# Humber NHS Foundation Trust

## Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

## Facts and data about this trust

Humber NHS Foundation Trust provides a range of community and inpatient 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 and Whitby. The trust serves a large geographical area with a population of 600,000 and it employs approximately 2650 staff at sites at locations across the catchment area.

Humber NHS Foundation Trust became a foundation trust in 2010.

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 provide specialist substance misuse services.

The trust provides community health services:

- Community health adult services.
- Community inpatient services.

The trust has recently acquired five GP practices:

- Field House Surgery
- Hallgate Surgery
- Market Weighton
- Northpoint Medical Practice
- The Chestnuts Surgery

It also has one adult social care location at Granville Court

## Registered locations

The trust had 15 locations registered with the CQC (on 4 October 2017).

| Registered location | Code | Local authority |
|---|---|---|
| **Field House Surgery** | RV9Y4 | East Riding of Yorkshire |
| **Granville Court** | RV929 | East Riding of Yorkshire |
| **Hallgate Surgery** | RV9X9 | East Riding of Yorkshire |
| **Hawthorne Court** | RV941 | East Riding of Yorkshire |
| **Maister Lodge** | RV938 | Kingston-upon-Hull |
| **Market Weighton** | RV9Y1 | East Riding of Yorkshire |
| **Millview** | RV942 | East Riding of Yorkshire |
| **Miranda House** | RV945 | Kingston-upon-Hull |
| **Newbridges** | RV934 | Kingston-upon-Hull |
| **Northpoint Medical Practice** | RV965 | Kingston-upon-Hull |
| **The Chestnuts Surgery** | RV9Y3 | East Riding of Yorkshire |
| **Townend Court** | RV915 | Kingston-upon-Hull |
| **Westlands** | RV933 | Kingston-upon-Hull |
| **Whitby Hospital** | RV9X8 | North Yorkshire |
| **Willerby Hill** | RV936 | East Riding of Yorkshire |

## Bed Numbers

The trust had 238 inpatient beds across 18 wards, none of which were children's mental health beds. The trust also had 40 outpatient clinics a week and 139 community clinics a week.

| | |
|---|---|
| **Total number of inpatient beds** | 238 |
| **Total number of inpatient wards** | 18 |
| **Total number of day case beds** | 0 |
| **Total number of children's beds (MH setting)** | 0 |
| **Total number of children's beds (CHS setting)** | 0 |
| **Total number of outpatient clinics a week** | 40 |
| **Total number of community clinics a week** | 139 |

We carried out a comprehensive inspection of the trust in April 2016. We found that the trust was in breach of six regulations for which we issued requirements notices and in breach of a further

two regulations which we issued warning notices for. We told the trust they must make the following improvements

- The trust must urgently review their rapid tranquilisation policy which was dated for review in February 2016 and their safeguarding children policy which was due for review in March 2016.
- The trust must ensure that mandatory training reaches its compliance rate of 75% in all services.
- The trust must ensure that suitable and trained members of staff are deployed to fill their current vacancy rates.
- The trust must ensure that accurate, complete and contemporaneous patient records are kept.
- The trust must ensure that all records, electronic or paper based, are accurate, up-to-date, fit for purpose.
- The trust must ensure that the trust has an effective governance system in place to include the assurance and auditing of systems and processes, to asses, monitor and drive improvement in the quality and safety of the services provided.
- The trust must urgently review the access to toileting facilities whilst patients are in seclusion when they are displaying settled behaviour.
- The trust must ensure that all staff are trained in the use of seclusion and ensure that adherence to trust and national guidance addresses how, when and by whom the clinical reviews are undertaken
- The trust must ensure that physical health monitoring is undertaken whilst patients are in seclusion.
- The trust must ensure that they provide patients with sufficient activities to aid their recovery.
- The trust must ensure that the persons employed by the services receive such support training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that staff have an understanding and feel engaged with the trust vision and strategy.
- The trust must ensure that interventions where service users were controlled or restrained are subject to review to ensure these were necessary to prevent, or a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint.
- The trust must ensure that restrictive practices within the forensic and acute mental health services are reviewed.

We have reviewed evidence in relation to these areas of improvement at this inspection (October 2017).

## Is this organisation well-led?

### Leadership

The trust board along with the council of governors set the strategic goals and objectives for the organisation. They monitored how the trust was performing against these objectives and made sure appropriate action was taken where necessary.

The trust board and senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. The trust board had 13 members, made up of executive and non-executive directors. The board had undergone some changes over the last 12 months with some additions of both executive and non-executive directors, including the substantive appointment of a new chief executive and a non-executive director with significant experience in the mental health field.

Providers must take proper steps to ensure that their directors (both executive and non-executive) or equivalent, are fit and proper for the role. The fit and proper person requirement was one of the regulations that was applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information.

Those who are unfit would include individuals on the children's or adults' barred lists. They must not be prevented from holding a director's post under other laws such as the Companies Act or Charities Act.

We reviewed two executive directors' personnel files and two non-executive directors' personnel files, which contained evidence that the directors had the skills, knowledge and experience required to lead effectively. They included a checklist with tasks such as self-declaration, interview notes, a curriculum vitae and supporting statement as well as evidence of a current disclosure and barring service check. The trust's own process for assuring themselves that directors were fit and proper were effective.

The trust had a workforce and organisational development strategy 2017-2022, which underpinned the trust's overall strategy. The aspiration of the strategy was 'to have a healthy organisational culture; a capable and sustainable workforce; and effective leaders and managers who are at the heart of achieving our vision and our organisational values'. The strategy was set out into four areas:

- Healthy Organisational Culture
- Capable & Sustainable Workforce
- Effective Leadership & Management
- Enabling Transformation & Organisational Development

These all dovetailed into the vision, values and mission of the trust. We were satisfied that this was being implemented effectively.

The trust had a Pharmacy Strategy that ran to 2018. Most of the objectives had been achieved except the purchase of a community pharmacy that had now been cancelled. Earlier this year the trust had an external review and had implemented an action plan to address issues identified.

Workforce planning for the pharmacy department was challenging because they were a small team covering a large geographical area. An external pharmacy chain supplied medicines. Clinical pharmacists covered all inpatient wards.

The chief pharmacist was the chair of the drugs and therapeutics committee and antibiotic prescribing steering group.

The medicine safety officer attended the clinical risk management group weekly. This was attended by care group directors and the director of governance. This ensured that pharmacy issues were communicated regularly to the senior leadership team.

The trust had a programme of board visits to services. We saw a timetable of visits, which showed that different executives and non-executive leads had visited some services. This programme of visits showed dates through 2016 -2017 and the non-executive directors confirmed that a further programme of visits was confirmed for 2017-2018.

We undertook a number of focus groups and staff interviews and there was a mixed picture as to whether all staff were aware of the board or senior leaders within the trust. Some felt that the board were highly visible and they had met them in their working area on the programme of visits, but others felt that they did not really know any higher management beyond their directorate care director and were not aware of members of the executive and non-executive teams visits to clinical areas.

A new national leadership development framework 'developing people – improving care a national framework for action on improvement and leadership development in NHS funded services' was published in December 2016 by a coalition of teams across health and social care.

The practice of identifying, developing and supporting a current and future pipeline of compassionate, inclusive leaders was recognised as a condition for success and was one of the key components of the framework. This framework has three main parts, succession planning, selection and development and support.

The trust's distributed leadership plan was aligned to the trust strategic objectives and the national leadership developmental framework. It was agreed at the May 2017 board and the deputies' forum was asked to identify the key priorities for the next 12 months aligned to the trust strategy.

The aim was to create an environment where everyone contributed to the success of the organisation. The leadership development programme focussed around supportive leadership and management, behaviours for Bands 7 and 8a and clinicians and managers with a combination of taught sessions and action learning sets.

This training included six modules: Health/Wellbeing; Leadership/Management; Teams/Team Working; Managing Change; Persuasive Communication; Corporate Credibility. Staff were also able to access the leadership academy and local Universities' programmes. Development needs were identified through appraisals. At the time of inspection, 25 staff had commenced this training, however the trust had a programme to roll this out further.

Succession planning was undertaken by the remuneration and terms of service committee for board level posts and board members received an annual appraisal where development needs were identified and addressed. The council of governor's terms and conditions committee was responsible for the review of non-executives, which included identifying skills, knowledge, experience and diversity.

The executive board had 17% black and minority ethnic members and 67% women.
The non-executive board had 0% black and minority ethnic members and 29% women.

| | BME % | Women % |
|---|---|---|
| Executive | 16.7% | 66.7% |
| Non-executive | 0.0% | 28.6% |
| **Total** | 7.7% | 46.1% |

## Vision and strategy

The trust had a clear vision and set of values based on quality and sustainability. The trusts vision was 'we aim to be a leading provider of integrated health services, recognised for the care, compassion, and commitment of our staff and known as a great employer and valued partner'.

Staff were consulted on and agreed to a new set of core values which were caring, learning and growing. The trust used this as their strap line for the new strategy and this was visible on trust literature and their website.

The trust had a five year strategy 2017-2022, 'Caring learning and growing together to deliver excellent health and social care'.

The trust identified six strategic goals, key objectives and supporting measures to achieve their goals and deliver key improvements, to ensure that the strategy outcomes were measurable.

The NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations. These are called sustainability and transformation partnerships.

A multi-year plan has been developed showing how Humber, Coast and Vale services will evolve and become sustainable over the next five years, included in this plan is York and Scarborough, Hull and East Riding of Yorkshire and North East Lincolnshire.

