Humber NHS Foundation Trust

Adult community-based services (mental health)

Quality Report

Willerby Hill,
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Willerby Hill	RV936	Newbridges – Recovery Intervention Team	HU9 2BH
Willerby Hill	RV936	Haltemprice - Recovery Intervention Team	HU10 6UE
Willerby Hill	RV936	Beverly Health Centre - Recovery Intervention Team	HU17 BZ
Willerby Hill	RV936	John Symons House Recovery Intervention Team	HU2 8TB
Willerby Hill	RV936	Psychosis Service for Young People in Hull and East Riding (PSYPER)	HU6 8QG

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Humber NHS Foundation Trust delivers adult community-based services in partnership with the local authority. Services include: the recovery intervention team; the adult community recovery and psychological team; and the psychosis service for young people in Hull and East Riding (PSYPHER).

Staff were aware of safeguarding policies and knew how to protect people from abuse, as well as who to contact in the safeguarding team. Staff had also received training on incident reporting. Safeguarding and other incidents were discussed in team meetings and supervision sessions.

The trust's risk register identified capacity issues within community teams. There were high referral rates and long waiting lists ranging from 80 to 120 people in some areas. The trust told us that there were plans to try and reduce this risk. Staff told us that they had high caseloads and that it was difficult meeting demand. They also said that this resulted in them working overtime. Documentry information provided by the trust showed that some staff had high case loads.

We found that staff assessed people using a range of risk assessments, including the Galatean Risk Screening Tool (GRIST), recovery plans and care plans. People told us that they received good care, and that the multidisciplinary teams worked well together.

Community teams stated they had to print out information about people as there were three different electronic systems in use. This meant that there was a risk that information might be out of date.

Summary of findings

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

Are services safe?

Staff had received safeguarding training and knew how to protect people from abuse. They also knew about safeguarding policies and processes. Staff were also trained in incident reporting and knew how to record incidents electronically. The trust cascaded lessons learnt for staff to discuss locally.

Are services effective?

People who use services had risk and relapse plans in place. These were linked to their care plans, which were reviewed regularly. The Recovery Star model was used to support people to track the progress of their recovery. Audits were carried out and the results discussed as part of continuous learning in supervision and team meetings. The multidisciplinary teams worked well together.

The trust reported that the Local Authority and Health Staff are on separate IT systems, all patients are on the MH system, all staff can see both systems and there is a single integrated paper record that all staff can access and write in. The trust had three types of electronic records systems in place, but the community teams reported they could not access all three, staff had to print out information. This meant that there was the risk that information may not be up to date.

Are services caring?

People told us that they were treated with dignity and respect. We saw that people had access to appropriate literature and information. Staff were skilled and knowledgeable, and people told us that there was good team working and that they felt involved in their care.

Are services responsive to people's needs?

People and staff told us that there was a range of therapeutic and social activities available. Crisis and care plans were reviewed regularly.

An increase in referrals had led to waiting lists as the community teams did not have enough staff to cope with demand. This had been recorded on the trust's risk register and there was an action plan in place to deal with it.

Summary of findings

Are services well-led?

Staff were aware of the trust's vision. The multidisciplinary teams worked well together and there was good leadership and support from local line managers. In addition, there was managerial and clinical supervision in place to support staff, and personal development plans were being used.

Staff had access to training and development. They also had an understanding of the whistleblowing policy and were confident in using it, if required.

Summary of findings

Background to the service

Humber NHS Foundation Trust delivers adult community-based services in partnership with the local authority. The teams comprise nurses, social workers, occupational therapists, psychologists, care officers and psychiatrists. Services include:

- Recovery intervention team (Newbridges) – the team provides community-based support for people who are experiencing psychosis. The team use assertive outreach ways of working.
- Adult community recovery and psychological team (John Symons House, Haltemprice CMHT and Beverly Health Centre) – this is a community-based service that works with people who have mental health problems, such as severe or chronic depression, anxiety, personality disorders.
- Psychosis service for young people in Hull and East Riding (PSYPER) – this is a trust-wide early intervention service for people experiencing psychosis for the first time for people aged 14 to 35.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur, Inspection Manager, Care Quality Commission (CQC, Mental Health) and Cathy Winn, Inspection Manager, CQC (Community Health Care).

