# Humber Teaching NHS Foundation Trust

## Inspection report

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Date of inspection visit: 07 Jan to 15 Feb 2019
Date of publication: 14/05/2019

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

| Overall rating for this trust | Good |
|---|---|
| Are services safe? | **Requires improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Good** |
| Are services well-led? | **Good** |

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

# Summary of findings

## Background to the trust

Humber NHS Foundation Trust provides a range of community and inpatients mental health services, community health services, learning disability services, children's and addiction services, and GP services to people living in Hull, the East Riding of Yorkshire, Whitby and Scarborough. The trust serves a large geographical area with a population of 600,000 and it employs approximately 2500 staff at sites at locations across the catchment area.

The trust provides 10 of the core mental health services:

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

The trust also provides specialist substance misuse services.

The trust provides community health services:

- Community health adult services.
- Community inpatient services.
- Community health services for children and young people.

The trust has seven GP practices:

- Field House Surgery.
- Hallgate Surgery.
- Market Weighton.
- Northpoint Medical Practice.
- The Chestnuts Surgery.
- Princes Medical Centre
- Peeler House Surgery

They also have one adult social care location at Granville Court.

Humber NHS Foundation Trust became a foundation trust in 2010.

# Summary of findings

We undertook a well led review at Humber NHS teaching foundation trust on 15, 16 and 17 October 2017. At that inspection we rated the trust good overall and good in effective, caring, responsive and well led and requires improvement in safe.

At that inspection we also issued 15 requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of five legal requirements in nine services.

Regulation 18 – Staffing

Regulation 12- safe care and treatment

Regulation 17 – good governance

Regulation 15- Premises and equipment

Regulation 9 – Person-centred care

We told the trust that it must take action to bring services into line with 15 legal requirements. This action related to nine services and trust wide services.

Trust wide

- The trust must ensure that all staff receive supervision and appraisals in line with trust policy.

Wards for adults of working age and psychiatric intensive care units

- The trust must ensure that staff receive the full range of mandatory training, including immediate life support training and search training.
- The trust must ensure there are enough staff to meet safe staffing levels and provide activities, section 17 leave and engagement with patients on the wards.
- The trust must ensure that staff receive supervision and appraisals in line with trust policy and have time to attend regular team meetings.
- The trust must ensure that it maintains accurate, complete and contemporaneous patient records whereby staff can access results and update patient related information in a consistent manner across the service.

Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure that all patients have a completed and up to date risk assessment and management plan.
- The trust must ensure there is enough suitably qualified staff on duty and that all staff have completed the mandatory training to help them carry out their roles.

Forensic inpatient or secure wards

- The trust must ensure that staff attendance at mandatory training meets their required target, to ensure staff are skilled and competent to perform their role.

Wards for older people with mental health problems

- The trust must ensure that the service has enough suitably qualified staff on duty to fill shifts. Staff must complete mandatory training and receive individual clinical supervision in accordance with trust policy and targets.

Wards for people with a learning disability or autism

- The trust must ensure that staff including temporary bank staff undertake all mandatory training courses.

# Summary of findings

Community based mental health services for adults of working age

- The trust must ensure that the compliance for mandatory training courses reaches the 75% target.

Mental health crisis services and health-based places of safety

- The trust must ensure that the rooms used by the rapid response service at Miranda House are properly maintained.
- The trust must ensure that staff know what the freedom to speak up guardian is and who they are.
- The trust must ensure that staff at the rapid response service receive the appropriate training.
- The trust must ensure that an audit schedule is in place for mental health crisis and health based place of safety services to ensure that services can be assessed, monitored and improved.

Substance misuse services

- The trust must ensure that staff regularly review each patient's recovery plan in line with trust policy and best practice.
- The trust must ensure that each patient receives regular clinic reviews in line with trust policy and best practice.

Community health services for adults

- Ensure mandatory training compliance and safeguarding training compliance and targets are met across the services.
- Ensure governance systems and processes are in place across all community health services for adults' areas and embedded within teams.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Good** 

## What this trust does

Humber NHS Foundation Trust provides a range of community and inpatients mental health services, community health services, learning disability services, children's and addiction services, and GP services to people living in Hull, the East Riding of Yorkshire, Whitby and Scarborough.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

# Summary of findings

We inspected five complete core services.

- Mental health crisis and health based place of safety.
- Specialist community mental health services for children and young people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Forensic/ secure wards.
- Community health services for adults.

In addition to this two GP practices and Granville Court (adult social care service) have been inspected and rated as good.

These were selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated well led for the trust as good. We rated effective, caring, responsive and well led as good across mental health and learning disability services. We rated safe as requires improvement.
- We rated nine of the trusts 11 mental health services as good and two as requires improvement, and whilst the rating for acute wards for adults of working age and psychiatric intensive care units remained as requires improvement, the safe key question was now rated as good. In rating the trusts mental health and learning disabilities as good we considered the previous ratings of services not inspected this time, and deviated from the ratings principles.
- We rated two of the core services as good that we inspected this time. Mental health crisis and health based place of safety services were rated as requires improvement at our last inspection in 2017 and was now rated good in all key questions.
- Six GP practices which had been inspected were rated as good in all key questions.
- The adult social care location at Granville court was inspected and rated in January 2018 and was rated as good in all key questions.
- The trust had a clear vision, strategy and vision. Staff knew and understood the trust's vision, values and strategy, had opportunity to be involved of the development of these and understood how achievement of these applied to the work of their team. The trust board and senior leaders had the appropriate range of skills, knowledge and experience to perform its role.
- Staff felt respected, supported and valued amongst their local teams. Staff knew and understood the trust's vision and values and their behaviours reflected these.

# Summary of findings

- Staff treated patients with compassion and kindness. They largely respected patients' privacy and dignity and supported their individual needs. Staff understood how to protect patients from abuse and were trained to do so. Feedback we received from patients was positive. Friends and family test results were consistently positive.
- Staff were aware of what incidents they should report as adverse events and were and generally managed them well, they also knew what should be reported, their duty in reporting these and in meeting the requirements of the duty of candour.
- Patients could now access a mental health bed in a timely manner when in crisis. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit.

However:

- We rated community health services for adults as requires improvement in safe, effective and well led. This was the third inspection where this core service has been rated as requires improvement, and at this inspection effective has gone down one rating from good to requires improvement. This has led to an overall rating in community health services as requires improvement.
- There was improvement at our last inspection in the forensic and secure services leading to a rating of good over all. This improvement has not been sustained and has now been rated as requires improvement in safe and well led.
- Despite there being a programme of board visits to clinical areas and board members reporting that significant engagement was undertaken with staff, some staff reported that board members were not visible and staff did not always feel supported or listened to.
- Staff did not feel they were always consulted properly about changes to services. There were not always enough staff in all services.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service. Staff did not always record details of safeguarding concerns under the designated section of the electronic patient record.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services.
- Children and young people were waiting over 18 weeks to receive treatment in some areas.

Our full Inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website – .

## Are services safe?

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

- In community health services for adults, staff in all teams did not always complete and update risk assessments.
- There was no caseload management tool used in community health services for adults to determine the number of nursing staff required in each locality.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service. Staff did not always record details of safeguarding concerns under the designated section of the electronic patient record.
- In forensic services visits between patients and their family and friends were always observed by staff. This was a blanket restriction and did not consider risks around visits on an individual basis.

# Summary of findings

- Staff had not always ensured that they were recording their responsibilities under the Mental Health Act Code of Practice relating to seclusion. Nursing and medical reviews were not always documented or occurring within the prescribed time frames. Patients in seclusion did not have individualised personal emergency evacuation plans in place.
- Forensic services did not always manage patient safety incidents well. We found that action plans were not always completed in a timely manner.
- Staff were not all following the service protocol for lone working and there were deviances in who staff would inform following a visit.
- There were not always enough staff to maintain safer staffing levels in wards or services.