The senior responsible officer for this sustainability and transformation plan is the chief executive officer of Humber NHS Foundation trust and the priorities that have been identified by the mental health delivery board were:

- Out of area mental health placements for all age adults
- Access to crisis and liaison services
- Community mental health teams
- Perinatal mental health services
- Health and justice for adults children and young people
- Older people and dementia

The leadership team regularly monitored and reviewed the progress on delivery of the sustainability and transformation programme and how this plan aligned with the trusts overall strategy 2017-22. Humber NHS Foundation Trusts strategy 2017-22 aimed to complement the

work overseen by the commissioners and that outlined in the regional sustainability and transformation plans.

The trust identified six strategic goals in its strategy, with key objectives and supporting measures to achieve their improvements. These six goals were:

- Innovating quality and patient safety
- Enhancing prevention, wellbeing and recovery
- Fostering integration, partnership and alliances
- Developing an effective and empowered workforce
- Maximising an efficient and sustainable organisation
- Promoting people, communities and social values

The trust monitored these objectives to ensure that they delivered on them. There were methods of evaluation and regular reporting structures. The board also oversaw this process by strategic performance management.

The key priorities of the trust regarding medicines optimisation were outlined in the medicines optimisation strategy and action plan. Medicines Information and prescribing guidelines were included in the objectives in the clinical audit effectiveness strategy.
Improved medicines management and knowledge within the trust was part of the patient safety strategy.

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations this is through the NHS standard contract. The NHS Equality and Diversity Council in 2014 announced that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workplace.

The Equality Delivery System was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It was a system that helped NHS organisations improve the services they provided for their local communities and helped provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. In November 2012 shared intelligence looked at how the equality and delivery system had been adopted by NHS organisations. From this a refreshed system was made available called the equality and diversity survey 2.

The organisational equality objectives for the trust were developed from the equality and diversity system 2 and workforce race equality standard outcomes, as well as friends and family tests and staff survey results.

The trust used external consultants to conduct engagement exercises with patients and staff to agree equality and diversity survey 2 self-assessment grading and set priorities.

"Promote equality and value diversity" was included within the "healthy organisational culture" pillar of the workforce and organisational development strategy 2017-22. Outcome 1.10 of the plan related to achieving the equality and diversity survey 2 standard.

The trust had an equality and diversity policy in place that was last reviewed in January 2016 The equality and diversity annual report to the board in 2016/17 included preparation for future and ongoing legislative and contractual requirements for example gender pay gap reporting and the workforce disability equality standard.

However, there was no dedicated equality strategy and whilst diversity was mentioned within the workforce and organisational development strategy, only one of 43 strategic targets related specifically to equality work.

Service users were involved in the development of the strategy, however the trust acknowledged that this was limited and agreed that they had work to do on this area. This appeared to be mainly due to the need to get a strategy in place in a timely manner after the substantive appointment of the chief executive.

We undertook a number of focus groups with staff across the care services and geographical locations. They expressed mixed opinions about the vision and values of the trust and whether these had been embedded. All staff were sent out a communique attached to their pay slips which was a smaller copy of the trust strategy and staff were aware of this.

There were still a number of staff groups who approached the inspection team before and during the well led review and felt that the trust had not improved since our last inspection, however we undertook some core service inspections prior to the well led review and it was clear that some areas had undertaken a significant amount of staff engagement and the services had improved for the patients.

The trust also undertook a barometer check and found that out of 300 staff 80-85% of staff knew and understood the vision and values, however this is only a small percentage of the overall staff group of 2500.

## Culture

There were mixed views about whether staff felt supported, respected and valued. These views came through staff interviews and focus groups undertaken with staff before the well led review. In the 2016 NHS Staff Survey the Humber NHS Foundation trust had better results than other similar trusts in one key area:

| Key finding | Trust score | Similar trusts average |
|---|---|---|
| KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month | 94% | 93% |

However in the same survey in 2016, the trust had worse results than other similar trusts in 22 key areas:

| Key finding | Trust score | Similar trusts average |
|---|---|---|
| KF12. Quality of appraisals | 2.89 | 3.1 |
| KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.57 | 3.77 |
| KF 31. Staff confidence and security in reporting unsafe clinical practice | 3.52 | 3.71 |
| KF 17. Percentage of staff feeling unwell due to work related stress in the last 12 months | 47% | 39% |
| KF 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves | 65% | 55% |
| KF 19. Organisation and management interest in and action on health and wellbeing | 3.56 | 3.74 |
| KF 1. Staff recommendation of the organisation as a place to work or receive treatment | 3.47 | 3.71 |
| KF 4. Staff motivation at Work | 3.83 | 3.94 |
| KF. 7 Percentage of staff able to contribute to improvements at work | 65% | 74% |
| KF 8. Staff satisfaction with level of responsibility and involvement | 3.80 | 3.90 |
| KF 9. Effective team working | 3.63 | 3.87 |
| KF 14. Staff satisfaction with resourcing and support | 3.21 | 3.33 |
| KF 5. Recognition and value of staff by managers and the organisation | 3.32 | 3.55 |
| KF 6. Percentage of staff reporting good communication between senior management and staff | 23% | 35% |
| KF 10. Support from immediate managers | 3.68 | 3.88 |
| KF 2. Staff satisfaction with the quality of work and care they are able to deliver | 3.76 | 3.89 |
| KF 3. Percentage of staff agreeing that their role makes a difference to patients/ service users | 86% | 89% |
| KF 32. Effective use of patient / service user feedback | 3.37 | 3.68 |
| KF 24. Percentage of staff / colleagues reporting most recent experience of violence | 72% | 88% |
| KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | 30% | 28% |
| KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | 25% | 21% |
| KF 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse | 52% | 58% |

In the survey four out of the five key questions relating to leadership and culture had worse results than other similar trusts. Findings 1, 6, 17 and 26 had not improved significantly since 2015.

The trust scored the same as the national average for key finding 21 (% believing the organisation provides equal opportunities for career progression / promotion) at 87% and showed no change since 2015.

The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 1% and 7% better than the England average for patients recommending it as a place to receive care for five of the six months in the period (February 2017 to July 2017). February, April and June saw the highest percentage of patients that would recommend the trust as a place to receive care (95%). The trust was 9% points lower than the England average in March 2017. However only one in three eligible responders completed the survey, therefore the validity of this data is therefore limited.

The trust was better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in four of the six months.

| | Trust wide responses | | | | England averages | |
|---|---|---|---|---|---|---|
| | Total eligible | Total responses | % that would recommend | % that would not recommend | England average recommend | England average not recommend |
| **July 2017** | 4,793 | 102 | 90% | 5% | 89% | 4% |
| **June 2017** | 4,812 | 95 | 95% | 2% | 88% | 4% |
| **May 2017** | 4,588 | 61 | 92% | 3% | 89% | 4% |
| **April 2017** | 4,407 | 58 | 95% | 2% | 89% | 4% |
| **March 2017** | 4,561 | 59 | 80% | 5% | 89% | 4% |
| **February 2017** | 4,223 | 63 | 95% | 2% | 88% | 5% |

From April 2014, NHS England introduced the staff friends and family test in all NHS trusts providing acute, community, ambulance and mental health services in England. The staff friends and family test was developed by NHS England. Research has shown a relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation are generally.

The staff friends and family test asked staff members whether they would recommend the trust as a place to receive care and as a place to work. The trust showed a declining trend over the last six quarters for the percentage of staff that would recommend the trust as a place to work. Quarter one had the highest scores for staff recommending the trust as a place to receive care and work for both 2015/16 and 2016/17. Response rates were the highest in Q4 2015/16 and are therefore more likely represent the staff views overall. The percentage of staff that would recommend this trust as a place to work in Q4 16/17 stayed about the same when compared to the same time last year.

