We rated effective as good because:

- Patients receiving a service had comprehensive assessments of their needs which included consideration of their clinical, mental health, physical health and their well-being.
- Information about patients' care and treatment and their outcomes was collected and monitored.
- The teams participated in local and national audits although front line staff were not always involved.
- Staff were qualified and skilled to deliver care and treatment to their patients but there were some gaps in their mandatory training.
- Patient care and treatment was planned and delivered in line with current best practice and evidenced based guidance.
- Staff were supported to deliver effective care and treatment and received good support from their managers and peers.
- When patients moved between services the necessary teams were involved and kept up to date.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005.
- Staff could access the information they needed to assess, plan and deliver care in a timely way.
- Where patients were subject to the MHA community treatment orders (CTOs) there was some good practice in place to ensure patients' rights were protected. However, the trust had identified in some community teams where improvements were needed.

However,

- The trust had identified in some of the community teams where improvements were needed in relation to monitoring patients who were subject to CTOs.
- We found there were gaps in some of the mandatory training requirements for staff.
- South Durham and Darlington EIP service did not have adequate security to their offices where records were stored.
- Staff reported to us that there were sometimes long waiting times for specific therapies for example family therapy and access to advanced psychological therapies.

Our findings

Assessment of needs and planning of care

We looked at 26 care records across the service. Each patient had a comprehensive assessment. Patients' needs were assessed on allocation to the teams and care was delivered in line with their individual care plans. Records showed that physical health needs were identified and managed effectively.

Care records we looked at mostly contained either a FACE risk assessment or other specific risk assessment tools. The records were up to date. When patients had been recently discharged from hospital, their seven day follow up visit had been recorded and summary discharge information had been sent to their GPs.

Records reviewed indicated recovery focused care plans were in place. Records also identified where patients were on medication which required monitoring, for example clozapine and lithium. Some teams we visited had specific monitoring clinics where patients' attended.

Care plans were reviewed on a regular basis and updated or discontinued as appropriate. Most care records contained relapse prevention plans called 'staying well'. These provided specific details of interventions which should be put in place if the patients' mental health deteriorated to prevent a relapse of their illness. Patients we spoke with provided examples of the plan they had in place.

Patient information was stored securely at most teams we visited. Staff had access to a computerised electronic note system. Some paper records were maintained. These could not be scanned onto the system and they were stored securely in most of the team bases we visited.

The South Durham and Darlington EIP service did not have adequate security to their offices where records were stored. We found people accessing the base were able to

Are services effective?

Good

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

freely wander about as doors to the team offices had no locks or keypads to restrict entry. This was highlighted to the manager who agreed to raise this issue for immediate attention by the trust.

When other teams were involved in patient pathways, they had access to current information using the computerised system.

Best practice in treatment and care

The National Institute for Health and Care Excellence (NICE) guidance was followed by clinical staff when prescribing medication.

Evidence demonstrated the teams had implemented best practice guidance within their teams. This included the promotion of psychological treatments accessible to patients, and implementation of NICE guidelines in psychosis.

Lithium and Clozapine were being monitored where necessary by the teams involved. We found good examples of Lithium and Clozapine monitoring in community teams with dedicated staff. Stockton affective disorder team had a systematic process to monitor patients prescribed Lithium. We found if any concerns had been highlighted regarding patient blood levels, these were escalated and discussed weekly with the consultant psychiatrist and team. The patient's GP was informed where necessary. We saw minutes of these meetings with associated actions, which ensured patients were continually monitored and kept safe. New patients were provided with a Lithium booklet, alert card and blood result booklet.

Blood tests need to be constantly up to date to monitor the levels of Lithium to prevent the effects of toxicity, should the patient's levels become too high. Data collected from pharmacy indicated the numbers of patients who were overdue Lithium blood level tests. This data (most recent) was accurate as of the 7 January 2014 and identified 66 patients out of 766 were overdue. Only four teams where lithium had been prescribed had fully monitored their patients. Scarborough CMHT had four patients who needed monitoring and one of these was overdue. CMHT H&R East had six patients overdue out of 20; CMHT H&R West had four patients out of 23 that needed monitoring.

Best practice guidelines had been implemented within clinical practice. Care pathways were underpinned by good practice and recovery pathways. 'Super flow', a pathway for psychosis and affective disorder, and 'model lines', a stepped-care model, were used to organise the provision of services. These were to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. This model allowed patients to step up or down the pathway according to changing needs and in response to treatment. The recovery star outcome tool was also used by all psychosis teams.