The team included CQC inspectors and a variety of specialists including: Mental Health Act commissioners, psychiatrists, a specialist registrar, a student nurse, nurses including a specialist palliative care nurse and children's nurses, occupational therapists, psychologists, social workers, a community hospital manager, a therapies manager, a district nursing specialist practitioner, a respiratory nurse specialist, hospital managers, a GP and Experts by Experience who had used the service or were a carer of someone using a service.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health services inspection programme.

How we carried out this inspection

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

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

We carried out an announced visit to the adult community-based services on 20 to 23 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We observed how people were being cared for and reviewed their care or treatment records. We also met with people who used services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider's services say

People who used services said that staff treated them with dignity and respect. The multidisciplinary team communicated well with each other and worked well together. They told us that staff were compassionate and caring.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should continue to work with key stakeholders and take active measures to reduce waiting lists in community mental health services.

Humber NHS Foundation Trust

Adult community-based services (mental health)

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Newbridges – Recovery Intervention Team	Willerby Hill
Haltemprice - Recovery Intervention Team	Willerby Hill
Beverly Health Centre - Recovery Intervention Team	Willerby Hill
John Symons House Recovery Intervention Team	Willerby Hill
PSYPER	Willerby Hill

Mental Health Act responsibilities

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

We did not monitor the MHA in this core service or meet with people under Community Treatment Orders. Staff were aware of the MHA and had received appropriate training.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not monitor the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS) in this core service. Briefings in the trust had taken place in relation to the Cheshire judgement and its implications. People were reassessed if it was thought that the judgement may have impinged on them. Staff did have access to training and stated they would like further training.

Are services safe?

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

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

Summary of findings

Staff had received safeguarding training and knew how to protect people from abuse. They also knew about safeguarding policies and processes. Staff were also trained in incident reporting and knew how to record incidents electronically. The trust cascaded lessons learnt for staff to discuss locally.

Our findings

Track record on safety

Capacity to undertake an increasing caseload was an identified risk. The trust's risk register recorded that capacity within community teams was a concern. The community team reviewed the risks at least quarterly and provided updates to the senior managers. An incident form was completed every time a person could not be allocated from the waiting list so that an audit trail could be maintained. Staff told us they were working hard, but the number of referrals had increased and this had impacted on waiting times.

Staff described how risks and safety of home environment was assessed. The records we saw documented assessments for potential risk and plans against the risk of a relapse. Safety of the person's home environment was assessed for both the person using the service and for staff entering homes.

Learning from incidents and improving safety standards

The trust had an electronic incident reporting system called 'Datix' for reporting any incidents, concerns or near misses. Staff told us that they knew how to report incidents and had been trained in the software system being used.

Risks were documented and this information formed management plans. Staff were not aware of any serious untoward incidents, but were able to give us an example of an incident that had occurred in the last six months that related to verbal aggression. Staff completed an incident form and the intervention plan was modified to take account of the risks. The risks were monitored and reviewed.

Staff told us they had seen briefings about the recent Deprivation of Liberty Safeguards (DoLS) high court judgement and that they have been asked to re-assess people as a consequence.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff were trained in safeguarding vulnerable adults and children. The staff we spoke with were knowledgeable about their responsibilities in regards to safeguarding, and had made appropriate safeguarding referrals, although we were told that these incidents did not happen frequently. We saw documentation that demonstrated that the trust's Board had an overview of the safeguarding across the trust.

Prompts relating to safeguarding were identified at initial assessment, multidisciplinary meetings and Care Programme Approach (CPA) meetings. Staff informed us that safeguarding was managed well, that they knew the process and who to speak to, and that the safeguarding team was accessible. Staff told us that there were also good relationships and accessibility to the police. Staff said they had an opportunity to discuss safeguarding during multi-disciplinary meetings, and during supervision meetings with managers, to share learning.

There was a lone working policy and procedure in place, which staff told us was working well. We saw that people's whereabouts were recorded when out of office, and that the duty worker was responsible for ensuring those out had returned safely.