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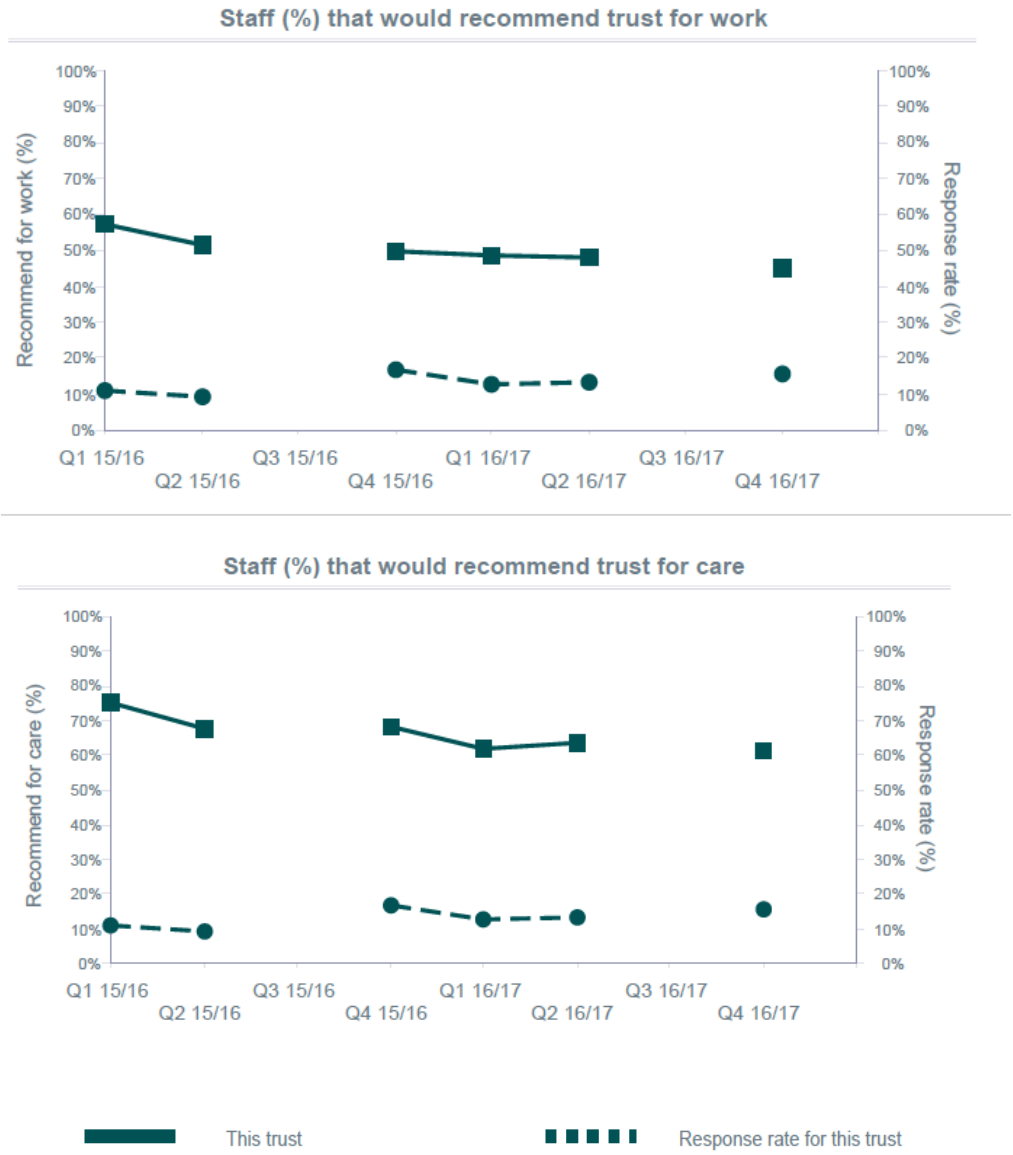
as a place to receive care and work for both 2015/16 and 2016/17.Response rates were the highest in Q4 2015/16 and are therefore more likely to represent the staff views overall. The percentage of staff that would recommend this trust as a place to receive care in Q4 16/17 decreased when compared to the same time last year

There is no reliable data to enable comparison with other individual trusts or all trusts in England.




In staff focus groups, there was still an overwhelming theme from staff that they were not fully engaged in the trust's goals, strategy and vision. They felt that the trust did not listen or make any changes based on their feedback or felt unable to give this feedback in the first place.

Senior managers within the trust as well as non-executive directors were interviewed as part of the well led review. They were asked about their one biggest risk to the organisation. Most felt that this was staffing and the workforce. The staff vacancy rate of Humber NHS foundation trust for qualified nurses was 61.9 and the nursing assistant vacancy rate was 85. Both of these vacancy rates were high. The trust was fully aware of these issues and this was referred to within the workforce and organisational strategy and the trust strategy. The geographical location of the trust and the spread of services may have contributed to some of the issues, as was the national shortage of qualified mental health and learning disability nurses.

The trust had developed a ‘welcome to Humber’ package to incentivise staff to work for the trust. The trust have also looked at skill mix and numbers and completed a review of the staffing levels on all in-patient services using the Hurst safer staffing model. The head of nursing worked closely with Professor Hurst, clinical care directors, matrons and charge nurses to complete a review of the complexity of patients and staffing levels of all units. This review identified a greater complexity of need within the adult mental health services, which resulted in an immediate increase to establishments. However, recruiting and retaining these staff remains an ongoing challenge for the trust.

Staffing was monitored daily by the charge nurses and matrons, with any staffing concerns escalated in line with the trust safer staffing escalation policy. The board in turn then received a monthly safer staffing quality dashboard.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | 31 May 2017 | 2080.2 | N/A |
| Total number of substantive staff leavers | 1 June 2016- 31 May 2017 | 727.9 | N/A |
| Average WTE* leavers over 12 months (%) | 1 June 2016- 31 May 2017 | 30.4% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | 31 May 2017 | 110.8 | N/A |
| Total vacancies overall (%) | 31 May 2017 | 4.6% | Not given |
| Total permanent staff sickness overall (%) | 31 May 2017 | 5.2% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | 31 May 2017 | 746.4 | N/A |
| Establishment levels nursing assistants (WTE*) | 31 May 2017 | 393.2 | N/A |
| Number of vacancies, qualified nurses (WTE*) | 31 May 2017 | 61.9 | N/A |
| Number of vacancies nursing assistants (WTE*) | 31 May 2017 | 85.8 | N/A |
| Qualified nurse vacancy rate | 31 May 2017 | 8.3% | Not given |
| Nursing assistant vacancy rate | 31 May 2017 | 21.8% | Not given |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) 21042 11805 | 1 June 2016- 31 May 2017 | 7065 (59.8%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016- 31 May 2017 | 1960 (16.6%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016- 31 May 2017 | 2094 (17.7%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016- 31 May 2017 | 11603 (55.1%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016- 31 May 2017 | 742 (3.5%) | N/A |
| Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016- 31 May 2017 | 1844 (8.8%) | N/A |

*WholeTime Equivalent

The pharmacy team stated that there was a need to increase the amount of staff (currently 3.7 WTE technicians and 4.3 WTE pharmacists) and there were plans to increase one technician vacancy from a three day per week post to a five day week post but more evidence was required to support this business case. The role of the technicians on the ward has changed and now ward staff are responsible for doing the regular audits with oversight from pharmacy staff. Nurses do a self-check and technicians prioritise actions based on results. One day per week of technician time

is allocated to the community mental health services. The medicines safety officer has been working with the access team.

We met with three trade unions as part of the well led review. All three of them expressed that there were difficulties in working with the trust. When we discussed with the trust they felt that they had good relationships and an open dialogue with the trades unions, so they agreed that there might be some further work needed to engage with them.

Poor staff performance was addressed appropriately where needed. The trust had a disciplinary policy and procedure and a code of conduct policy. Processes were transparent and where staff were not performing at a reasonable standard action was taken.

There had been 10 cases of staff suspended across all grades since April 2016. The trust had followed their procedures in these disciplinary procedures.

Grievances are any concerns, problems or complaints that you can raise with your employer about your employment and in most cases problems and concerns would be resolved informally through discussion with managers without using a formal procedure. If this was not possible, the trust grievance procedure provided an effective channel for staff to raise any complaint formally with management. We were made aware by some staff through our communication prior to the well led review that there were issues with the grievance procedure. As part of our inspection we reviewed six grievances, four that were completed and two that were still on going. From our review of these, we concluded that these were being addressed appropriately and in line with the trust policy.

Staff had raised concerns about bullying and harassment within the staff survey. The human resources director stated that investigation of reported cases led her to believe that staff were not being bullied or harassed, they were being performance managed. We did not find this as a theme from our staff focus groups.

At 21 June 2017 trust wide training compliance was 74% against the trust target of 75%. This is worse than the end of year compliance rate of 84% at 31 March 2017. However, of the training courses listed 11 failed to score above 75%. These included information governance, basic life support, conflict resolution, display screen equipment, equality and diversity, immediate life support, infection prevention and control, management of actual or potential aggression, moving and handling, paediatric basic life support and safeguarding children.

We inspected some core services prior to the well led review and we found that eight core services had not reached the compliance level of 75%, there were also a number of courses within these core services that failed to reach the compliance levels.

| Core service | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Community Inpatients | *73%* | *51%* |
| Specialist community mental health services for children and young people. | 77% | *59%* |
| Community mental health services for people with a learning disability or autism | 81% | *63%* |
| Mental health crisis services and health-based places of safety | 82% | *63%* |
| Wards for older people with mental health problems | 78% | *64%* |
| Wards for people with learning disabilities or autism | 83% | *69%* |
| Community-based mental health services for older people | 84% | *73%* |
| Acute wards for adults of working age and psychiatric intensive care units | 87% | *73%* |
| Community-based mental health services for adults of working age. | 86% | 75% |
| Forensic inpatient | 86% | 75% |
| Community health services for adults | 82% | 77% |
| Long stay/rehabilitation mental health wards for working age adults | 87% | 79% |
| Other | 85% | 80% |
| Community health services for children, young people and families | 92% | 84% |
| **Grand Total** | **84%** | ***74%*** |

On our last inspection, we also found that only 50% of staff were trained in the Mental Capacity Act, current compliance at the time of inspection was 83% of staff trained.

We also found that Mental Health Act was not included on the list of mandatory training on our inspection in April 2016, however, there had been a significant amount of work undertaken around the Mental Health Act and the trust compliance with this mandatory course was now 79%.

The trust's target rate for appraisal compliance was 85%. At 31 May 2017, the overall appraisal rates for non-medical staff was 83%.