The trust had implemented local commissioning for quality and innovation (CQUIN) to support operational improvements in the quality of services, whilst creating new, improved patterns of care. Information reviewed indicated the trust had completed 291 local audits against various CQUIN targets. Some of these included the friends and family test, assessment and treatment of patients with severe mental illness to improve their mental and physical health care.

Teams recorded patient outcome measures using the short Warwick-Edinburgh mental well-being scale. This assessed patients' wellbeing over a period of time. Although the use of this was in its infancy at the trust we saw records which indicated this was being monitored by the trust. Staff were able to tell us about the use of this with their patients.

Health of the Nation Outcome Scales (HoNOS) were used to assess patients. This covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. Information reviewed identified 94.5% of service users on the adult mental health pathway had been assessed using the Health of the Nation Outcome Scales clustering tool.

Patients had access to psychological therapies as recommended by NICE. However staff reported to us that there were sometimes long waiting times for specific therapies for example family therapy and access to advanced psychological therapies. We found community teams provided individual psychological therapies as well as other patient support groups. Examples of this were dialectical behaviour therapy (DBT), cognitive behavioural therapies. We visited a DBT group and other patient support groups during our inspection.

Some teams we visited had social workers attached to their teams who were accessible and provided support and interventions to patients to address any housing and benefit needs. Patients' care plans identified where patients had been signposted to outside agencies.

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We found patients' employment status was recorded in the records. We found some teams had good links to specific employment support for patients. These included,the Shaw Trust, Morrison's Trust, Mental Health Matters, employment centres and various work placements to help facilitate patients return to work.

The early intervention psychosis teams had access to a vocational assessment tool. This was used to gather information which helped patients to look at and address their goals and aspirations. This included learning new skills, undertaking training courses and looking at voluntary and or paid work.

The trust had recently (October 2014) opened a recovery college in Durham as a two year pilot. This provides a learning centre offering courses based on patients personal recovery. Some of the courses incuded managing stress, living healthily, and sleeping well.

All the patient records had considered individual healthcare needs. Some patients were monitored via their local GPs. We found some good examples of how teams ensured that the physical healthcare needs of patients were being met. For example, Hartlepool psychosis service provided physical wellbeing appointments to patients annually. Electrocardiograms (ECGs), blood tests, body mass index (BMI) checks, smoking cessation, blood pressure and sexual health checks were offered and discussed.

North Tees psychiatric liaison team produced outcome measures specific to the service provided. These identified the reduction in patients' lengths of stay at the acute hospital and associated costings due to the service intervention.

Senior staff within community teams had participated in clinical audits. A clinical re-audit report of supervision at nine teams in Durham & Darlington adult mental health teams had been completed (January 2014). Results indicated an amber compliance rating of between 50-79%. Senior management provided action plans for implementation of supervision and recommendations with target dates for completion.

Skilled staff to deliver care

The staff working in the community adult teams came from a range of professional backgrounds included nursing, medical, occupational therapy, psychology, healthcare support workers and social workers. Some teams had specific non-medical prescribers trained within their teams. The teams operated within a multi-disciplinary team (MDT) framework.

New staff had a period of induction with the teams they were employed in. Teams had induction programme for all new staff and some of these were competency based.

Staff mostly reported they had been appraised and supervised by their line managers and that they were supported by them as well as by their peers. Scarborough community teams reported supervisions had been cancelled due to their supervisors being absent but reported clinical and managerial supervision was 'better' and they were being supported by their manager.

Team meetings happened regularly and some teams had invited local groups/services to their meetings. This provided staff and external agencies with information about each other's service provision and any new initiatives.

The trust's expected baseline for mandatory training was 95%.

Records showed that most staff were not up-to-date with all statutory and mandatory training and there were identified gaps at the following three location areas covering the community adult teams. These included Durham & Darlington (D&D) adult mental health (AMH), Teesside AMH and North Yorkshire (NY) AMH.

- Equality & diversity, fire, safeguarding children level 1, safeguarding adults, health & safety & information governance – all three locations had >80% of staff who met the core training requirements, with the exception of 'infection control'.
- Infection control was just below 80% with Durham & Darlington (D&D) AMH only having 78.5% of staff meeting requirements.
- This correlates to the jump we saw in the numbers of staff who did not meet the core requirements for infection control – all three locations had >20% still to be trained – with D&D reporting the highest at 21.5%.
- Safeguarding children level 1 for all three locations had performed better with >89% of staff meeting the core requirements.