However:

- Staff assessed and managed risks to patients and themselves well except in community health services for adults. They followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Ward staff participated in the provider's restrictive interventions reduction programme. Trust risk registers accurately reflected the risks of the trust and staff.
- Staff understood how to protect patients from abuse and or exploitation and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and or exploitation and they knew how to apply it. Staff could identify safeguarding concerns and had effective working relationships with the local authority when raising concerns about a vulnerable adult or child.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff knew what should be reported and their duty in reporting these and in meeting the requirements of the duty of candour.
- In forensic services mandatory training rates had improved since our last inspection.
- In community child and adolescent mental health services managers recognised the requirement to improve staffing levels to respond to increases in autism referrals and long waiting lists. This was reflected in a recruitment drive to form a specific team for this care pathway.

## Are services effective?

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

- Staff provided a range of care and treatment interventions in line with national guidance.
- There were full multidisciplinary team approaches and staff worked closely with members of the mental health response team and external agencies including the police and ambulance service.
- Most ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Generally, managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- In community child and adolescent mental health services staff were experienced and received specialist training to meet the needs of the children and young people using the service.

# Summary of findings

- In community child and adolescent mental health services staff from different disciplines worked together as a team to benefit the child or young person. They supported each other to make sure there were no gaps in their care. Teams had effective working relationships with relevant services outside the organisation.

However:

- In mental health crisis and health based place of safety, staff prioritised patient care above the need to receive formal supervision and staff clinical supervision was low. Community health services staff were not always receiving supervision or appraisals.
- In community health services although care and treatment provided appeared evidence based, there were no care pathways for staff to follow to ensure patients were receiving consistency of care. Staff were not always competent.

## Are services caring?

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

- Feedback we received from patients was positive. Friends and family test results were consistently positive
- We observed staff treating patients with respect and compassion.
- Surveys were conducted to capture the views of patients and carers.
- Staff involved patients and those close to them in decisions about their care and treatment.
- In forensic services patients had been involved in a range of creative activities to improve the wards, including art projects and the creation of a DVD about life in the service.
- Children, young people and their parents or carers had good opportunities to be involved when appropriate in decisions about the service.

However:

- In acute wards for adults of working age and psychiatric intensive care units the measures the trust had taken to protect patients' privacy and personal details was not always effective.

## Are services responsive?

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

- Staff helped patients with communication, advocacy and cultural and spiritual support.
- There had been an improvement in the way staff managed patient beds. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The service had clear criteria to support the triage of patients to the most appropriate service.
- The service regularly audited call volumes and adapted staffing to be available at peak times.
- The service ensured patients detained under section 136 of the Mental Health Act received prompt assessments and were detained for the shortest time possible.
- In forensic services staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison.
- Staff worked closely with schools, families and external organisations to establish and maintain engagement and relationships with the wider community.

# Summary of findings

However:

- We did not see that staff provided information on wards for patients with lesbian, gay, bisexual and transgender needs, (LGBT). We did not see evidence that staff had links with local LGBT organisations but on the trust website, we saw that staff were involved with the Hull Pride campaign in 2018 and staff and patients from across the trust attended the event.
- Two of the meeting rooms at Miranda House did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.
- There were some difficulties with works issues not being completed in a timely manner which affected privacy and dignity in the forensic services.
- Children and young people were waiting over 18 weeks to receive treatment.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- The trust board and the senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. Whilst there had been some changes of personnel within the board since our last inspection, the board had the ability to deliver high quality care.
- The trust had a board of directors who were responsible for safe delivery of services and committed to delivering the strategy.
- There was a clear vision, strategy and set of values. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Processes were in place to support delivery of the strategy. The trust had an operational board, a council of governors and seven committees.
- The trust had started to use statistical process control, which is a method of quality control which employs statistical methods to monitor and control processes. This enabled better evaluation and moved away from cumbersome dashboards for the board.
- There was a board development programme, which was introduced for the senior management team. Board level posts and board members received an annual appraisal where professional development needs were identified and addressed.
- The trust had a distributed leadership plan that supported the overarching workforce and organisational development strategy. Succession planning and development of leaders was a priority for the trust and they had a leadership development programme.
- The trust had an efficient process for management of risk and quality. The trust had recently introduced a daily risk huddle this group reviewed risk items from the previous 24 hours which allowed immediate escalation of any risk issues. The trust also had a weekly clinical risk management group. This group had oversight of briefings, investigations, escalation of issues and commissioning of thematic reviews.
- The trust had an extensive internal and external audit programme and plan to monitor quality and review risks. The trust held its first ever research and development conference in 2018, which was well received by trust staff and external attendees.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust policies described the process for staff to raise concerns about quality and safety of services.

# Summary of findings

- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution. Staff had the opportunity for development and progression. Most managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- The trust remained part of the sustainability and transformation partnership.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five points had no change and nine had changed negatively.
- Staff treated patients with compassion and kindness. Patients who used the services reported positive and inclusive relationships with the trust. Patients constantly recommended the trust as a place to receive care in the family and friends test between April 2018 and September 2018.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five which had no change and nine that had changed negatively. The trust recognised staff success by staff awards and through ongoing feedback.
- The trust had updated its complaints policy and all complaints were now completed within timescales.
- The trust had appointed a freedom to speak up guardian and a deputy. Both had dedicated time to undertake this role and this included speaking at the induction programme for new staff to highlight the service, training, local and national events and developing the strategy further.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust risk management policy, incident reporting policy, serious incident policy and freedom to speak up policy all described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- NHS improvements told us that the trust was proactive in using benchmarking data to develop cost improvements programmes. As at the last inspection all cost improvement programmes went through a robust internal assessment process, this process remained the same at this inspection.
- The Trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received.
- The trust was currently involved in 17 National Institute for Health Research projects and 17 non National Institute for Health Research projects.

However:

- At our last inspection in 2017, staff expressed risks and worries around staffing numbers, skill mix and change management. Some staff reported the same at this inspection especially in community health services for adults. Despite the trust board having a comprehensive programme of site visits, there was still a mixed picture from staff who at times felt that the directors were not visible enough.
- The trust had an equality and diversity policy but no strategy, this focused mainly on staff not service users and had no clear statement of what success would look like, this also lacked an operational plan to under pin its delivery. The trust's patient and carer experience strategy included consideration of equality and diversity.

# Summary of findings

- The trust were undertaking a shaping the vision – care services structure consultation. This had raised many anxieties in staff who felt that they had not been fully informed or consulted with. This included medical staff.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services. Children and young people were waiting over 18 weeks to receive treatment in some areas. Some information relating to the community child and adolescent mental health services on the trust website was out of date. The risk register had only been implemented two weeks pre- inspection in community health services for adults.
- There were still reported difficulties when working with the trade unions.
- Whilst the trust reached their overall target of 85% for mandatory training, some courses fell below this. Appraisals in all areas did not meet the trusts target. The trust's target rate for clinical supervision was 80%. As at 31 August 2018 the overall clinical supervision compliance was 77%.
- The electronic patient record system remained slow and had varied implementation with some staff creating local records.
- In mental health crisis and health based place of safety services staff informed us despite the service level agreement and patient directives being in place there continued to be difficulties in obtaining medication out of hours.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in acute wards for adults of working age and psychiatric intensive care services, child and adolescent mental health services and trust wide. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including 13 breaches of legal requirements that the trust must put right. We found 27 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued six requirement notices to the trust. Our action related to breaches of thirteen legal requirements in four core services. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

## What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

# Summary of findings

## Outstanding practice

The trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received. The information showed how the trust were performing at organisation, care group and team level. This live link was available via the trusts internet page and patients, carers and staff could access this immediately. In February 2019 the live link showed that 216 people had responded to the survey and that 94% of them would recommend their services to friends and family if they needed similar care or treatment.