Nine of the 19 teams (47%) achieved the trust's appraisal rate. Of the core services failing to achieve the trust's appraisal target, compliance ranged from 43% for specialist community mental health services for children and young people to 84% for community-based mental health services for older people.

| Core Service | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % of non-medical staff who have had an appraisal |
|---|---|---|---|
| **Substance Misuse** | 21 | 17 | 81% |
| **CHS - Children, Young People and Families** | 219 | 209 | 95% |
| **MH - Forensic inpatient** | 199 | 188 | 94% |
| **Other** | 517 | 481 | 93% |
| **MH - Community mental health services for people with a learning disability or autism** | 75 | 68 | 91% |
| **MH - Wards for people with learning disabilities or autism** | 68 | 61 | 90% |
| **CHS - Urgent Care** | 9 | 8 | 89% |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 36 | 32 | 89% |
| **MH - Mental health crisis services and health-based places of safety** | 81 | 71 | 88% |
| **MH - Community-based mental health services for older people** | 135 | 114 | 84% |
| **MH - Wards for older people with mental health problems** | 54 | 44 | 81% |
| **MH - Community-based mental health services for adults of working age.** | 298 | 237 | 80% |
| **Adult Social Care** | 14 | 11 | 79% |
| **CHS - Adults Community** | 244 | 175 | 72% |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 163 | 116 | 71% |
| **PMS** | 66 | 46 | 70% |
| **CHS - Community Inpatients** | 42 | 21 | 50% |
| **MH - Specialist community mental health services for children and young people.** | 128 | 55 | 43% |
| **Total** | **2349** | **1938** | **83%** |

Annual appraisals were offered to all staff and development needs were addressed against service objectives. Managers were responsible for their staff's development, particularly those who demonstrated the aptitude and desire for promotion, including providing support and advice on career aspirations and opportunities.

The trust also had a comprehensive distributed leadership strategy 2017-2022 and this contained plans for succession planning.

The trust did not provide any data in relation to their appraisal compliance for medical staff.

The trust's target rate for clinical supervision was 100%. As of 30 June 2017, the overall clinical supervision compliance was 69%. However, there was no standard measure for clinical supervision and trusts do collect this data in different ways.

Only one of the trusts 16 teams achieved the trust's clinical supervision target. The highest compliance was 100% in the older adults' mental health wards.

Whilst we found in some core services the individual supervision rates did fall below the trust's target, the services had been creative about offering other opportunities to reflect on practice. For example within forensic and secure services staff now had access to daily reflective practice sessions and a weekly reflective practice session with members of the psychology team.

| Core Service | Number of clinical supervision sessions required | Number of clinical supervision sessions undertaken | Clinical supervision rate (%) |
|---|---|---|---|
| **MH - Wards for older people with mental health problems** | 12 | 12 | 100% |
| **MH - Wards for people with learning disabilities or autism** | 106 | 100 | 94% |
| **Adult Social Care** | 99 | 93 | 94% |
| **CHS - Adults Community** | 76 | 70 | 92% |
| **MH - Community mental health services for people with a learning disability or autism** | 129 | 117 | 91% |
| **MH - Community-based mental health services for adults of working age.** | 863 | 762 | 88% |
| **Other** | 46 | 39 | 85% |
| **MH - Specialist community mental health services for children and young people.** | 209 | 177 | 85% |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 112 | 87 | 78% |
| **CHS - Children, Young People and Families** | 391 | 299 | 76% |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 618 | 471 | 76% |
| **MH - Community-based mental health services for older people** | 222 | 156 | 70% |
| **MH - Forensic inpatient** | 1710 | 851 | 50% |
| **PMS** | 31 | 10 | 32% |
| **CHS - Community Inpatients** | 45 | 0 | 0% |
| **CHS - Urgent Care** | 9 | 0 | 0% |
| **TOTAL** | **4678** | **3244** | **69%** |

There was a clear complaints policy that set out its timelines for investigating and reporting. The policy included how to deal with a concern and compliant, how to acknowledge the duty of candour regulation, and how this policy adhered to confidentiality and code of conduct.
We reviewed six complaints from the trust and all were comprehensive, thorough and followed the complaints procedure.

The trust told us they were achieving their three working day target for responding to complaints, however were failing to achieve their targets for completing a complaint within 25 days. Because of this, the quality committee had agreed that from the 1st October 2017 the trust would pilot a staged complaints process pathway

- 30 days – for complaints about one team/service area and up to six issues
- 40 days- for complaints that involve more than one team/complex cases/multiple significant issues
- 60 days – very complex cases/multiple significant issues and may involve external partners. Agreement from the director of nursing must be granted for this time scale to occur.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

| | In Days | Current Performance |
|---|---|---|
| What is your internal target for responding to* complaints? | 3 | 100% |
| What is your target for completing a complaint? | 25 | 38% |
| If you have a slightly longer target for complex complaints please indicate what that is here | The trust said "Given the complexity of some complaints we are currently reviewing our policy to introduce this." | N/A |

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

| | Total | Date range |
|---|---|---|
| Number of complaints resolved without formal process*** in the last 12 months | 471 | 1 April 2016- 31 March 2017 |
| Number of complaints referred to the ombudsmen (PHSO) in the last 12 months | 2 | 1 June 2016- 31 May 2017 |

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

Where complainants were dissatisfied with the outcome of the initial investigation, the complaint was re-opened and options included further investigation, a meeting with the complainants or a telephone conversation with the investigating manager.

In Quarter 1 2016-2017, 11.54% of complainants were not happy with the initial response, 15.1% in Quarter 2, 9.86% in Quarter 3 and 6.9% in Quarter 4.

This gave an average total for the year of 10.68%, compared to 13.44 % the previous year. This was a reduction of 2.76%.

The complaints team had developed a training programme in conjunction with the adult mental health care group on management of complaints; this began as a pilot in February 2017 and aimed to improve the overall management of complaints. The learning from this pilot was to inform any changes required to the training programme before its roll out across the Trust during 2017/18.

Of the 234 complaints responded to during 2016/17, 58 were upheld and 67 were partly upheld. From the total of 125 combined upheld and partly upheld complaints responded to, 31 (25%) related to communication concerns and was the highest primary subject concern.
Only two of these complaints were referred to the parliamentary and health service ombudsman (PHSO) and these were not upheld.

This trust received 269 compliments during the last 12 months from 1 June 2016 to 31 May 2017. Community health services inpatients had the highest number of compliments with 27%, followed by community health services for adults with 17%.

The trust reviewed the compliments centrally and they felt that these demonstrated that patients and carers were pleased with the service they had received and had taken the time to thank the staff who cared for them. The trust felt that the collation of this data showed that more needs to be done to ensure that all teams are recording the compliments they receive and submitting them to the complaints and patient advice and liaison service. They have plans to address this in the coming year during the roll out of patient experience, complaints and patient advice and liaison service training.

Equality and diversity training was made mandatory within the last 12 months. Approximately half of staff (53%) had received equality and diversity training at that point. At the time of the well led review this rate had reached 79%.

The trust had an equality and diversity leaflet available throughout the trust.
An email inbox was set up to allow staff, including those from protected groups, to “speak up” about their experiences at work. Currently this was not well-utilised, so the equality and diversity managers were exploring options to allow for anonymous feedback.

Staff side were involved in policy review and formation. They provided challenge and input on equality and diversity issues and involvement in the impact assessments. Staff side also approached the human resources lead for diversity informally when needed to discuss individual cases.

The trust chaplain had developed a spiritual champion’s forum, which had developed guidance called “caring for people with spiritual needs” and a “spiritual assessment tool” to ensure that patients’ needs were recognised and met.

A “distributed leadership” model had been adopted and staff charters within the culture change programme had encouraged inclusion.

Of the 32 key findings in the 2016 staff survey, black and minority ethnicity scores were better than for their white counterparts in 21. The sample size for black and minority ethnicity staff was too low to report for five, leaving six poorer results for black and minority ethnicity staff.

The need to provide better support for NHS workers to raise concerns was highlighted in the Francis freedom to speak up review, published in February 2015. The review was set up in response to evidence that NHS organisations did not appropriately react to the concerns raised by staff, including the maltreatment of those speaking up.

The review advocated the establishment of freedom to speak up guardians to act as impartial and independent sources of advice to NHS workers. It also proposed the establishment of an independent national officer to support the guardians' role and to conduct reviews into cases where there was evidence that NHS bodies had not followed good practices to support speaking up.

As of April 2017 all trusts had to have appointed freedom to speak up guardians. Trusts were responsible for appointing and resourcing their guardian, although the national guardians' office also provided guardians with additional training and support.

Following the retirement of the freedom to speak up guardian the trust had recently recruited a new freedom to speak up guardian and staff knew who this was. There had been one referral to the guardian in the four weeks since they had taken on the role, which had led to a serious incident investigation being undertaken.

There had also been three notifications which the freedom to speak up guardian had dealt with.

Staff were aware of the whistleblowing procedure. There had been 14 alerts in the year 2016-2017, these had however come to the trust via the CQC. Following these whistleblowing alerts improvement plans were put in place for two teams with a focus on team building and quality of care and improved systems and processes. The trust also reviewed sub-contracting arrangements with a private provider and strengthened the contractual arrangements and monitoring. Staff were also reminded to follow safer staffing escalation policy. The trust also appointed a principal social worker to oversee professional management and development for social work employees following another whistleblowing concern.

The CQC received three concerns about Maister Lodge, an older adults inpatient service, and whilst two of these concerns pre dated June 2016, the last concern was received June 7th 2016. Following the last concern, an external investigation was undertaken resulting in a development plan, implementation of which was supported by the Improvement Academy

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

This is called Duty of candour. The trust had a policy and procedure on Duty of candour in line with national policy, which articulated the key steps to be undertaken.

Posters and leaflets on the application of Duty of candour were available within the trust policy The requirement for Duty of candour was reviewed for all unexpected deaths within the weekly clinical risk management group.