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- Clinical risk assessment and management (CRAM) training for staff indicated 14% of staff had not received this training in Durham and Darlington AMH with 23% in North Yorkshire AMH and 21% in Teesside AMH.

All three locations had achieved 100% training in investigation of incidents & complaints.

D&D, Teesside and North Yorkshire AMH had achieved >80% for training in the following:

- Dual diagnosis
- Clinical supervision
- CPA & care co-ordination
- Medicines management
- Safeguarding children level 2 (with the exception NY AMH)
- Clinical risk assessment and management (CRAM),(with the exception of Teesside and North Yorkshire AMH)

Most managers had access to the electronic staff records (ESR) for their teams' mandatory training records and staff received alerts when training was overdue. At Stockton affective disorder team we found the manager was also alerted when training was overdue and these were reported into the monthly managers meeting. The training helped to ensure staff were able to deliver care to people safely and to an agreed standard.

Staff reported they had access to other training specific to their team and patient need. Some staff had received psychosocial training and family therapy. The community mental health team/assertive outreach West had staff trained in cognitive analytical therapy (CAT) and dialectical behaviour therapy (DBT). Staff throughout the teams visited had access to specific training.

The trust did not consider training in The Mental Capacity Act (MCA) Mental Health Act (MHA) and Deprivation of Liberty Safeguards (DoLS) training to be mandatory. However, team managers told us they would expect staff to access these and some teams had dates already planned for 2015.

Many staff had received specialist training for their roles within the community adult teams they worked in. An example of this was suicide prevention training. Some individual teams had attended team development days and specific topics related to their teams had been discussed. One example of this was North Tees psychiatric liaison team, where the focus of this day had been to address physical health assessments of patients.

At the time of the inspection, managers told us that they were addressing performance issues of staff and teams where necessary. These were addressed in supervision, team meetings and by application of the trust disciplinary process. Staff records reviewed confirmed this. The TEWV supervision policy outlines guidance for the supervision of employees and details requirements for managerial, clinical, educational/training and professional supervision of clinical and non-clinical employees.

Multi-disciplinary and inter-agency team work

Regular and effective multidisciplinary meetings were in place. We observed a range of meetings through our inspection. These included team business meetings, peer 'POD' supervision meetings, leadership meetings, daily cell meetings (part of model lines approach), daily handover meetings with inpatient and crisis teams and daily recovery and case load management meetings.

These meetings provided effective handovers within the teams we visited to keep staff updated about patient risks and to oversee and manage team and individual caseloads.

All teams had good working links with primary care services and effective patient handovers were in place with GPs. Computerised electronic note systems allowed trust staff to have access to updated information. When patients were discharged from inpatient services and back into their communities the computerised system prompted staff to complete a discharge summary to send to the patients GPs.

Most teams had access to social workers and approved mental health practitioners (AMHPs) within their teams. These staff were employed by local authorities but formed part of the community teams. Staff reported some problems with this arrangement in place as local authority staff were required to input information on to their own recording system and were then required to input information onto the trust system. This meant there was duplication in their workload as the systems were not linked.

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Adherence to the MHA and the MHA Code of Practice

Teams had access to MHA training. However, this was not mandatory. Some managers at the teams we visited told us that care coordinators were expected to attend. We observed a team meeting at Hartlepool psychosis service and saw training dates were provided to staff to make them aware of MHA training as well as DoLS and the MCA. Tees Psychiatric liaison team had arranged bespoke training for staff about the MHA, MCA and DoLS.

Scarborough CMHT had completed their own audit of patients who were subject to community treatment orders (CTOs). The manager found from the audit that improvements were needed. Records in South Durham and Darlington EIP service indicated there were processes in place for monitoring CTOs. However, there was no evidence of patients' rights being repeated. Other teams we visited had good systems in place to monitor patients subject to CTOs, for example, the CMHT East. Records reviewed informed us that patients had their rights explained to them routinely and these had been documented by the patient and the care coordinator.

We also found examples of risk assessments and care plans in relation to patients subject to CTOs. These were important as a breach of the patients' conditions as stipulated within their CTO could mean that patients could be recalled back to hospital. It is therefore important that staff that provided care and treatment to patients who are subject to a CTO are aware of their conditions stipulated in the order when providing care and treatment. We found patient records were stored appropriately.