The trust had developed a bereavement package for deaths that occurred because of physical ailments. As part of that bereavement package the charity health stars paid for bereavement cards to be printed. Patients and carers developed the messages inside the card. The bereavement package included a card, advice on how to deal with bereavement for the carers, a card from the clinician who dealt with the loved one, links to funeral homes. This package was developed following the trusts last CQC inspection as the trust recognised that when people were grieving they don't want to be asked lots of questions, so staff don't complete the survey when they are with the carers but do it afterwards to be respectful. The team are hoping to roll these packages out to children and mental health services.

Staff on Westlands had developed a toolkit for use with patients at risk of suicide

and self-harm. They were in the process of providing training for staff on other wards.

The trust had reduced their out of area transfers for acute admissions by redesigning the acute pathway including adding five beds, supported by developments of the crisis pad, step down beds and clinical decisions unit.

The Social Mediation and Self-Help (SMASH) programme is a group-based programme which takes referrals from schools. They work with young people aged 10-16 years who may be at risk of developing mental health problems, this is a unique collaboration between Humber Teaching Foundation Trust and the SMASH programme which worked with a wide range of partners across health, social care, communities, education, young people and families. The programme has received national recognition from Thrive, Royal College of Psychiatrists and Young Minds. The programme is a finalist in the HSJ Innovation in mental Health Award. Although referrals to the children and adolescent mental health services continue to rise, consistent with the national picture, the programme has delivered an accessible early intervention programme which has begun to reduce the numbers requiring access to specialist treatment.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services

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**We told the trust that it must take action to bring services into line with six regulations in respect of thirteen breaches of legal requirements. This action related to four services.**

**Action the trust MUST take to improve:**

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

- The trust must ensure patient care plans are personalised, holistic and reflect all the identified needs of patients. (Regulation 9).
- The trust must ensure staff act in line with the Mental Capacity Act and code and practice in assessing capacity, making best interest decisions and allowing patients to make unwise decisions. (Regulation 11).

# Summary of findings

- The trust must ensure staff complete consent to treatment records for all detained patients. (Regulation 11).
- The trust must ensure staff on the wards feel supported, valued and that they are consulted appropriately on service developments. (Regulation 17).
- The trust must ensure systems and processes designed to monitor and improve the service are implemented consistently across the service and staff have adequate guidance so they understand what is expected of them. Audits must identify and address effectively any areas of concern. (Regulation 17).

Community health services for adults

- The trust must ensure all staff receive supervision and appraisals. (Regulation 18).
- The trust must ensure that accurate and complete patient records are maintained. Risk assessments and care plans should be completed and regularly reviewed. (Regulation 17).
- The trust must ensure regular audits are conducted to assess, monitor and improve the quality and safety of services. (Regulation 17).

Forensic services

- The trust must ensure there are sufficient skilled and competent staff to safely meet the needs of patients. (Regulation 18).
- The trust must ensure that that nursing and medical reviews for patients in seclusion take place and are documented within required timescales. The trust must ensure patients in seclusion must have individualised personal emergency evacuation plans in place. (Regulation 12).
- The trust must ensure there are appropriate systems in place to monitor actions from incident investigations and share learning from incidents amongst the staff team. (Regulation 17).
- The trust must ensure that systems to report, record and resolve maintenance issues in the service are in place and effective. Repairs to essential services such as laundry and shower facilities must be completed in a timely manner. (Regulation 15).

Specialist community mental health services for children and young people.

- The trust must review and reduce the waiting lists for treatment for children and young people to meet national guidance. (Regulation 9).

**Action the trust SHOULD take to improve:**

Trust wide

- The trust should consider further methods of engagement with staff at ward and service level.
- The trust should review the use and implementation of the Lorenzo electronic patient note system.
- The trust should consider further measures needed to ensure an increase in appraisals and supervision numbers in some core services.
- The trust should ensure participation at all levels when embarking on consultations which affect staff, roles and services.
- The trust should ensure that staff feel communicated with and consulted about trust wide decisions and consultations.
- The trust should ensure that supervision for staff reaches the required target.

# Summary of findings

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

- The trust should ensure they review minimum staffing levels in line with deputy director of nurses safer staffing report.
- The trust should carry out assessments with all patients to determine whether they need access to a personal alarm.
- The trust should ensure there are effective measures in place on all wards to protect patient confidentiality and ensure patients' privacy in bedrooms is not compromised.
- The trust should ensure ward managers receive timely feedback about serious incident investigations and that there is a robust process for sharing lessons learned from wider trust incidents and complaints including between each ward of the service.
- The trust should ensure information for lesbian, gay, bisexual and transgendered people is available and visible for patients and visitors.

Mental health crisis and health based place of safety

- The trust should ensure systems and processes are in place for staff to access medication out of hours.
- The trust should ensure staff record safeguarding concerns under the designated area of the electronic patient records.
- The trust should ensure staff receive regular supervision in line with trust targets.
- The trust should ensure the meeting rooms at Miranda house promote patients right to dignity and privacy.
- The trust should consider staff access to the equipment necessary to complete physical health checks in the community.
- The trust should consider ways to improve senior managers visibility to staff and increase staff confidence in raising concerns.

Community health services for adults

- The trust should consider ways to further engage with staff and improve communication.
- The trust should consider ways to improve cross locality communication between teams.
- The trust should ensure that all staff know how to report incidents.

Forensic services

- The trust should consider the use of individual risk assessments in relation to observed visits within the service.
- The trust should ensure that occupational therapy staff are not routinely used to support safe staffing levels on the wards.
- The trust should consider how to extend opportunities to support and involve families and carers.
- The trust should ensure that patients are able to make telephone calls in a way that does not compromise their privacy.

Specialist community mental health services for children and young people.

- The trust should ensure their website reflects the service's teams and care pathways.
- The trust should consider room space for appointments at the Beverley location in East Riding.

# Summary of findings

## Is this organisation well-led?

We rated well led good at the trust because:

- The trust board and the senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. Whilst there had been some changes of personnel within the board since our last inspection, the board had the ability to deliver high quality care.
- The trust had a board of directors who were responsible for safe delivery of services and committed to delivering the strategy.
- There was a clear vision, strategy and set of values. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Processes were in place to support delivery of the strategy. The trust had an operational board, a council of governors and seven committees.
- The trust had started to use statistical process control, which is a method of quality control which employs statistical methods to monitor and control processes. This enabled better evaluation and moved away from cumbersome dashboards for the board.
- There was a board development programme, which was introduced for the senior management team. Board level posts and board members received an annual appraisal where professional development needs were identified and addressed.
- The trust had a distributed leadership plan that supported the overarching workforce and organisational development strategy. Succession planning and development of leaders was a priority for the trust and they had a leadership development programme.
- The trust had an efficient process for management of risk and quality. The trust had recently introduced a daily risk huddle this group reviewed risk items from the previous 24 hours which allowed immediate escalation of any risk issues. The trust had also implemented a weekly clinical risk management group. This group had oversight of briefings, investigations, escalation of issues and commissioning of thematic reviews.
- The trust had an extensive internal and external audit programme and plan to monitor quality and review risks. The trust held its first ever research and development conference in 2017, which was well received by trust staff and external attendees.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust policies described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution. Staff had the opportunity for development and progression. Most managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- The trust remained part of the sustainability and transformation partnership.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five points had no change and nine had changed negatively.

# Summary of findings

- Staff treated patients with compassion and kindness. Patients who used the services reported positive and inclusive relationships with the trust. Patients constantly recommended the trust as a place to receive care in the family and friends test between April 2018 and September 2018.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five which had no change and nine that had changed negatively. The trust recognised staff success by staff awards and through ongoing feedback.
- The trust had updated its complaints policy and all complaints were now completed within timescales.
- The trust had appointed a freedom to speak up guardian and a deputy. Both had dedicated time to undertake this role and this included speaking at the induction programme for new staff to highlight the service, training, local and national events and developing the strategy further
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust risk management policy, incident reporting policy, serious incident policy and freedom to speak up policy all described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- NHS improvements told us that the trust was proactive in using benchmarking data to develop cost improvements programmes. As at the last inspection all cost improvement programmes went through a robust internal assessment process, this process remained the same at this inspection.
- The Trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received.
- The trust was currently involved in 17 National Institute for Health Research projects and 17 non National Institute for Health Research projects.