All matrons and team leaders were responsible for reviewing moderate harms within their care, assistant directors within the care groups for severe harms and care group directors for all deaths. An audit of Duty of candour was undertaken by the trust in May 2017, with immediate actions being taken to make system changes on the recording of this, a number of incidents reported as moderate harm and above were not patient safety incidents and therefore Duty of candour was not applicable.

Learning from the audit had been raised with the care groups and within the clinical risk management group. Following this audit, governance and risk produced a report detailing all moderate harms and above. This was then shared with the care groups to ensure compliance.

Training for Duty of candour commenced for 70 staff within the trust in 2016 led by the Director of Nursing and facilitated by an external organisation, specialising in patient safety. .From that an in house training programme on Duty of candour was developed that required all staff to attend.

This training was an interactive session enabling staff to discuss the background to Duty of candour, the importance of an apology and being open with patients and carers about what happened and the learning from the incident. Practice notes had been sent to clinical teams reminding them of their duties in relation to Duty of candour. A podcast was currently in development as a refresher for teams to use in team meetings. The assistant director of nursing also provided support to teams on individual cases as required assisting staff with the application of the statutory duty.

Implementing the workforce race equality standard (WRES) was a requirement for NHS commissioners and NHS healthcare providers including independent organisations, this was through the NHS standard contract. The NHS equality and diversity council in 2014 announced that it had agreed action to ensure employees from black and minority ethnicity backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The organisational equality objectives for the trust were developed from the equality and diversity system 2 and workforce race equality standard outcomes, as well as friends and family tests and staff survey results.

The trust used external consultants to conduct engagement exercise with patients and staff to agree equality and diversity survey 2 standard self-assessment grading and set priorities. "Promote equality and value diversity" is included within the "Healthy organisational Culture" pillar of the workforce and organisational development strategy 2017-22. Outcome 1.10 of the plan related to achieving the equality and diversity survey 2 standard.

The trust had an equality and diversity policy in place that was last reviewed January 2016. The equality and diversity annual report to the board in 2016/17 included preparation for future and ongoing legislative or contractual requirements for example gender pay gap reporting and workforce disability equality standard.

However, there was no dedicated equality strategy and whilst diversity was mentioned within the workforce and organisational development strategy, only one of 43 strategic targets related specifically to equality work

We inspected core services leading up to the well led inspection and we found that teams had positive relationships, worked well together and addressed any conflict appropriately.

## Governance

The trust had a board of directors. The board of directors was made up of a chief executive and five executive directors who delivered the strategy and a chairman and six non-executive directors. The chairman and non-executive directors were not employed by the trust and they worked part-time providing advice, challenge, and strategic leadership to the board.

We reviewed the last two sets of board meeting minutes and attended both parts of the most recent board meeting. These were well attended and offered suitable challenge on many matters and minutes of those and other committees were of a good standard.

The trust provided their board assurance framework, which detailed any risk scoring nine or higher (those above) and gaps in the risk controls which impacted upon strategic ambitions. The six strategic ambitions outlined by the trust were:

- Innovating quality and patient safety, this will be measured by delivering high quality, responsive care, by strengthening the trust's approach to patient's safety. Demonstrate a culture that listens, responds and learns, achieve clinical excellence matched by service excellence and delivery, capitalise on their research and development programme and exceed requirements set by the Care Quality Commission Assessment and other regulators.
- Enhancing preventions, wellbeing and recovery, this will be measured by developing a new ambitious prevention and recovery strategy. (Enhancing the use of social prescribing in both preventions and recovery approaches), empower people to manage their health and social care needs and deliver responsive care that improves health and reduces health inequalities (promote early intervention across all ages).
- Fostering integration, partnerships and alliances, this will be measured by being a system leader in the Humber, Coast and Vale STP initiatives, foster innovation to develop new health and social care service delivery models, strive to maximise their research approach through education and teaching initiatives, build trusted alliances with voluntary, statutory and non-statutory agencies and private sector.
- Developing an effective and empowered workforce, this will be measured by delivering an enhanced healthy organisational culture, invest in teams to deliver clinically excellent and responsive services and enable transformation and organisational development.
- Maximising an efficient and sustainable organisation, this will be measured on the trust being a flexible and agile organisation that responds positively to business opportunities across the wider geographical area, be a top-performing provider of integrated services, exceed the requirements set by NHS improvement regarding finance sustainability and build state of the art care facilities.
- Promoting people, communities and social values, this will be measured on the trust enhancing the economic wellbeing for adults and children by reducing poor health associated with low income. Support social and wellbeing enabling individuals and community to maximise potential within the social context. Improve environmental wellbeing through approaches to

reduce health inequalities and mitigate climate change and creating health places and communities now and for the future.

The risk register document the trust provided details 32 key risks, two of which have a current risk level of 15 or higher. Both remain unchanged from the previous update.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| Opened | ID | Description | Risk level (Initial) | Risk Score (Current) | Risk level (Target) | Link to BAF Strategic Objective No. | Last Review Date |
|---|---|---|---|---|---|---|---|
| **11/01/2017** | HR25 | Failure to recruit and retain appropriately qualified, skilled and experienced clinical workforce as a result of national shortages and rising demands outside of the Trust's control, will directly impact on the trusts ability to meet its objectives. | 16 | 16 | 12 | 4 | 27/06/2017 |
| **11/01/2017** | HR26 | Failure to implement the Trust's Workforce Plan and Strategy may result in an inability to achieve the changes to culture and reputation, which are aspired to by the organisation. | 16 | 16 | 12 | 4 | 27/06/2017 |

Equality analysis was undertaken for new and revised policies and papers that were then sent to the board. The template and guidance documentation was available on the trust intranet. Equality and diversity managers were also available to provide assistance and to signpost policy authors to relevant legislation or policy documents on the intranet.

The equality and diversity human resources manager managed the human resources analyst and had ready access to equality data when needed.

The equality and diversity patients' manager managed the complaints team and could readily identify issues relating to protected characteristics. There had been none reported over the past 12 months.

The workforce race equality standard and the equality and diversity system 2 outcomes led to changes in recruitment and selection. All black and minority ethnic candidates were interviewed for posts if they meet the essential requirements, similar to the disability confident standard, which was also met. One black and minority ethnic staff member was sponsored for the Florence Nightingale programme, which offered an increased availability of coaching and mentoring. This was available to all but encouraged particularly for black and minority ethnic and disabled staff.

Equality and diversity outcomes were monitored through the quality committee to the board. The annual equality and diversity report and any other issues were flagged ad hoc through patient experience or workforce leads to the senior management team.
There was no formal training provided for undertaking equality analysis, but the human resources lead planned to include this in the next revision of training. The equality and diversity system 2 plan did not include outcome targets for future monitoring.

Processes were in place to support the delivery of the trust's strategy. The trust had an operational board, a council of governors and seven committees. Each committee had its own reporting mechanism and flow chart to ensure the dissemination of information to staff groups as well as oversight by the board members. For example, the quality committee was chaired by a non-executive director and there were three sub committees, research and development committee, the patients safety group and the information governance group which all fed up to the quality committee.

We reviewed the last four sets of minutes of the quality committee and we could see that there was a sound and appropriate presentation of information, with exception reporting. Specific reports were also presented at these meetings, and we found there were appropriate summaries of the current benchmarked position. We found that these minutes for the last 12 months gave clear evidence of an increasingly mature and functional environment for quality assurance and improvement.

Medicines optimisation was well integrated into the governance structure for the trust. Medicines incidents reported on the Datix system were discussed at the medicines committee.

When we completed our comprehensive inspection in April 2016, we found that seclusion and long-term segregation of patients was not in line with the Mental Health Act code of practice. Monitoring checks were not effective and the senior team and staff did not ensure that safe care was being provided to patients in seclusion.

Training in the Mental Health Act at that time was not mandatory for staff at the trust. Only 99 of the trust's 2501 staff had completed Mental Health Act training.

At this well led review, we found that a significant amount of work had been undertaken by the trust in the area of the Mental Health Act. Seclusion practice was now in line with the trust policy and the Mental Health Act code of practice. We also found that 79% of staff had now been trained in the Mental Health Act.

All Mental Health Act policies and procedures were updated in line with annex B of the Mental Health Act code of practice and appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.

The trust had also undertaken significant work around restrictive interventions. 'Restrictive practice' has been explained as making someone do something they do not want to do or stopping someone doing something they want to do. It can include stopping people from going outside or from using the internet or phone. The Mental Health Act code of practice says these restrictions should not be imposed as blanket rules (where they apply to everyone on a ward regardless), but only if they are necessary because of a specific individual risk. Section 134 of the Mental Health Act (1983) states that the withholding of mail was only allowed in high security psychiatric

hospitals. In April 2016 we found that staff were routinely opening patients' mail within the forensic services.
The practice of withholding mail in the forensic services has now been completely eradicated and patients were now subject to individual care plans rather than blanket rules and procedures. We found that the restrictive practices were being monitored by the board by way of an improvement report: "restrictive practices" as recently as June 2107. It was a clear transparent report, which showed the monitoring and assurance framework summary and the direct links to strategic goals.

The trust had a physical health and care of the deteriorating patient policy. We found good examples of physical health monitoring within the core services that we inspected. Over the last 12 months the organisation had systematically examined the completion of national early warning scores (NEWS) in the increased scrutiny of restrictive practices within the trust.

Since the last CQC inspection in April, 2016 the trust introduced a series of rapid improvements, these have examined each individual case of seclusion, rapid tranquilisation and prone restraint. These reviews examined the individual practice of clinicians and reported on the deployment of national early warning scores following each incident and this had improved this element.