Good practice in applying the MCA

Most staff had not received training in the MCA and DoLS as this was not part of the trusts mandatory training requirements.

Staff were able to articulate the principles of the MCA and discussed how they assumed capacity of their patients unless this was identified during their care and treatment. Staff were aware of where to go for support and advice about the MCA and DoLS within the trust. The trust had a policy in place and this was accessible via their intranet.

In the patient records we reviewed we looked at mental capacity and found capacity was considered during the assessment process and had been recorded.

The affective disorder service Easington showed good examples the MCA, where concerns over patient financial vulnerabilities and these had been assessed appropriately. Tees psychiatric liaison team had devised an amended capacity assessment for patients attending A&E where patients may present intoxicated.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Feedback from patients who used the services was positive about the way staff treated them.
- Patients reported they were treated with respect and, kindness by staff.
- Patients reported they were involved and encouraged in making decisions about their recovery pathways.
- Patients' privacy and confidentiality were respected.
- Patients' social needs were understood and patients were assisted to maintain and develop their social networks and community support where needed.

Our findings

Kindness, dignity, respect and compassion

Patients told us that staff treated them with respect and were responsive to their needs. We saw staff were positive about the impact they had on patients' wellbeing. Staff spoke to patients in a respectful and dignified manner.

We observed all staff interacting with patients in a caring and compassionate way. Staff responded to patients in a calm and respectful manner. Staff appeared interested and engaged in providing good quality care to patients.

When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

Patients told us that staff provided practical and emotional support and that they felt confident in raising any issues with them. We received positive feedback from patients and their carers about the way staff treated them. Patients told us about the care and treatment they received, they told us;

- "Staff speak to me as a person and are not patronising".
- "Very happy with the service it's really changed my life, they are caring and respectful and they were here in half an hour when I was relapsing".
- "I have regular contact to see how I am doing and they take time to help me out".
- "They are very good, I'm very impressed. I would be in a mess without their help".
- "When I was admitted to hospital I lost my job and there's not a lot of help getting back into work".
- "They are caring, nice people, very happy, the NHS is fantastic".
- "I've got so many thank yous for all those who have looked after me "They are all really caring
- Other comments made were team are easy to access, easy to communicate with and really helped me progress in functioning socially and managing previous chaotic behaviour.

CQC provided comment cards for patients to complete throughout our inspection in relation to community adult teams. Patient comments included:

- Staff are very caring and flexible.
- CMHT (community mental health teams) did not engage with patient or parent.

Some people commented:

- No care plan.
- No follow up plan.

The records we reviewed did not support this. All contained up to date care plans and indicated that a copy had been provided to the patient. Where people had been discharged recently, 7-day follow up visits had been recorded. Most care records contained relapse prevention plans called 'staying well'.

The involvement of people in the care they receive

Patients generally told us they were involved in developing their care plans. Records we checked on their computerised system, identified patients had been involved and comments were recorded. Patients we spoke with were generally aware of the content of their care plans, although some patients said they could not remember having a copy.

Details of local advocacy services and local support groups were displayed in the location bases we visited. Information leaflets were available about the local services in the teams we visited. We saw North Durham psychosis team had collated an information pack for all patients. These provided good information about their treatment and care as well as providing contact numbers in an emergency or crisis.

The views of patients and carers using the services were gathered through the use of surveys and questionnaires.

Good

Are services caring?

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

Responses were fed back to staff teams and were displayed by most teams we visited to enable them to make changes where needed. We saw patients were encouraged to involve relatives and friends in their care if they wished. Some teams had carers support workers attached to their teams; they completed carer's assessments to ensure their needs were assessed and support was provided.

Patients at Hartlepool psychosis team attended a hearing voices group weekly at the team base. They told us this had kept them out of hospital and the team were very helpful and always at the end of a phone.

Carers and family members were involved and encouraged to be involved in their relatives care. Records at the affective disorder service in Easington identified carers had been involved and had been offered individual support. Carers support groups were available throughout the trust and information was available at the teams visited to inform carers of local groups and services available.

North Tees Liaison psychiatric team held a patient and carer event to consult with them about what they initially wanted the service to look like. Patients and carers were also involved on interview panels for all grades of staff and were involved in both TEWV and acute staff training in producing a video. Staff had a hand held devices to seek patient feedback as well as friends and family tests. We saw this in other teams we visited. The psychiatric liaison team involved patients in the recruitment of staff by producing a video about self-harming.