However:

- At our last inspection in 2017, staff expressed risks and worries around staffing numbers, skill mix and change management. Some staff reported the same at this inspection especially in community health services for adults. Despite the trust board having a comprehensive programme of site visits, there was still a mixed picture from staff who at times felt that the directors were not visible enough.
- The trust had an equality and diversity policy but no strategy, this focused mainly on staff not service users and had no clear statement of what success would look like, this also lacked an operational plan to under pin its delivery. The trust's patient and carer experience strategy included consideration of equality and diversity.
- The trust were undertaking a shaping the vision – care services structure consultation. This had raised many anxieties in staff who felt that they had not been fully informed or consulted with. This included medical staff.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services. Children and young people were waiting over 18 weeks to receive treatment in some areas. Some information relating to the community child and adolescent mental health services on the trust website was out of date. The risk register had only been implemented two weeks pre- inspection in community health services for adults.
- There were still reported difficulties when working with the trade unions.

# Summary of findings

- Whilst the trust reached their overall target of 85% for mandatory training, some courses fell below this. Appraisals in all areas did not meet the trusts target. The trust's target rate for clinical supervision was 80%. As at 31 August 2018 the overall clinical supervision compliance was 77%.
- The electronic patient record system remained slow and had varied implementation with some staff creating local records.
- In mental health crisis and health based place of safety services there continued to be difficulty for the service to access medication out of hour due to the trusts contract with the community pharmacy.

## Ratings tables

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | Not rated | Inadequate | Requires improvement | Good | Outstanding |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| **Symbol *** | →← | ↑ | ↑↑ | ↓ | ↓↓ |
| Month Year = Date last rating published | | | | | |

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

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

### Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 |

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

## Ratings for a combined trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community | Requires improvement ↓ May 2019 | Requires improvement ↓ May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement ↓ May 2019 | Requires improvement ↓ May 2019 |
| Mental health | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 |
| **Overall trust** | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 |

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

## Ratings for community health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community health services for adults | Requires improvement →← May 2019 | Requires improvement ↓ May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement →← May 2019 | Requires improvement →← May 2019 |
| Community health services for children and young people | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Community health inpatient services | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| **Overall*** | Requires improvement ↓ May 2019 | Requires improvement ↓ May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement ↓ May 2019 | Requires improvement ↓ May 2019 |

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

## Ratings for mental health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Good ↑ May 2019 | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement →← May 2019 | Requires improvement →← May 2019 |
| Long-stay or rehabilitation mental health wards for working age adults | Requires improvement Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 |
| Forensic inpatient or secure wards | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement ↓ May 2019 | Requires improvement ↓ May 2019 |
| Wards for older people with mental health problems | Requires improvement Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 |
| Wards for people with a learning disability or autism | Requires improvement Jan 2018 | Good Jan 2018 | Outstanding Jan 2018 | Outstanding Jan 2018 | Good Jan 2018 | Good Jan 2018 |
| Community-based mental health services for adults of working age | Requires improvement Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 |
| Mental health crisis services and health-based places of safety | Good ↑ May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good ↑ May 2019 | Good ↑ May 2019 |
| Specialist community mental health services for children and young people | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 |
| Community-based mental health services for older people | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Requires improvement Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Community mental health services for people with a learning disability or autism | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Requires improvement Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Substance misuse services | Good Jan 2018 | Requires improvement Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 | Good Jan 2018 |
| **Overall** | Requires improvement →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 | Good →← May 2019 |

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

## Ratings for primary medical services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Field House Surgery | Good Nov 2017 | Good Nov 2017 | Good Nov 2017 | Good Nov 2017 | Good Nov 2017 | Good Nov 2017 |
| Hallgate Surgery | Good Jul 2017 | Good Jul 2017 | Good Jul 2017 | Good Jul 2017 | Good Jul 2017 | Good Jul 2017 |
| Market Weighton | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 |
| Northpoint Medical practice | Good Aug 2018 | Good Aug 2018 | Good Aug 2018 | Good Aug 2018 | Good Aug 2018 | Good Aug 2018 |
| Peeler House Surgery | Good Feb 2019 | Good Feb 2019 | Good Feb 2019 | Good Feb 2019 | Good Feb 2019 | Good Feb 2019 |
| Princess Medical Centre | N/A | N/A | N/A | N/A | N/A | N/A |
| Chestnut surgery | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 | Good Aug 2017 |

## Ratings for adult social care services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Granville Court | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 |

# Community health services

## Background to community health services

The trust provides three community health services these being

- Community health inpatient services.
- Community health services for children and young people
- Community health services for adults

We inspected community health services for adults at this inspection

## Summary of community health services

**Requires improvement** 

Our ratings of these services went down.

We rated community health services for adults as requires improvement in safe, effective and well led. This was the third inspection where this core service has been rated as requires improvement, and at this inspection effective has gone down one rating from good to requires improvement. This has led to an overall rating in community health services as requires improvement

# Community health services for adults

**Requires improvement** ➔➔

## Key facts and figures

Humber Teaching NHS Foundation Trust provided community health services for adults to the areas of Whitby, Pocklington, Scarborough and Ryedale. The services for Scarborough and Ryedale had moved from an alternative provider to Humber Teaching NHS Foundation Trust in May 2018.

Services offered included community nursing, physiotherapy, occupational therapy, dietetics, heart failure service, cardiac rehabilitation, respiratory, diabetes, tissue viability, continence, speech and language, stroke services and musculoskeletal (MSK) physiotherapy. A health trainer team supported people to live a healthier lifestyle, working across East and North Yorkshire.

The service was previously inspected in September 2017, when community services were only provided from Whitby and Pocklington.

The previous rating for community services for adults was requires improvement. Safe and well led were rated as requires improvement, effective, caring and responsive was rated as good.

At this inspection, the community health services for adults was inspected.

Our inspection was announced (staff knew we were coming) the day before our inspection, to ensure that everyone we needed to talk with was available.

We visited staff bases at Whitby, Scarborough, Malton and Pocklington. We spoke with 42 members of staff and six patients. We reviewed eight patient records. We accompanied staff on home visits and observed a musculoskeletal (MSK) clinic and dietician's clinic.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- There were inconsistencies in completion of risk assessments and care plans. In Scarborough and Ryedale, the appropriate templates were not yet on the electronic record and staff had not received training. Care pathways were not in place for specific conditions.
- There was no caseload management tool used to determine required staffing levels. Staffing levels at Whitby were low.
- Participation in audits and benchmarking was low. This had been identified at our last inspection and although the team at Whitby had started to introduce audits, others had not.
- Staff were not receiving regular documented supervision and appraisal compliance was low in some areas, particularly Whitby.
- Feedback from staff about leaders was mixed and there were questions about the experience of some leaders who were new in to post. Morale was variable and staff told us communication and engagement from senior management was poor, particularly with regards to the new services.
- Although the community services staff were all employed by Humber Teaching NHS Foundation Trust, staff did not see themselves as part of a wider team and there was little cross team working.

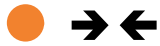
# Community health services for adults

- Issues identified at our last inspection had not been fully addressed. Although there had been some changes made in the Whitby team, these were recent changes and needed to be fully embedded.

However:

- Staff provided compassionate care and treatment to patients. Patients and their families were encouraged to be partners in their care.
- The health trainers service had good outcomes and supported people to live healthier lives.
- The service worked closely with commissioners to plan and deliver services to meet the needs of the local population.
- Governance systems were in place, with regular meetings taking place that ensured relevant information was fed down to practitioners and up to board level.