Feedback on the use of national early warning scores was sent to clinicians involved in the incident, their line manager and modern matron. Information on the practice and care of the secluded patient, those who were in receipt of rapid tranquillisation and prone restraint including the use of national early warning scores was collected together in the restrictive practice report which was presented to the restrictive practices group within the trust. These reports were also submitted to the quality and patient safety group and scrutinised by the quality committee.

Over the last 12 months the trust has piloted the use of an online survey tool used by services to assess the compliance to clinical guidelines 50 – "Acutely ill adults in hospital: recognising and responding to deterioration". There are plans to roll out this tool across the services.

A clear framework set out the structure of ward, team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.

Staff at all levels of the organisation understood their roles and responsibilities and when to escalate to a more senior person.

The trust was working with third party providers effectively to promote good patient care. The CQC received some information around the contract with a private provider via a whistle blower. At this point the trust reviewed sub-contracting arrangements with this provider immediately and strengthened the contractual arrangements and ongoing monitoring.

As part of the well led review we met with the Mental Health Act managers and we found there were robust arrangements to make sure that hospital managers discharged their specific powers and duties according to the provisions of the Mental Health Act 1983. They worked well with the Mental Health Act team and were able to give examples of using their discharge power and that they needed to look at the legal criteria when looking at discharge.

## Management of risk, issues and performance

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Equality and diversity outcomes were monitored through the quality committee to the board. The annual equality and diversity report and any other issues were flagged ad hoc through patient experience or workforce leads to the senior management team.

There was no formal training provided for undertaking equality analysis, but the human resources lead planned to include this in the next revision of training. The equality and diversity system 2 plan did not include outcome targets for future monitoring.

Processes were in place to support the delivery of the trust's strategy. The trust had an operational board, a council of governors and seven committees. Each committee had its own reporting mechanism and flow chart to ensure the dissemination of information to staff groups as well as oversight by the board members. For example, the quality committee was chaired by a non-executive director and there were three sub committees, research and development committee, the patients safety group and the information governance group which all fed up to the quality committee.

We reviewed the last four sets of minutes of the quality committee and we could see that there was a sound and appropriate presentation of information, with exception reporting. Specific reports were also presented at these meetings, and we found there were appropriate summaries of the current benchmarked position. We found that these minutes for the last 12 months gave clear evidence of an increasingly mature and functional environment for quality assurance and improvement.

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All Mental Health Act policies and procedures were updated in line with annex B of the Mental Health Act code of practice and appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.

The trust had also undertaken significant work around restrictive interventions. 'Restrictive practice' has been explained as making someone do something they do not want to do or stopping someone doing something they want to do. It can include stopping people from going outside or from using the internet or phone. The Mental Health Act code of practice says these restrictions should not be imposed as blanket rules (where they apply to everyone on a ward regardless), but only if they are necessary because of a specific individual risk. Section 134 of the Mental Health Act (1983) states that the withholding of mail was only allowed in high security psychiatric hospitals. In April 2016 we found that staff were routinely opening patients' mail within the forensic services.

The practice of withholding mail in the forensic services has now been completely eradicated and patients were now subject to individual care plans rather than blanket rules and procedures. We found that the restrictive practices were being monitored by the board by way of an improvement

report: “restrictive practices” as recently as June 2107. It was a clear transparent report, which showed the monitoring and assurance framework summary and the direct links to strategic goals.

The trust had a physical health and care of the deteriorating patient policy. We found good examples of physical health monitoring within the core services that we inspected. Over the last 12 months the organisation had systematically examined the completion of national early warning scores (NEWS) in the increased scrutiny of restrictive practices within the trust.

Since the last CQC inspection in April, 2016 the trust introduced a series of rapid improvements, these have examined each individual case of seclusion, rapid tranquilisation and prone restraint. These reviews examined the individual practice of clinicians and reported on the deployment of national early warning scores following each incident and this had improved this element.

Feedback on the use of national early warning scores was sent to clinicians involved in the incident, their line manager and modern matron. Information on the practice and care of the secluded patient, those who were in receipt of rapid tranquillisation and prone restraint including the use of national early warning scores was collected together in the restrictive practice report which was presented to the restrictive practices group within the trust. These reports were also submitted to the quality and patient safety group and scrutinised by the quality committee.

Over the last 12 months the trust has piloted the use of an online survey tool used by services to assess the compliance to clinical guidelines 50 – “Acutely ill adults in hospital: recognising and responding to deterioration”. There are plans to roll out this tool across the services.

A clear framework set out the structure of ward, team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.

Staff at all levels of the organisation understood their roles and responsibilities and when to escalate to a more senior person.

The trust was working with third party providers effectively to promote good patient care. The CQC received some information around the contract with a private provider via a whistle blower. At this point the trust reviewed sub-contracting arrangements with this provider immediately and strengthened the contractual arrangements and ongoing monitoring.

As part of the well led review we met with the Mental Health Act managers and we found there were robust arrangements to make sure that hospital managers discharged their specific powers and duties according to the provisions of the Mental Health Act 1983. They worked well with the Mental Health Act team and were able to give examples of using their discharge power and that they needed to look at the legal criteria when looking at discharge.

## Information management

We reviewed two sets of board meeting minutes, both public and private and there was a clear emphasis on quality and sustainability. Information was used to measure for improvement, not just assurance.

Information Governance is the way organisations 'process' or handle information. It covers personal information, for example that relating to patients/service users and employees, corporate information and financial and accounting records.

The information governance toolkit was a Department of Health policy delivery vehicle that the health and social care information centre (HSCIC) was commissioned to develop and maintain. It drew together the legal rules and central guidance set out by the Department of Health policy and presented them in in a single standard as a set of information governance requirements. The organisations in scope of this were required to carry out self-assessments of their compliance against the information governance requirements.

There were different sets of information governance requirements for different organisational types. However all organisations had to assess themselves against requirements for:

- Management structures and responsibilities
- Confidentiality
- Data protection.
- Information security

The trust had completed its information governance toolkit. This had however not been reviewed and was at the self-assessment stage. The trust had rated itself as satisfactory and an overall score of 78%.

The trust was aware of its performance using key performance indicators and other metrics. This data then fed into the board assurance framework.

The trust was working to improve electronic prescribing with the patient record system.

All pharmacy interventions were recorded on a clinical pharmacist intervention log. The database was monitored and reported back to the trusts quality meeting. Technicians produced detailed reports following ward visits. The pharmacy team used Datix, the database and the perfect ward app. Daily medicine optimisation questions were embedded into routine practice.
The trust were high reporters of incidents. On the national reporting and learning system mostly low or no harm incidents showed that pharmacy incident reporting was embedded in staff practice

We were assured by the core service inspections and focus groups that team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient 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. This information was reported to the trust's risk management system (DATIX) where staff were encouraged to report all incidents/matters of concern.

Briefing reports were produced via the system where the incident/concern was deemed to be significant or serious. In turn these were circulated to members of the clinical risk management meeting which met weekly to review the briefings and agree investigation methodology and escalate immediate actions if required.

The clinical risk management meeting commissioned thematic reviews when concerns regarding incident trends and themes were noted. The executive team were immediately notified of all incidents declared as serious incidents.

The clinical risk management group reported quarterly to the quality and patient safety group.

Information from sub groups in relation to clinical audit, National Institute for Health and Care Excellence (NICE) compliance, safeguarding performance data, mortality reviews and patient and carer feedback, reducing restrictive interventions, infection control and ligature risk audits was also reported to the quality and patient safety group to allow triangulation of information in relation to quality and safety for discussion and agreement of actions to be taken.

The quality and patient safety group reported to the newly established quality committee for assurance purposes. The quality committee was a board subcommittee and was chaired by a non-executive.

We found that when we attended a private board meeting a reportable issues log was presented. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.

This report identified ongoing concerns in relation to safeguarding, serious incidents, human resources investigations, inquests, freedom to speak up, complex complaints and claims.

Information was in an accessible format, timely, accurate and identified areas for improvement. The trust had a care group performance tracker 2017-18 (mental health) which was produced in May 2017. This provided a summary on the progress being made against the key NHS performance indicators together with operational measures that underpinned the strategic operational plan 2017-18 presented as the care group's integrated performance tracker. This tracker including the monitor dashboard, the Care Quality Commission dashboard and the performance indicator return forms.

The trust had a digital plan 2017-21. The digital plan explained how they intended to use digital technology to deliver their six strategic goals over the next five years. It also showed how the trust were going to develop their core living and growing values underpinned by the digital plan.

The trust had implemented an electronic patient care record system. We found varied implementation and views about the system and we could see that implementation remained problematic. We found in practice that the system was very slow and at time held up patient reviews whilst it loaded. The trust had however developed a second phase implementation and time line, which was to run between May 2017 and December 2017.

The electronic system protected the safety of patient information. Staff were required to pass security settings to access the system and only permitted to view or add to individual records in a professional capacity.

The trust had developed a data quality dashboard for their electronic care notes system that was used by front-line services to monitor data volumes and potential errors and omissions from individual patient records.

The trust also used another electronic care notes system and they had developed data quality reports for services using this, which again provided services with record-level detail of potential issues. The trust checked their data quality against other trusts using NHS Digitals data quality publications. Notifications were completed and sent to the CQC as and when required.

The trust commissioned an independent review of governance arrangements against the Monitor well-led framework, which was completed in May 2017.

There had been significant turnover of key board positions, so the trust recognised that there was a number of areas of governance that required improvement.

The report commented that whilst they did find a number of concerns, such as staff and service user engagement, accountability structure and assurance arrangements, the report commented that under the leadership of the chief executive, if the recommendations in the report were fully implemented they were confident that the concerns could be addressed.