Records management

The trust reported the Local Authority and Health Staff are on separate IT systems, all patients are on the MH system, all staff can see both systems and there is a single integrated paper record that all staff can access and write in.The community team reported recorded information on a different system to the main trust and printed off information for psychiatrists and other team members, this potentially led to the risk of information not being up to date when professionals viewed progress.

Are services safe?

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

Assessing and monitoring safety and risk.

Assessments were carried out using a range of tools, such as the Galatean Risk and Safety Tool (GRiST), and were reviewed regularly. The assessments were translated into risk plans. We saw good multi-agency working in reviewing and monitoring risk plans.

Understanding and management of foreseeable risks

We looked at records and found that assessments for potential risk, and plans against the risk of a relapse, fed into case notes and care plans well. Safety of the person's home environment was assessed for both the person using the service and for staff entering homes.

Are services effective?

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

Summary of findings

People who use services had risk and relapse plans in place. These were linked to their care plans, which were regularly reviewed. The Recovery Star model was also used to support people to track the progress of their recovery. Audits were carried out and the results discussed as part of continuous learning in supervision and team meetings. The multidisciplinary teams worked well together.

Our findings

Assessment and delivery of care and treatment.
Care and treatment was provided in the form of a range of groups, for example. Dialectic Behaviour Therapy (DBT) was provided by the staff although it was not funded by commissioners. While it was resource and time-demanding, staff and people who use services reported positive outcomes. Family therapy and recovery groups were also provided. We were informed that an 'Emotions' groups was being planned and a 'hearing voices group' took place. Occupational therapists ran groups, such as the gardening and allotment project, and supported activities of daily living such as cooking to promote people's independence.

Outcomes for people using services
The trust's Recovery star process was in place and recorded at the beginning and end of treatment, so that people using services could see the progress they were making. We saw interventions, such as participation in recovery skills group, being scored within the Recovery star and completed online. Staff told us that this tool was discussed during their staff supervision sessions to track people's progress.

Systems were in place so that outcomes for people could be reviewed and improved. Care plans had monthly electronic audits completed by Band 7 nurses, and this was now being developed to involve other people, such as medical staff. Staff told us that audits, for example of case notes and capacity and demand, were undertaken and the results of these were used in team meetings and lessons learnt were discussed to improve practice.

Staff reviewed individual care plans depending on people's needs.
Staff identified that a person's mental capacity was documented if it was not present. They knew who to talk to and discuss issues about mental capacity. The Mental Capacity Act (MCA) 2005 was part of staff's mandatory training.

Staff, equipment and facilities
Supervision meetings were held with staff and their line managers to support them in their role and their development. Staff described the supervision arrangements as good and said that they had direct supervision with a senior social worker, which occurred monthly. Supervision with a psychologist and peer supervisor occurred when required.

Managerial supervision was provided monthly and caseloads were reviewed. Difficult cases were discussed. Time management and training was discussed within managerial supervision meetings.

Training was provided to staff in the trust and in the local authority and were described as good by staff. Training on the MCA, safeguarding, DoLS and the Mental Health Act (MHA) 1983 was provided by the local authority. The trust's intranet advertised the training available and managers encouraged attendance.

The recovery star tool is used to assess outcomes by encouraging people who use the services to track their progress with staff.

The trust had three types of electronic records systems in place, but because the community teams could not access all three, staff had to print out information for psychiatrists. This meant that there was the risk that information may not be up to date when making decisions.

Multidisciplinary working
We observed a multidisciplinary meeting and staff reported that multidisciplinary teams were working openly and jointly well together. People using services were always present at multi-disciplinary meetings and were expected to attend. Staff attending multi-disciplinary meetings also spent time discussing referrals and making plans. Staff gave examples of how they linked with voluntary organisations when needed. People told us that they felt other professionals knew about them and that there was good communication among team members. This was helpful if the key worker was not available.

Are services effective?

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

People using services and staff said that the key worker communicated well with the GP. Staff told us that there was good liaison with the crisis team, who prepared and introduced people to them.

Mental Health Act (MHA) 1983

The CQC inspection team did not did not monitor the MHA. The community teams do manage people on Community Treatment Orders (CTOs), but they did not come forward to speak to us. The community teams reported that the numbers of people on CTOs were increasing and that this also impacted on their caseloads.