## Is the service safe?

**Requires improvement** 

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

- The service did not always manage patient safety incidents well. We found that action plans were not always completed in a timely manner. We found that following a serious incident investigation in the Whitby team in March 2018, not all the proposed actions had been completed or properly embedded. Target dates for completion were September 2018, but we found that some actions were not completed, such as regular documentation audits. Following our inspection, the provider told us there had been an agreement with the commissioners for extended timescales.
- Staff in all teams did not always complete and update risk assessments. There were inconsistencies in the completion of risk assessments and care plans. Staff told us in some areas were waiting for appropriate templates to be added to the electronic patient record and for training to be provided. The electronic patient record did not contain a prompt to remind staff that assessments needed to be completed and relied on individual practitioners setting themselves a reminder. There was variation in the standard of documentation and record keeping and regular documentation audits had not been completed, despite this being a recommendation following a serious incident.
- Although staff had the right qualifications, skills and experience to provide the right care and treatment; staffing levels were low, particularly in the Whitby nursing and therapy teams. Community nurse staffing levels in Whitby were low due to maternity leave and staff leaving. Therapy staffing levels in Whitby had significantly reduced, over the last few years, since the move from another provider, and this meant that there were some difficulties managing patients who required long term specialist rehabilitation.
- Community nurse staffing levels in Whitby were low due to maternity leave and staff leaving. Therapy staffing levels in Whitby had significantly reduced, over the last few years, since the move from another provider, and this meant that there were some difficulties managing patients who required long term specialist rehabilitation.

However:

- Staff understood how to protect patients from abuse and worked with other agencies to do so.
- The service controlled infection risk well. Staff adhered to arms bare below the elbows policy and followed infection control techniques when seeing patients in clinics or the home environment.

# Community health services for adults

## Is the service effective?

**Requires improvement**  

Our rating of effective went down. We rated it as requires improvement because:

- The effectiveness of care and treatment was not always monitored and findings used to improve. Participation in audits and benchmarking was limited. This had been highlighted as an issue at our previous inspection in September 2017. Although the therapy team at Whitby had started to undertake audits, elsewhere there was no audit plan in place and we saw no evidence of participation in national audits.
- The service did not always make sure staff were competent for their role. Regular appraisals and supervision were not taking place. There were gaps in management and support arrangements for staff, such as appraisal and supervision. Staff did not have regular documented supervision sessions and appraisal rates were low, particularly at Whitby. This had been highlighted as an issue at our last inspection in September 2017.
- Staff of different kinds did not always work effectively together as a team. Despite community teams being multi-disciplinary, consisting of nurses and therapists, some teams still worked as individual teams rather than as an integrated team.
- The service provided care and treatment based on national guidance. However, staff told us there were no pathways in place for them to refer to for the management of specific conditions, for example end of life care, wound care or falls. Senior leaders told us that pathways were available on the trust intranet for the tissue viability team and the falls pathway was under review. However, staff we spoke with could not show us any pathways and there was therefore a risk that patients would not receive consistency of care.

However:

- Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. Consent to care and treatment was obtained in line with guidance and where appropriate mental capacity was assessed and recorded.
- The health trainers weight management programme had achieved good outcomes.
- Patients were supported to manage their own health. The health trainers service supported people to live healthier lives.

## Is the service caring?

**Good**  

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

- Staff cared for patients with compassion. Staff treated patients with dignity, respect and kindness. They showed compassion.
- Feedback we received from patients was positive. Friends and family test (FFT) results were consistently positive.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families were involved and encouraged to be partners in their care. Staff spent time talking to patients and their families.

- Staff provided emotional support to patients to minimise their distress. Staff communicated and provided information in a way that people understood. Time was given for people to ask questions.

## Is the service responsive?

**Good** 

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

- The service planned and provided services in a way that met the needs of local people. They worked closely with commissioners.
- Specialist services were available for those patients with more complex needs. People's individual needs were considered. The service was meeting the accessible information standards.
- Waiting times were minimal. Therapy services in Whitby had improved their waiting times since our last inspection in September 2017. Although there were 1200 patients on a waiting list for musculoskeletal physiotherapy, this was being appropriately managed and any urgent referrals were being seen within two weeks.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Staff knew how to deal with complaints and leaflets were available to share with patients. Feedback from complaints was shared at team meetings.

## Is the service well-led?

**Requires improvement** 

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

- There had been changes in the service since our last inspection in September 2017, with the addition of community services for the Scarborough and Ryedale locality. Several of the service managers, team leaders and clinical leads were relatively new in post. Feedback from staff was mixed, some felt that their leaders did not have the experience to lead effectively. Staff in the central access team in Scarborough were unclear who their manager was.
- The culture did not always make staff feel supported and valued. There did not appear to be any consistencies in practice across the different localities. Despite being part of the same trust, there appeared to be no cross team working due to the commissioning of services by three different commissioners. Staff did not see themselves as part of a wider team.
- The service engaged with patients, but there was limited evidence of change following engagement. Feedback was collected via the friends and family test, but we saw no evidence of changes in practice due to patient feedback. Engagement with staff was variable. Morale was variable and in some areas, was particularly low. Although leaders told us they held ongoing engagement events with staff, some staff felt there had been poor communication from senior management and lack of engagement.
- Issues identified at our last inspection, such as lack of clinical supervision, no programme of internal or national audit, risk register not containing all risks and communication with staff, had not been dealt with in a timely manner as we found similar issues at this inspection.

However:

# Community health services for adults

- Governance systems and processes were in place. There were governance structures in place that ensured information was fed up to board level and down to community teams as appropriate.
- There was a new team leader in post in Whitby, who had recognised the work that needed to be done and had started to implement appropriate changes. The therapy team in Whitby had implemented changes following the last inspection.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health services

## Background to mental health services

The trust provides 10 of the core mental health services:

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

The trust also provides specialist substance misuse services.

## Summary of mental health services

**Good** 

We rated nine of the trusts 11 mental health services as good and two as requires improvement, and whilst the rating for acute wards for adults of working age and psychiatric intensive care units remained as requires improvement, the safe key question was now rated as good.

In rating the trusts mental health and learning disabilities services as good we considered the previous ratings of service not inspected at this time and deviated from the ratings principles.

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

**Requires improvement** 

## Key facts and figures

Humber NHS Foundation Trust provides inpatient acute and intensive care services for adults of working age with mental health conditions. Patients are admitted informally or detained under the Mental Health Act 1983.

The trust has four acute wards for adults who require hospital admission due to their mental health needs:

- Avondale is an acute assessment ward that provides assessment and treatment for a period of up to seven days for adults experiencing acute episodes of mental ill health who cannot be safely treated in other settings. It has 14 beds and treats both men and women. Patients who require care for more than seven days are transferred to alternative services within the trust.
- Mill View Court provides care and treatment to both male and female patients who are experiencing an acute episode of mental illness and crisis. From April 2018, Mill View increased provision from 10 to 15 beds.
- Newbridges provides care and treatment to males only who are experiencing acute mental illness and crisis. It has 18 beds primarily for males of working age. The ward is a standalone unit located in east Hull.
- Westlands provides care and treatment to females only who are experiencing acute mental illness and crisis. It has 18 beds primarily for women from age 16 to age 65. The ward is a standalone unit located in west Hull.

The trust also has a psychiatric intensive care service for men and women who present with higher levels of risk and require greater observation and support. It has a capacity of 14 beds but at the time of the inspection, due to staffing shortfalls, only 10 beds were available to admit patients.

Both Avondale and the psychiatric intensive care unit are based in Miranda House, which is on the outskirts of Hull city centre.

At the last comprehensive inspection in September 2017, we rated this core service as requires improvement overall, with the caring and responsive key questions rated as good, and the safe, effective and well led key questions as requires improvement.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and sought feedback from patients and staff at focus groups.

We visited all five wards between 8 and 10 January 2019.