## Engagement

The trust has engaged with the public over a number of issues over the last 12 months, including public events in March 2017 to identify the trust priorities for the quality accounts and market stalls events held as part of the annual members meeting.

There were a number of feedback methods that the trust use such as:

- Comments boxes for patient views.
- NHS Choices website.
- CAMHS parent/carer group and patient forum
- Older people's mental health dementia involvement group for East Riding.
- Humber centre patient council (Our Voice).
- Patient participation groups are also established in GP surgeries.
- Patient and carer stories are shared at board meetings
- Council of governor meetings.
- Mental health inpatient wards use "you said/we did" feedback tools in weekly community inpatient meetings.
- Complaints, PALS concerns and compliments are received by the patient experience team.

Granville Court is a home for people with profound and multiple learning disabilities with associated complex healthcare needs, due to the difficulty for residents to feedback their views, staff reviewed the services provided on behalf of their residents with their families and carers. Internal peer review visits took place where questionnaires were handed out to give service users and carers the opportunity to feedback about the services. .

The Humber centre patients council had developed standards for community meetings and was developing carer involvement. Co-production with patients including completion of a mural at the Humber Centre by patients and staff has improved the surroundings. A link role for patient and carer experience has been developed. Work was underway to improve the dining experience. We undertook a number of focus groups before the well led review for those patients detained under the Mental Health Act and those on older adults wards.

We had mixed feedback and comments about their experiences whilst in the care of Humber NHS Foundation Trust.

Some patients felt there were not enough staff, there were not enough activities, staff were unfriendly, some did not get enough 1:1 time with the staff, the no smoking policy was unfair, involvement in their care plans was poor and access to medical staff was varied.

They did however say that staff respected their privacy, food was ok, staff are very nice but very busy, staff attitude has improved, staff supported a patient with discharge plans.

The Trust Strategy included feedback in its development such as:

- Patient/carer feedback, which informed the patient and carer experience plan, this included development of seven pledges setting out the patient/carer experience commitments.
- Staff feedback was obtained through supervision, appraisal, the staff survey and consultation with the council of governors who represent staff views.
- Consultation with Trust Board Members;
- Feedback from wider stakeholders and partners
- The trust sought to actively engage with people and staff in a range of equality groups

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The trust used briefing notes to circulate any important clinical issues to the trust staff and a midday email to all staff.

We spoke to external stakeholders who said they received open and transparent feedback on performance from the trust. The older adults inpatient services worked closely with external stakeholders such as commissioners and NHS Improvement. Commissioners had recently visited both older adults services to see the standard of care and treatment provided, these visits were undertaken jointly with the trusts quality team.

The trust lost a large community health services contract in April 2017; stakeholders felt that losing this contract was taken personally by the trust, which then impacted on relationships. They felt the trust could be more receptive. Specialised commissioning also contracts the Humber Centre medium secure services. They feel that there has been an improvement in delivery of services since the CQC's last visit in April 2016.

The alcohol and drug services had experienced many changes since our previous inspection in April 2016. This involved changing the culture from a mainly clinical provision to one that offered choice, a holistic approach and promoted visible recovery. Many patients had been with the service for a long period. This meant that staff also had to promote and encourage the change in culture with patients.

All staff we spoke with told us they were positive about the new direction of the service. Staff morale within the whole service was high. We observed commitment and an excellent team attitude between trust staff and staff from the alcohol and drug service.
Since our last inspection, the trust had redesigned mental health crisis and health based place of safety services. The trust invited staff to participate in the design of the service at different stages

of the process. After the opening of the rapid response service, the service held development days where staff could attend and share their vision and ideas about the development of the service in the future. These sessions feed into an overall development and improvement plan for the service with clear actions, dates and identified staff to oversee them.

Ward staff in the rehabilitation services felt that senior managers had not kept them sufficiently informed of the future of the service and had concerns about how the service would operate in the future.
The trust had a service level agreement with a pharmacy who provided the medication supply and two pharmacist and technicians from there had training provided by the trusts pharmacy team. The service level agreement included clinical service as well as supply. Pharmacy staff engaged with patients and carers on the wards and as part of multi-disciplinary team meetings.

The pharmacists and pharmacy technicians were allocated specific wards to increase engagement with doctors and nurses. The medicines safety officer attended the regional network every three months.

We spoke to the trust's lead governor and governor representatives including staff representatives. As an NHS foundation trust governor, the role is to hold the trust's non-executive directors to account for the performance of the board and represent the interests of members and the public. The governors said they have a good relationship with the trust and the board members attend the council of governors meetings and development days. All of the governors had areas of responsibility and held the non-executive directors to account. They felt it was an improving trust with ambition, however there was some way to go and changes should have been made some time ago. The governors felt that the trusts five year plan was comprehensive, and the trust job was to now make this understandable to all staff, as communication was a changing picture for clinical staff.

There was only one referral of a nursing staff from the trust to the nursing and midwifery council in the last 12 months, this has now concluded and was closed. There were two health and care professional tribunals, these concluded, one staff was struck off the register, and one agreed a voluntary removal.

The East Riding of Yorkshire and Hull clinical commissioning group had cause to write to the trust in 2017 due to issues around their management of the serious incident process. This was seen as a supportive measure and to receive clarification that there was assurance around the serious incident process.

The trust was actively engaged collaboratively with external partners with work around the sustainability and transformation plans.

## Learning, continuous improvement and innovation

| | Historical data | | Projections | |
|---|---|---|---|---|
| **Financial Metrics** | Previous financial year (2 years ago) | Last financial year (2016/17) | This financial year | Next financial year (2018/19) |
| **Income** | £129,482,000 | £142,991,000 | £122,739,000 | £111,178,000 |
| **Surplus** | -£1,220,000 | £852,000 | £233,000 | £733,000 |
| **Full costs** | £128,262,000 | £143,843,000 | £122,972,000 | £111,911,000 |
| **Budget** | -£1,000,000 | -£377,000 | £233,000 | £733,000 |

The Trust income is expected to shrink to £109.6m in 2017/18 due to the loss of the East Riding Community Services contract, but the following income streams have been acquired by the trust in 2016/17

- Successful acquisition of two GP Practices (Turnover £1.5m)
- Impact of successful retention of 0-19 Tender (Reduced Turnover £0.5m)
- Impact on East Riding Community Service (£28.0m)
- Successful Tender Outcome for Granville Court Learning Disability Services (Increase Turnover £1.0m)

A number of further Income opportunities existed for the Trust, which included

- Further acquisition of GP practices
- Tender with NHS England for a CAMHS Tier 4 Services

Major risk to the financial sustainability of the Trust and the ability to deliver the 2017-18 and 2018-19 financial control totals were:

- East Riding Community Tender - unsuccessful outcome will leave the trust with some stranded cost, which needs to be quantified
- Demographic Growth - Failure to secure demographic growth in line with sustainability and transformation plan assumptions
- CQUIN (The CQUIN scheme is intended to deliver clinical quality improvements and drive
- transformational change). - 0.5% of CQUIN to be held in risk reserve linked to delivery of patch
- control total

NHS Improvements (NHSI) has evidence that financial performance has been consistently strong For example, cash, capital and revenue plans were being delivered in line with plans and national requirements.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

| Accreditation scheme | Core service | Service accredited | Comments and Date of accreditation / review |
|---|---|---|---|
| **AIMS - WA (Working Age Units)** | Acute wards for adults of working age and psychiatric intensive care units | | Newbridges, Westlands and Millview Court have not been re-accredited following recent review. This was based on failure to achieve some of the required standards. The decision was made by the Committee in June 2017. |
| **AIMS - PICU (Psychiatric Intensive Care Units)** | Acute wards for adults of working age and psychiatric intensive care units | PICU | September 2016 |
| **AIMS - AT (Assessment and triage wards)** | Acute wards for adults of working age and psychiatric intensive care units | Avondale | February 2016 |
| **AIMS - OP (Wards for older people)** | Wards for older people with mental health problems | Millview Lodge | Not provided |
| **AIMS - Rehab (Rehabilitation wards)** | Long stay / rehabilitation mental health wards for working age adults | Hawthorne Court- January 2016 | January 2016 |
| **ECT Accreditation Scheme (ECTAS)** | Not provided | ECT- June 2016 | Not provided |
| **Accreditation for Psychological Therapies Services (APPTS)** | Not provided | East Riding Emotional wellbeing service (IAPT April 2016 | Not provided |

The trust was actively participating in clinical research studies. The research and development group was chaired by the medical director and fed directly to the trust's quality meeting. The Trust's Research Strategy was approved by the Board and launched at Trust Research Conference in May 2017.

The objectives of the Trust's research strategy were:

- Embed research as core business
- Increase participation in research
- Maximise research income
- Create new partnerships for applied research
- Increase capacity and capability for research
- Excellence in the quality, safety and governance of research
- Translate research into practice

Staff in the acute and PICU services had opportunities to contribute to research and we saw examples of this. The trust employed a research nurse that worked with inpatient mental health services on studies to support retention and recruitment, carer involvement and audits relating to national clinical guidance. The nurse was completing their PhD thesis on professional decision making in ending episodes of seclusion.

Effective systems were in place to identify and learn from unexpected deaths.

We undertook a learning from deaths review prior to the well led inspection. We followed the CQC learning from deaths monitoring and inspection tool. This framework provided a method to assess the process for reviewing and investigating individual deaths, In order to assess whether the trusts policy was implemented in reviews, the engagement with families and carers and whether the investigation of the deaths of vulnerable people were treated the same as everybody else who may have died.