Mental Capacity Act (MCA) 2005

Staff had received training on the MCA and DoLS and following the Cheshire West Ruling on 19 March 2014 , but they described this as an area where more training was required as they were still unsure about it.

Are services caring?

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

Summary of findings

People told us that they were treated with dignity and respect. We saw that people had access to appropriate literature and information. Staff were skilled and knowledgeable, and people told us that there was good team working and that they felt involved in their care.

Our findings

Kindness, dignity and respect

People who used services and carers described being very well looked after by the service. They named staff and made comments such "x saved my life. Listened to me, believed in me, notices what's going on for me". People said that their psychiatrist was really good, and that the team maintained good contact with people in the community. Staff were described as caring and responsive. People had access to appropriate literature and information.

People using services involvement

Staff reported, and people told us, that involvement of people using the service in their care planning was promoted. People said that the staff and care plans respond to their needs. Where there was dissatisfaction, care plans were reviewed and the rationale underpinning them was explained to the service user. People and staff stated that there was strong emphasis on promoting independence and setting realistic goals.

Staff and people explained that feedback was encouraged. The trust used a satisfaction survey called Meridian, which provided real-time feedback to the staff about people's view of the services.

Emotional support for care and treatment

People who use services reported that staff were responsive to their requirements and maintained contact with them, providing good information and emotional support. We saw evidence of the involvement of Independent Mental Capacity Advocates with people who used services.

Carers were involved in individual care plans. We saw evidence of thorough carer assessments on case notes and were told that there was a carer's centre on Monday to Friday to support carers.

Are services responsive to people's needs?

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

Summary of findings

People and staff told us that there was a range of therapeutic and social activities available. Crisis and care plans were reviewed regularly.

An increase in referrals had led to waiting lists as the community teams did not have enough staff to cope with demand. This had been recorded on the trust's risk register and there was an action plan in place to deal with it.

The trust reported he Local Authority and trust staff were on separate IT systems .all patients are on the MH system, all staff can see both systems and there is a single integrated paper record that all staff can access and write in.The trust had three types of electronic records systems in place, the community teams reported they could not access all three, staff had to print out information. This meant that there was the risk that information may not be up to date.

Our findings

Planning and delivering services

Care plans seen were holistic with people's social, medical, mental health, leisure and personal interests taken into account.

Care and treatment was provided in the form of a range of groups, for example. Dialectic Behaviour Therapy (DBT) was provided by the staff although it was not funded by commissioners. While it was resource and time-demanding, staff and people who use services reported positive outcomes. Family therapy and recovery groups were also provided. We were informed that an 'Emotions' groups was being planned and a 'hearing voices group' took place. Occupational therapists run groups, such as the gardening and allotment project, and support activities of daily living to promote independence.

People using services had started their own support groups one afternoon a week and a service user forum was about to be started by the trust.

Right care at the right time

The trust was aware that capacity in community mental health teams was a risk, and it was on the trust's risk register, with an action plan to mitigate the issues. The risks were reviewed by the Board.

Referrals to the team came though single point of access and were increasing. Telephone triage was in place, although staff may pick up referral and direct to the relevant place when they were in the office. Some people may be referred to and be seen by the Improving Access to Psychological Therapies Programme (IAPT) service, some people may be transferred internally. The single point of access was used to see people for no longer than six sessions.

The number of referrals had been increasing, resulting in significant waiting lists, with people waiting for just over a year in some cases. The number of people waiting ranged from 80 to 120 people across the teams. Staff told us that they did not have the capacity to deal with demand resulting in staff coming in on overtime at weekend to help deal with the caseload and waiting lists. People on the waiting list were informed that the team or GP could be contacted. Community staff and administrative staff described the impact of responding to many people who rang in a distressed state, requesting services, when the waiting lists were high.

To try and reduce the waiting list, the trust had introduced a clinic triage service. A member of staff was reviewing the waiting lists and the appropriateness of referrals, directing people to services that best met their needs. Referral meetings were then held to discuss referrals.initiatives included saturday morning waiting list clinics

Waiting lists for physiotherapists were approximately one year and we were informed that there were difficulties in recruiting physiotherapists and occupational therapists to the area.