During the inspection visit, the team:

- visited the wards, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- received 12 comments written on comment cards
- spoke with six carers of patients who were using the service
- looked at the care and treatment records for 19 patients
- spoke with the managers of each ward and a service manager

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

- spoke with 27 other staff including doctors, nurses, pharmacists, modern matrons, healthcare staff, occupational therapy assistants and service managers
- carried out a specific check of the medicines management on the wards
- observed one handover meeting and two multidisciplinary meetings

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always develop patient care plans which were holistic, recovery-oriented and personalised. Staff did not always carry out an assessment to determine if patients needed a personal alarm. They did not always adhere to the principles of the Mental Capacity Act when patients had capacity to make decisions for themselves and they did not always complete patients consent to treatment in a timely way.
- Staff did not have appropriate information for patients who identified as lesbian, gay, bi-sexual or transgender. Some of the measures the trust had taken to protect patients' privacy and personal details were not always effective.
- Governance processes were not effective in ensuring staff applied policy and practice consistently across the service and it was not always possible to tell from audit reports what improvements were required. The trust had not reviewed minimum staffing levels for the service. Staff did not feel supported or listened to by senior leaders.
- Staff did not always receive timely feedback when the trust investigated serious incidents. They did not have a robust system in place to share lessons learned with staff from incidents and complaints from across the wider trust.

However:

- They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The service provided safe care. Overall, the ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness. They respected their dignity and understood the individual needs of patients. They involved patients and families and carers in care decisions whilst maintaining patient confidentiality.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

## Is the service safe?

**Good** ↑

Our rating of safe improved. We rated it as good because:

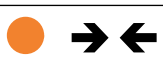
# Acute wards for adults of working age and psychiatric intensive care units

- Wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. Staff managed patient safety incidents well. They recognised incidents and reported them appropriately. Managers investigated incidents and discussed them frequently. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Whilst staff assessed and managed risk, staff did not always carry out an individual assessment to determine if patients needed access to a personal alarm.
- On Mill View Court, some medical devices had not been cleaned in line with the cleaning schedule and there were some gaps where we could not see that staff had checked the emergency equipment when they should have done.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service.
- Whilst the trust had carried out a safer staffing review, they had not reviewed minimum staffing levels for the service following this review.

## Is the service effective?

**Requires improvement** 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always develop individual patient care plans which reflected the assessed needs. They were not always personalised, holistic and recovery-oriented.
- We could not see evidence that staff assessed and recorded mental capacity clearly for patients who might have impaired mental capacity. Staff did not always know where to find information about a patient's capacity in the care record and some clinicians did not record capacity to consent to treatment for patients detained under the Mental Health Act.
- Some staff did not understand the process of best interest decision making and some staff were not clear that patients had the right to make unwise decisions for themselves when they had capacity.
- The trust had not carried out any audits on staff adherence to the Mental Capacity Act and the code of practice

However:

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

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Patients' access to advocacy was well embedded across all wards.

## Is the service caring?

**Good** 

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

- Staff treated patients with compassion, kindness and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately whilst maintaining patient confidentiality.

However:

- The measures the trust had taken to protect patients' privacy and personal details were not always effective.

## Is the service responsive?

**Good** 

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

- There had been an improvement in the way staff managed patient beds. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, and care needs. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy and separate lounges for female patients.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

- Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However:

- Staff did not have appropriate information for patients who identified as lesbian, gay, bi-sexual or transgendered.

## Is the service well-led?

**Requires improvement** 

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

- Some of the systems in place were burdensome for front-line staff. The electronic care records system was slow and not all staff knew where information was stored. Staff had been asked to report all incidents of patients smoking but staff thought this was unrealistic.
- Some systems and processes were not consistent across the service. The service was supposed to be smoke free but some patients continued to smoke unchallenged. Teams had different standard agendas for team meetings and different paper records for patients. Audit reports did not always identify what improvements were required.
- We did not see evidence that leaders shared lessons learned with staff from incidents and complaints which occurred in the wider trust or that staff shared lessons learned with each other across the different wards.

However:

- Managers at ward level had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. They were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in audit and quality improvement activities.

# Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

# Forensic inpatient or secure wards

**Requires improvement** 

## Key facts and figures

Humber NHS Foundation Trust provides forensic inpatients services at the Humber Centre for Forensic Psychiatry, which is a purpose-built hospital at Willerby hill in Hull. The service provides low and medium secure forensic services for mentally disordered or learning disabled male offenders and men with a personality disorder who require assessment, treatment and rehabilitation within a secure environment.

At the time of the inspection, the service comprised of five wards.

- Derwent ward is a medium secure ward providing care for up to 10 patients with complex mental health problems who require high levels of support, assessment and intervention. At the time of our inspection, the ward had nine patients.
- Ouse ward is a medium secure ward providing care for up to 14 patients who require less intensive support. At the time of our inspection, the ward had 13 patients.
- Swale ward is a medium secure ward providing care for up to 15 patients with personality disorders that are functionally linked to their offending and risk behaviours. At the time of our inspection, the ward had eight patients.
- Ullswater ward is a medium secure ward providing care and treatment for up to 12 patients with a learning disability and a diagnosed mental disorder. At the time of our inspection, the ward had 12 patients.
- Darley ward is a low secure ward providing care and treatment for up to eight patients who have not made the anticipated progress within traditional low-secure services, who may have been involved within services for a number of years. At the time of our inspection the ward had eight patients.

At the time of the inspection, the Humber Centre was going through a process of change. The ratio of medium to low secure beds had been subject to review and was due to change, moving to a higher number of low secure beds. Ullswater ward had plans to move from medium to low secure by April 2019. The timescale for completion of Swale ward to move from medium to low secure was unknown.

At the last comprehensive inspection in September 2017, we rated this core service as good overall, with the effective, caring, responsive and well led key questions rated as good, and the safe key question rated as requires improvement.

We visited all five wards between 23 and 25 January 2019. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services. Four carers and eight patients attended focus groups before the inspection and provided feedback on their experiences of the service.

During the inspection visit, the team:

- visited the wards, looked the quality of the environment and observed how staff were caring for patients
- spoke with six patients who were using the service.
- spoke with six family members by telephone.

# Forensic inpatient or secure wards

- looked at the care and treatment records for six patients including their positive behavioural support plans and restrictive intervention plans, five seclusion records, two long-term segregation records and six restraint records.
- spoke with ward managers, modern matrons, a service manager and an assistant director.
- spoke with 24 other staff including doctors, nurses, pharmacists, healthcare assistants, occupational therapists, associate practitioners, psychologists, a GP and administrators.
- observed a multi-disciplinary meeting, a reflective practice session and a morning meeting.
- attended and observed three activities with patients and staff.
- looked at policies, procedures and other documents related to the running of the service, including cleaning records, portable appliance testing, health and safety records.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- There were not always enough staff to maintain safer staffing levels on the wards. There was a frequent reliance on occupational therapy staff to support safe staffing levels. Patient leave was often cancelled due to staffing levels.
- There were not always timely responses to carry out maintenance and repairs on the wards. Showers on Ouse ward and one of the laundry rooms within the service had been out of use or awaiting repair since November 2018. Offensive graffiti on a window in Derwent ward had not been reported for repair or replacement.
- Governance processes did not operate effectively at ward level and across the service. There were ineffective systems in place to monitor actions from incident investigations and learning from incidents was not routinely shared with staff.
- Staff did not always document that required reviews had taken place for patients in seclusion. Whilst in seclusion, patients did not have personalised emergency evacuation plans in place.
- Staff observed all visits between patients and their family members and friends. This was not individually risk assessed.
- Carers did not always feel well supported, involved or informed about their loved one's care.

However:

- Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding
- Staff developed holistic, recovery-oriented care plans informed by comprehensive assessments. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received supervision and appraisal. Ward staff worked well together as a multi-disciplinary team and with those outside the wards who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

# Forensic inpatient or secure wards

- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharges were rarely delayed for other than a clinical reason.