We found a few examples of patients with advance decisions in place for how they would like to be supported if their mental health deteriorated.

The CQC community mental health patient experience survey 2014 informed us the trust was performing about the same as other trusts in all the comparable questions answered by patients

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because:

- Services were planned and delivered in a way that meets the needs of the local population.
- Care and treatment was coordinated with other services and providers.
- Services were responsive to any identified and increased risks to patients.
- Patients could access the right care at the right time and access to care is managed taking account of their needs and risks.
- Waiting times were monitored by local teams and the trust and patients were kept informed of any delays or cancellations.
- Complaints and concerns were monitored by the teams and the trust and information was readily available to inform patients of how they would make a complaint.
- Community teams in rural areas were flexible and responsive to patient need often arranging appointments in an area close to their homes.

Our findings

Access, discharge and transfer

Data was submitted by the trust reporting the average number of days patients waited between referral to assessment and referral to treatment for the period 1 April 2014 to 31 August 2014.

Adult services failed to meet the trust's 98% target with 83% of patients being seen within four weeks of external referral.

Referrals into community adult teams were accepted either by a duty team or to a single point of access (SPA). Some teams had waiting lists and others had no waiting list. The waiting lists were risk assessed and where patients had been identified as being high risk, they were allocated urgently. Other patients were sent a letter by a duty worker advising them of emergency contact numbers if needed and informing them they would be contacted again in 6-8 weeks. Scarborough CMHT had patients on their waiting list and urgent referrals were usually seen within 72 hours. Routine referrals would be seen within 28 days.

All teams visited were able to responded urgently to patient referrals when needed and arrangements would be made to see patients on the same day. Where patients needed out of hours intervention, this was arranged by the team and the crisis intervention teams.

Duty or SPA teams triaged the referral information and made assessment appointments, where they gathered further information from professionals involved and the referrers into the service. Teams had access the crisis teams throughout the trust and joint visits were arranged accordingly in response to patient contact.

North Durham Psychosis staff reported for psychological input from referral to assessment time was 1-2 weeks; however, staff told us there were no targets set by the trust to monitor initial patient assessment to them being in receipt of treatment.

We saw teams had systems in place to respond to patients who telephoned into the services. These included liaison with their care coordinators, duty and buddy systems in place to respond to patients if their allocated worker was absent. Teams were responsive to patients in crisis and who contacted them. We found some good examples of how teams worked proactively to engage with people who found it difficult or were reluctant to engage. An example of this was at Hartlepool psychosis service where they met patients in local cafes and care programme approach (CPA) reviews took place in patients' homes if needed.

Assertive outreach teams were also in place throughout the trust to provide input and a service to patients who were identified as difficult to engage.

Data provided informed us that the proportion of patients on the CPA who were followed up within seven days of discharge from psychiatric inpatient care remained above the England average from April 2013 to September 2014 (dipping in Q1 2014/15).

Good links were in place with support services that provided lifelong support to the forces and their families. Information was available at most teams visited to inform ex-service personnel and veterans of support available. Records indicated the trust were monitoring patients who had previously been involved with the armed forces and access to services were fast tracked and prioritised through the system. Good links at the community mental health team west were in place with the local armed forces base.

Good

Are services responsive to people's needs?

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

Patients who did not attend (DNA) their appointments were followed up by community teams. The trust monitored DNA patients as well as cancelled appointments. Duty and buddy systems were in place at most teams and they re-engaged with patients who DNA appointments if their identified worker was absent.

Due to the remote locations of some of the community teams they provided flexibility in patient appointment times. Arrangements were made to see patients locally to where they lived for example in their local GPs surgery or a community facility.

Facilities promote recovery, dignity and confidentiality

In all of the teams we visited and where patients were seen, the facilities were clean, comfortable and mostly well furnished. Some teams shared visiting rooms and these needed to be booked in advance. The interview rooms were adequately sound proofed to maintain patients' privacy. Reception areas provided a range of information such as complaints information, local self-help groups, advocacy services and information about the teams and treatments provided.

Meeting the needs of all people who use the service

The teams had access to language translation through the trust and they could access interpretation services and access patient information in various languages.

Listening to and learning from concerns and complaints

From the trust's inspection information submitted prior to our inspections, there were a total of seven complaints received in the last 12 months (1st September 2013 to 31st August 2014) for the community adult mental health services we inspected. Two of them were upheld.