The crisis intervention plan was clear and worked well. We saw an example of a letter for people to take when they had to attend the accident and emergency department.

Crisis and care plans were reviewed every three months. We saw risk and relapse plans in place and these were more frequently reviewed and responsive to need.

The trust reported that the Local Authority and trust staff are on separate IT system, all patients are on the MH

Are services responsive to people's needs?

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

system, all staff can see both systems and there is a single integrated paper record that all staff can access and write in. The trust had three types of electronic records systems in place, but because the community teams could not access all three, staff had to print out information. This meant that there was the risk that information may not be up to date.

Care pathway

The key worker coordinated the care plan, and the emphasis was to prevent admissions and minimise out-of-hours admissions. We found good care plans and discharge plans. People who used services stated they were always able to speak with someone and had a clear plan with the key worker. People told us that their care plans were discussed with them and were simple and easy to follow, the fact that as few people as possible were involved in the care was helpful.

Learning from concerns and complaints

People who used services told us they knew how to contact patient advice and liaison service (PALS) or were directed to them staff. Information leaflets were available and given to people. Complaints were discussed with complainants by staff. People told us that their concerns were addressed and the community teams were responsive. Staff reported the most common complaint was that they were not always accessible.

The number of complaints was low, four examples were given by staff, and these related to two complaints about the cancellation of appointments; these were reviewed by two senior clinicians. It was found that correspondence had been sent about the cancellations. In another instance, a person had asked how to make a complaint and this had been facilitated. In all cases the teams reported that complaints were taken seriously resulting in a review of the persons care plan in order to be more responsive and discussed in team meetings to analyse lessons learnt.

Are services well-led?

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

Summary of findings

Staff were aware of the trust's vision. The multidisciplinary teams worked well together and there was good leadership and support from local line managers. In addition, there was managerial and clinical supervision in place to support staff, and personal development plans were being used.

Staff had access to training and development. They also had an understanding of the whistleblowing policy and were confident in using it, if required.

Our findings

Vision and strategy

Staff reported that key messages about the trust were communicated to them via team meetings, emails and bulletins. Staff indicated that while messages were cascaded to them, they were not always aware that messages went to senior managers. They told us that senior managers and the Board members were known to them.

Community teams described working 'above and beyond' what was required, in view of the increased demand and capacity issues, and that their teams supported each other to deliver the maximum service. Staff spoke passionately about the work they did and how rewarding it was.

Responsible governance

Performance of the service was monitored in order to drive improvement through a range of audits. Arrangements for clinical supervision and managerial supervision were in place to discuss caseloads and learning from incidents, complaints and audits. We saw that audits of records and documentation were regularly undertaken, using the 'defensible documentation audit tool'. This audit process did not extend to electronic records and some staff said they had not received feedback following the defensible documentation audits.

Leadership and culture

Community teams stated they used peer group support to maintain morale. Staff described enjoying working in a friendly, supportive and productive environment.

Staff described the local line management as supportive and told us that general managers were visible. Staff described their supervision arrangements as good. For example, if a care plan was breaking down, then a staff member could approach a colleague or supervisor for immediate supervision. Equally time could be booked in to discuss with a doctor. We looked at supervision records and we saw that formal supervision meetings took place weekly.

Staff told us that they had an annual personal development plan and were supported in their training and development by managers. Existing skills were looked at to identify learning needs. One staff member described having coaching sessions with a director, another had manager had started action learning sets with modern matrons and a manager, as part of continues learning for improvement.

Engagement

Staff were aware of the whistleblowing policy and would use it. A copy of the policy was available on the trust's intranet site. The teams actively sought feedback by asking people to the Meridian satisfaction surveys. Staff were knowledgeable about how to access advocacy services for people.

Performance improvement

A stress management plan was in place following the staff stress survey to manage stress levels We saw that the teams invested time and resources into supporting staff. Staff we met with understood their roles, aims and objectives in regard to improvement and learning. We saw that monthly team meetings focussed on maintaining a high quality of service delivery and improving ways of working.