## Is the service safe?

**Requires improvement** 

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

- There were not always enough staff to maintain safe staffing levels on the wards. There was a frequent reliance upon occupational therapy staff to maintain safer staffing levels.
- While staff recognised incidents and reported them appropriately, there was not a robust system in place to disseminate learning from incidents. Staff were unclear about actions arising from incident investigations and did not feel informed. De-brief sessions for staff did not always take place in a timely manner.
- Whilst wards were generally clean and well maintained, there was offensive graffiti etched into a window on one ward. This had been there for some time and had not been reported. Showers on Ouse ward and one of the laundry rooms within the service had been out of use or awaiting repair since November 2018.
- Visits between patients and their family and friends were always observed by staff. This was a blanket restriction and did not consider risks around visits on an individual basis.
- Staff had not always ensured that they were recording their responsibilities under the Mental Health Act Code of Practice relating to seclusion. Nursing and medical reviews were not always documented/occurring within the prescribed time frames. Patients in seclusion did not have individualised personal emergency evacuation plans in place.

However:

- Staff assessed and managed risks to patients and themselves well and generally achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Mandatory training rates had improved since our last inspection.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.

## Is the service effective?

**Good** 

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

# Forensic inpatient or secure wards

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multi-disciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The care plans included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff regularly explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired capacity.
- Staff completed thorough assessments of physical and mental health of all patients on admission and at regular intervals. Patients had access to the full range of specialists required to meet their needs, including physical health care.

However:

- There was a frequent reliance on using occupational therapy staff to support safer staffing levels on the wards. This meant that planned therapeutic activities could not always take place.

## Is the service caring?

**Good** 

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood individual needs of patients and supported patients' involvement in their care and treatment.
- Staff involved patients in care planning and risk assessment and sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Patients had been involved in a range of creative activities to improve the wards, including art projects and the creation of a DVD about life in the service.

However:

- Carers did not always feel involved or informed about their loved one's care. Family members did not feel they had been given enough information about the imminent changes to the security status on Ullswater and Swale wards which had caused them anxiety.

# Forensic inpatient or secure wards

## Is the service responsive?

**Good** ➔➔

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison.
- Patients had their own bedrooms and could keep their personal belongings safe.
- The wards met the needs of all people who used the service. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- Patients complained that the food quality was not always good and menus were repetitive and had not been changed for many years.
- Whilst concerns and complaints were investigated, there were ineffective systems in place to learn lessons from the results and share these with the staff team and the wider service.

## Is the service well-led?

**Requires improvement** ➔

Our rating of well-led went down. We rated it as requires improvement because:

- Our findings from the other key questions did not fully demonstrate that governance processes operated effectively at ward level. There were ineffective systems in place to ensure actions from incident investigations were completed and a learning from incidents was not routinely shared.
- Processes to share information with staff teams were not well developed. Ward level team meetings had no structured agenda which meant there was a wide variation in the content of the meetings and how these were documented.
- Ward level managers were frequently required to work across the wards as a result of staffing shortfalls. This meant that leadership capacity on the wards was reduced and impacted on the completion of management tasks.
- Two senior management posts were vacant and there were no plans to replace these as the management structures were being reviewed. This impacted upon the leadership capacity at a senior level, although some support was being provided by an assistant director.

However:

- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed.
- There were plans in place to implement ward governance meetings, with clear terms of reference and structured agenda format.
- Managers maintained a risk register, which generally reflected the concerns of staff.

# Forensic inpatient or secure wards

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

**Good** ↑

## Key facts and figures

Humber NHS Foundation Trust provides a mental health response service for the Hull and East Riding areas based at Miranda House in Hull.

The mental health response service is a single point of access into the trust's:

- community mental health services for adults
- inpatient services
- home based treatment
- improving access to psychological therapies
- counselling and psychology services
- early intervention teams
- addiction services
- trauma services
- eating disorder services
- perinatal services.

The service also signposts to third sector organisations and primary care.

The mental health response service works 24 hours a day, seven days per week. They provide home based treatment mainly between 8am and 8.30pm seven days per week and outside of these hours if required. The service aims to provide an alternative to an admission to hospital inpatient wards.

The service triages all referrals and then tailors the service provision to the patients' needs. This includes urgent mental health assessments and Mental Health Act assessments for people who could be a risk to themselves or others, including those at risk of severe self-neglect and those who are being considered for mental health hospital treatment. The service also provides non-urgent mental health assessments at assessment clinics across the Hull and East Riding areas. It also signposts and provides information to people and organisations about other services that can be accessed in the local areas.

The trust provides a health based place of safety at Miranda House for people detained under section 136 of the Mental Health Act.

The service gate keeps access to a crisis pad in Hull. The crisis pad is commissioned by the trust but is provided by an external organisation under a service level agreement.

At the last inspection, the core service was rated as 'requires improvement' overall. We rated the key questions 'safe' and 'well led' as 'requires improvement' and 'effective', 'caring' and 'responsive' as 'good'. At this inspection, we inspected all of the key questions.

Our inspection was short notice 'announced' one working day prior so staff knew we were coming in order to ensure that everyone we needed to talk to were available.

# Mental health crisis services and health-based places of safety

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- toured the care environments at the mental health response service and place of safety at Miranda House, and observed how staff were caring for patients
- completed six observations which included initial assessments, multidisciplinary team meetings, a medical review and a team meeting
- interviewed 13 staff members including the service manager, team leader, approved mental health professional, nurses, social worker, and health care assistants
- spoke with one former patients admitted to the place of safety
- spoke with two carers of patients using the mental health response service
- spoke with two patients using the mental health response service
- reviewed four patient records of patients using the mental health response service
- reviewed three patients records of patients who had used the place of safety
- reviewed a range of documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Managers made sure they had staff with a range of skills needed to provide high quality care.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.

# Mental health crisis services and health-based places of safety

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

However:

- Compliance with clinical supervision was low.
- There continued to be difficulty for the service to access medication out of hours due to the trust's contract with the community pharmacy.
- Staff did not always have access to equipment to enable them to complete physical health monitoring whilst on community visits.
- Two of the meeting rooms at Miranda house did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.
- Staff reported a lack of confidence in the trust to support them in raising concerns.

## Is the service safe?

**Good** ↑

Our rating of safe improved. We rated it as good because:

- Interview rooms and the health based place of safety were clean and well maintained.
- There were robust risk assessment and management processes in place and staff demonstrated a good application of risk management.
- Staff could identify safeguarding concerns and had effective working relationships with the local authority when raising concerns about a vulnerable adult or child.
- Staff were aware of what incidents should be reported and their duty in reporting these and in meeting the requirements of the duty of candour.

However:

- Staff did not always have access to equipment to enable them to complete physical health monitoring whilst on community visits.
- Staff did not record details of safeguarding concerns under the designated section of the electronic patient record.
- Staff were not all following the service protocol for lone working and staff practice varied with respect to who they would inform when they returned from a visit.

## Is the service effective?

**Good** →←

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

- Staff completed detailed assessments of patient needs including their physical health and mental health needs.

# Mental health crisis services and health-based places of safety

- Staff completed regular clinical audits including compliance with section 136 of the Mental Health Act and used these to monitor and improve the performance of the service.
- Staff provided a range of care and treatment interventions in line with national guidance.
- There was a full multidisciplinary team approach and staff worked closely with members of the mental health response team and external agencies including the police and ambulance service.

However:

- Staff prioritised patient care above the need to receive formal supervision and staff clinical supervision was low. There were informal methods of supervision available to staff.

## Is the service caring?

**Good** 

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

- We observed staff treating patients with respect and compassion.
- The service tried to capture the views of patients and carers who had accessed the service through a range of surveys.
- Feedback from the patient and carer surveys was almost entirely positive.

## Is the service responsive?

**Good** 

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

- The service had clear criteria to support the triage of patients to the most appropriate service
- The service regularly audited call volumes and adapted staffing to be available at peak times.
- The service ensured patients detained under section 136 of the Mental Health Act received prompt assessments and were detained for the shortest time possible

However:

- Two of the meeting rooms at Miranda house did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.

## Is the service well-led?

**Good** 

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

- Managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- Staff felt respected and supported by service managers and had the opportunities for development and progression.