Data also indicated where complaints had been made the majority of complaints received and upheld were with regards to 'all aspects of clinical treatment' and 'attitudes of staff'.

Information on how to make a complaint was displayed in the teams we visited, as well as information on the patient advice and liaison service (PALS) and advocacy services.

Patients we spoke with told us they would initially raise issues with their identified staff member and felt comfortable doing so.

Staff informed us they tried to address patients concerns informally as they arose. Staff were aware of the trusts formal complaints process and knew how to signpost people as needed to PALS.

Patient complaints were fed back to staff in their team meetings. This meant staff were kept informed of any complaints made against their team so that improvements were made and actions were implemented to improve their service to patients.

Are services well-led?

Good

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

Summary of findings

We rated well-led as good because:

- There were clear visions and values and staff were aware of these and the trusts quality strategy.
- Structures, processes and systems were in place around governance and these fed upward from team to the trust board and were fed back down to teams.
- The teams had processes in place to manage team performance and the quality of care and treatment provided.
- Information about patient and carer experience was reported back to teams from information collated in relation to the friends and family test.
- There was an effective process in place to identify, monitor and address risk issues.
- The leadership at the trust had been visible and engaging at most of the teams we visited.
- The staff were open and transparent and was aware of their 'Duty of Candour' in relation to the NHS organisation they worked in.
- There was a strong focus on continued learning and improvements for staff within the teams they worked in.

Our findings

Vision and values

Staff were aware of the trusts vision and values and the trusts quality strategy for 2014-2019. Staff were motivated and dedicated to give the best care and treatment they could to patients in receipt of community mental health services. Staff were supportive of the changes to the models of care and some teams were piloting new initiatives to improve the services provided.

Most staff were aware of senior managers within the trust. The chief executive was accessible to the teams we visited and had engaged with many of the community teams. One staff member told us they had emailed the senior managers in the trust to seek career advice and arrangements had been made to meet with the staff member.

Staff reported they knew who their locality managers were and some reported they had visited their teams.

Good governance

We found the services were well managed and had good governance structures in place. Staff had clear roles and a management structure that was understood by staff.

There was opportunity for staff to submit organisation/ team risks to the trust risk register. Most staff reported they liked working at the trust and felt well supported by their managers.

TEWV had a governance structure in place. Community team managers reported into specific governance teams monthly.

Most staff we spoke with told us they were not involved in clinical audits within their team but had an awareness of trust audits in place.

The psychiatric liaison team had audited their peak activity times; this had resulted in staff staggering their start time to improve cover late at night.

Data submitted indicated the trust's overall key performance indicators (KPIs) for the number of early intervention in psychosis for new cases were 619 against a target of 237.This meant the trust had exceeded the target of early interventions for patients with psychosis.

Leadership, morale and staff engagement

Most staff described strong leadership at team level and said they felt respected, valued and supported. Some community adult teams in TEWV had new management arrangements in place. Staff reported positively about this. Comments made by staff were:

- Staff morale had improved.
- Sickness and workloads had improved.
- The leadership have a vision for teams, with a clearer purpose in their jobs.
- There were 'hands on' managers.

Staff reported they were able to raise concerns without fear of victimisation and were aware of the trust whistleblowing policy.

Staff told us they had opportunities and were encouraged to undertake further education to support them in their job

Are services well-led?

Good

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.

roles as well as being encouraged to attend outside conferences. Managers told us there was support for new managers and they were available to undertake a management qualification.

Commitment to quality improvement and innovation

Community teams had completed a clinical audit into suicide prevention within 23 community teams that were randomly selected by the trust. The audit toolkit used, was devised from the general audit tool from the preventing suicide - A toolkit for mental health services (NPSA, 2009). The report dated January 2014 indicated the community teams were collectively compliant overall. The report data reviewed in this audit indicated that to sustain improvements the trust should repeat this audit and address areas identified.

The trust quality accounts for 2013/14 indicated the trust participated in the national audit of psychological therapies (NAPT) in adult mental health, the national audit of schizophrenia and monitoring of patients prescribed Lithium.

The trust were committed to supporting research across the services as described on their website. They work closely with the mental health research group at Durham university. The trust currently has a number of National Institute of Health Research (NIHR) studies. They are involved as an active and committed partner in the establishment of the new North East and North Cumbria clinical research network launched in 1 April 2014.

The trust published research in a medical journal which showed evidence that cognitive behavioural therapy may be an alternative for patients with psychosis who do not take antipsychotic medication.