# Mental health crisis services and health-based places of safety

- There were effective process to identify, understand, monitor and address current and future risks.
- Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

However:

- Staff informed us despite the service level agreement and patient directives being in place there continued to be difficulties in obtaining medication out of hours.
- Staff reported senior managers were not visible within the service. Staff reported a lack of confidence in the trust to support them in raising concerns.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

# Specialist community mental health service for children and young people

**Good** ➔➔

## Key facts and figures

Humber NHS Foundation Trust provide specialist community mental health services for children and young people up to 18 years of age for both East Riding of Yorkshire and Hull. The service is commissioned by two clinical commissioning groups.

The provision provided by Humber Teaching NHS Foundation Trust is made up of the following:

Contact Point

Contact Point provides a single point of access, that has been designed to improve the ease of access and availability of CAMHS for children, young people and their families.

The primary role of the Contact Point is to review and respond to all referrals and contacts by undertaking a robust telephone triage. Staff determine the most appropriate response to meet the needs outlined and if necessary signpost to other relevant services. Referrals accepted to a CAMHS clinical pathway are then passed to the core CAMHS teams for assessment and treatment.

Hull and East Riding have separate contacts points.

Core CAMHS

Following triage, children and young people are allocated to a team depending on their care pathway. Teams are as follows:

Hull team one:low mood, anxiety, early onset psychosis

Hull team two:conduct, Attention Deficit Hyperactivity Disorder, long term conditions, learning disabilities

Hull team three:deliberate self-harm, trauma

Hull autism team:autism assessment and diagnosis

East Riding team one:anxiety, depression, trauma, self-harm earl onset psychosis

East Riding team two:conduct, Attention Deficit Hyperactivity Disorder

The service has additional teams specifically for children and young people experiencing eating disorders, involved in the youth justice system and forensics. Teams operate from a variety of locations across Hull and East Riding

CAMHS Crisis Response Team

The crisis response team operates 24 hours a day, seven days a week. This element of the service is for young people (under 18) who are experiencing a mental health crisis, those who:

- are at risk of immediate and significant self-harm,
- are an immediate and significant risk to others due to their mental health,
- are being considered for admission to a mental health inpatient unit,
- are in acute psychological or emotional distress that is causing them to not be able to go about their daily activities, such as going to school and looking after themselves.

# Specialist community mental health service for children and young people

This team offers short-term help in the community until there is a resolution of the immediate crisis (usually within 3-7 days). They provide a timely response, working flexibly and tailor the intervention to meet the needs of the individual and family. The aim of this service is to prevent children and young people (under 18) from hospital attendance or admission if no medical intervention is required, keeping them at home with their families.

During this inspection, we visited and spoke with staff from Hull and East Riding contact point and core teams.

We previously inspected this core service between 11 April 2016 and 15 April 2016. The inspection report was published 10 August 2016. We found some areas for improvement. We rated the service as requires improvement in responsive. The service was rated as good for safe, caring, effective and well led.

This inspection was undertaken between 15 January 2019 and 16 January 2019. This inspection was announced on the day prior to attending. We inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- visited seven teams within two locations and looked at the quality of the environment
- spoke with five young people who were using the service
- spoke with seven carers of children and young people who were using the service
- spoke with the service manager and responsible clinician
- spoke with ten other staff members including nurses and healthcare support workers,
- looked at the care and treatment records of 13 children and young people
- observed one psychiatrist appointment
- observed one multi-disciplinary meeting and one multi-agency meeting
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff identified risks for children and young people from referral, whilst on waiting lists and whilst in treatment. They put plans in place to decrease or mitigate the risks; this included crisis plans where appropriate. Parents, carers, young people and other professionals knew what actions to take if there was a deterioration in health. Staff responded appropriately and promptly if this occurred.
- Staff knew how to protect children and young people from abuse. They recognised when people were suffering from significant harm. Staff had good relationships with external teams to assess holistic needs and if required, knew how to make safeguarding referrals.
- Teams included a full range of specialists required to meet the needs of children and young people. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with external organisations to provide additional support.

# Specialist community mental health service for children and young people

- Staff treated children and young people with compassion, kindness, respected their privacy and dignity and understood individual needs. They actively involved them and their families and carers in care decisions. Children, young people and their parents or carers had good opportunities to provide feedback on the service and be involved in service developments.
- Staff offered flexible times and locations for appointments including weekends and evenings. They responded promptly and appropriately when contacted by children, young people or their parents and carers and took positive steps to encourage those who found it difficult to engage.
- Managers were experienced and had good knowledge of the service. Staff felt supported and valued; they felt able to contribute to service improvements and raise concerns if needed. Governance systems ensured information was shared effectively amongst teams and with external organisations.

However:

- The service had long waiting lists above the NHS constitution of 18 weeks. This was mostly in Hull for the attention deficit hyperactivity disorder pathway.
- Room space was limited in the Beverley location in East Riding.

## Is the service safe?

**Good** ➔➔

Our rating of safe stayed the same. We rated it as good because:

- Staff identified and managed risks appropriately. They responded promptly to deterioration in a child or young person's health.
- The environments were clean, had good furnishings and were well maintained.
- Staff were mostly compliant with mandatory training requirements. They were booked onto courses where there had been previous difficulties in dates available.
- Managers recognised the requirement to improve staffing levels to respond to increases in autism referrals and long waiting lists. This was reflected in a recruitment drive to form a specific team for this care pathway.
- Staff recognised safeguarding concerns and the actions they needed to take when needed.
- Staff knew what constituted and incident and how to report these. They knew their responsibilities relating to duty of candour.

## Is the service effective?

**Good** ➔➔

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

- Staff carried out comprehensive assessments to identify the needs of the children and young people. Care plans reflected identified needs and were personalised, holistic and up to date.
- Staff delivered interventions in line with guidance and best practice. They participated in the evidence based Children and Young People's Improving Access to Psychological Therapies Programme.

# Specialist community mental health service for children and young people

- Staff were experienced and received specialist training to meet the needs of the children and young people using the service.
- Staff from different disciplines worked together as a team to benefit the child or young person. They supported each other to make sure there were no gaps in their care. Teams had effective working relationships with relevant services outside the organisation.
- Staff had a good understanding of the Mental Capacity Act and Gillick Competency and applied this to ensure children and young people had a sufficient level of understanding to make decisions. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

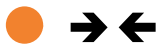
## Is the service caring?

**Good** 

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

- Staff provided positive support to children, young people and their parents or carers. They treated them with dignity and respect.
- Staff involved children, young people and their parents or carers in decisions around their treatment and their care plans.
- Staff promoted feedback from children, young people and their parents or carers to consider improvements.
- Children, young people and their parents or carers had good opportunities to be involved when appropriate in decisions about the service.

## Is the service responsive?

**Requires improvement** 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Children and young people were waiting over 18 weeks to receive treatment. This was mainly for those referrals for young people diagnosed with a learning disability or autism.
- Staff working from Beverley in East Riding experienced difficulties in finding room space.

However:

- Staff offered children and young people flexibility for their appointments in terms of location and times. They took steps to engage with those who found it difficult or were reluctant attend.
- Staff responded promptly and appropriately when children, young people, their carers or parents contacted the service.
- Staff worked closely with schools, families and external organisations to establish and maintain engagement and relationships with the wider community.

# Specialist community mental health service for children and young people

## Is the service well-led?

**Good** 

Our rating of well-led stayed the same. We rated it as good because:

- Managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and supported staff.
- Staff knew and understood the trust's vision and values and their behaviours reflected these.
- Staff felt respected, supported and valued amongst their teams.
- The service had systems and processes in place to ensure information was shared effectively.

However:

- Some information relating to the service on the trust website was out of date.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

**This guidance** (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment |

# Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led this inspection. We had access to one executive reviewer on this inspection, one who was a director of people. We also used a specialist advisor who had previous experience as a board level director.

We also used two specialist advisors, who had expertise in safeguarding and equality and diversity.

The inspection team covered five core services and included 10 inspectors, one inspection manager, two Mental Health Act reviewers, an assistant inspector, an analyst, a pharmacist and specialist advisers. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.