We reviewed six deaths of patients of the trust who had died since March 2017. These were not necessarily suspicious deaths and were chosen by the CQC.

The trust had policy 'learning from deaths of patients in our care policy and procedure' last reviewed in July 2017. This policy clearly identified the criteria of when a patient was in the care or receiving treatment by the trust. We found that the trust had followed their policy in all six reviews and there was a serious investigation checklist included in the case files. Each death review had terms of reference, which included reference to improvements rather than blame and identified areas of learning or changes in practice.

We could see that a single point of contact from the trust was identified to make contact for relatives and that a condolence letter was sent to those relatives.

The trust also had a mortality steering group with terms of reference for 2017/18. The mortality steering group was a subgroup of the trust's quality and patient safety group and reported directly to the trust's clinical risk management group.

The mortality steering group was responsible for developing the strategic approach to the mortality reviews within Humber NHS Foundation Trust.

Staff from the rehabilitation mental health services did not take part in any work that supported improvement and innovation such as quality improvement workshops or time out to work together to resolve problems in a systematic way. Staff on the ward felt isolated from other colleagues across the trust. However, the ward manager met with peers on a regular basis at directorate and trust wide meetings. This gave the ward manager opportunities to share information, and learning from across the trust with the ward team.

Staff in the substance misuse services were given the time and support to consider opportunities for improvements and innovation. In April 2017, all staff attended a service away day to look at the new recovery focussed model. Staff felt able to contribute their thoughts and felt that their input was valued. Staff used team meetings to escalate ideas to clinical networks and team leader forums for consideration.
In the community mental health services for adults of working age staff demonstrated an enthusiasm to want to improve the way they worked in spite of the pressure and anxiety they

experienced in the course of working. The psychiatrists and psychologists worked well with the managers and other staff to find ways of improving the service to the benefit of both staff and patients.

The Rapid Response Service had gone through a service transformation. During these changes, staff had opportunities to take part in working groups to share their views and contribute to the improvement and innovations in the service. Following this staff could take part in task and finish groups to be involved in developing the service.

In the community adult services, senior managers told us they had held a year end listening event in March 2017 and formed an action plan from this. One action was to hold a monthly drop in clinic for staff at Whitby Hospital to provide staff with the opportunity to talk to managers.

Staff contributed to service improvements and suggested opportunities for innovation such as the creation of bespoke self-harm training within the acute and PICU services.

In forensic services staff had used budgets creatively to ensure high quality care. They had reviewed the recruitment budget and worked closely with finance to develop the associate practitioner role, with the aim of ensuring more staff on the wards to engage in patient activities and support their care and treatment goals.

The medicines safety officer has been in post since July 2017 and worked with the lead medicine management nurse. Sixty nurses have been trained to be assessors of incidents and to cascade learning and challenge poor medicines management practice.

Following a recent external review , the trust needed to ensure an approach to improvement. From this an action plan was developed to drive forward this programme of change. This included embedding evidence based solutions and improvement methods, which supported practice across different teams and groups.

Some innovations include:

- SASH training (suicide and self harm training)
- Digital therapy options in IAPT
- The Launch of the crisis pad
- The Humber Centre Art Therapy department launched a staged mural project in July 2016, which has continued its success through into 2017
- Health promotion Group ENABLE which is run at Townend court

Some good practice and awards include

- A healthy lifestyle service has been shortlisted for an award
- The Social Mediation and Self-Help team (SMASH) received a special recognition award on Thursday during the 2017 Hull and East Riding Health Expo.
- Humber Recovery College won the Mental Health and Wellbeing category at the 2017 Hull Daily Mail Health and Care Awards.

The trust recognised staff success by staff awards and through feedback.

# Community health services

## Community health services for adults

Requires improvement

## Facts and data about this service

Information about the sites which offer community health services for adults at this trust is shown below:

| Location site name | Team/ward/satellite name | Number of clinics per month | Geographical area served |
|---|---|---|---|
| **Willerby Hill** | Neighbourhood Care Services | Appointments are made to suit individual needs | West Wolds |
| **Willerby Hill** | Tissue Viability Specialist Service (TSVN) | Appointments are made to suit individual needs | Hull & ER |
| **Whitby Hospital** | Heart Failure Specialist Nursing | appointments are made to suit individual needs | Whitby |
| **Whitby Hospital** | Neighbourhood Care Services | appointments are made to suit individual needs | Whitby |
| **Willerby Hill** | Health Trainers | Not stated | Not stated |
| **Willerby Hill** | Outpatient services | Not stated | Not stated |
| **Willerby Hill** | MSK | Not stated | Not stated |

## Is the service safe?

### Mandatory training

While the service did not meet the mandatory training target in June 2017, this had improved for the Pocklington neighbourhood care team and health trainer team in July 2017.

The trust set a target of 75% for completion of mandatory training with the exceptions of 90% for information governance training and 80% for prevent, safeguarding adults and safeguarding children training courses.

Overall as of 31 March 2017, staff in this service had undertaken 82% of the various elements of training that the trust had set as mandatory. This was slightly worse than the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% training target for one course which was conflict resolution with 63%.

Safeguarding adults training had the highest training compliance with 98%.
The trust provided an updated position as of 21 June 2017 that showed the overall training compliance for the core service was 77%. Six of the 15 courses failed to score above the CQC benchmark of 75%. The lowest scoring courses were immediate life support with 50% and basic life support with 42%. A comparison to the previous years showed that for immediate life support and basic life support this is the first time it has been completed by this core service.

A breakdown of compliance for mandatory courses in community health services for adults is shown below:

| Core Service | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| **Health and Safety** | 85% | 93% |
| **Information Governance** | 96% | 74% |
| **Mental Capacity Act** | 96% | 84% |
| **Basic Life Support** | Not provided | *42%* |
| **Conflict Resolution** | *63%* | *72%* |
| **COSHH** | 86% | **89%** |
| **Display Screen Equipment** | 80% | *57%* |
| **Equality and Diversity** | Not provided | 82% |
| **Fire Safety** | 82% | 85% |
| **Immediate Life Support** | Not provided | *50%* |
| **Infection Prevention and Control** | 79% | 76% |
| **Moving and Handling** | Not provided | *74%* |
| **Prevent** | 85% | 86% |
| **Safeguarding Adults** | 98% | 81% |
| **Safeguarding Children** | 75% | *71%* |
| Grand Total | 82% | **77%** |

Training was either face to face or on computers. Therapy services managers told us that where staff had not completed recent mandatory training, they were booked onto the course.

Staff learning requirements were discussed during appraisals in therapy services at Whitby hospital. Staff views of opportunities to develop and learn further varied at Whitby community services. Whitby hospital community service base had a staff information board, which held information about training opportunities, for example during our inspection there was a poster for tissue viability learning attached to the board. Staff training dates were also attached to the board.

Staff told us they were up to date with their mandatory training, however we heard of two examples when staff had cancelled training due to work pressure.

We received more recent mandatory training compliance data in the performance reports provided by the trust. The Pocklington community services performance report from August 2017 showed the teams overall mandatory training compliance was 79.5% against a trust target of 75% in July 2017. The lowest level of compliance was adult basic life support with 53.3% compliance in July 2017 against a trust target of 75%.

The performance report for the health trainers from August 2017 showed an overall team compliance rate for mandatory training of 76.8% against a trust target of 75%. The lowest compliance was adult basic life support at 25% compliance in August 2017. The Whitby performance report did not detail mandatory training completion rates.

The Trust provided some face to face mandatory training in Pocklington to make it more accessible for staff.
We saw a chart on the notice board in the Pocklington staff office, which listed all mandatory training requirements for individual staff and what they had completed. It also showed when

training was next due. Staff were sent a reminder by email four months before they were due to complete training.

## Safeguarding

Staff told us they had completed safeguarding level one and level two training and had recently received a safeguarding talk from the trust safeguarding team. Staff told us they would also report safeguarding concerns through the trust incident reporting system. Safeguarding adults mandatory training completion rates were 68% at 21 June 2017 and safeguarding children mandatory training completion rates were 37% at 21 June 2017. The Pocklington community services performance report from August 2017 showed the teams overall mandatory training compliance for July 2017 was 73.3% for adult safeguarding training level 2. The trust target was 75%.

Community staff had a good knowledge and understanding of safeguarding and could give examples of the types of abuse they needed to look for. They were aware of their responsibilities in relation to safeguarding and knew how and when to raise a safeguarding concern. Staff told us they would contact the local authority for referrals and advice and had access to a trust safeguarding team if required for advice.

Staff had recently received additional safeguarding training because of a serious incident.
Staff were able to initiate and contribute to multiagency vulnerable adult risk meetings, if they identified a vulnerable adult that would benefit from a meeting.

The Pocklington neighbourhood care service manager told us that they reported all pressure ulcers grade three and above to safeguarding.

3.6% (2942) of patients attending community health adult services within the last 12 months were identified as being a child aged 17 years or under.

The trust have provided the number of the safeguarding referrals made at trustwide level but have been unable to provide a breakdown of this information by core service.

## Cleanliness, infection control and hygiene

Staff adhered to the ‘bare below the elbow’ policy and carried hand gel on visits to patients to ensure infection control techniques. Staff had access to personal protective equipment such as gloves.

All treatment rooms appeared clean and had handwashing facilities. Hand gel dispensers where situated in the treatment rooms and at the entrance to the building. There were separate bins for the disposal of clinical and no-clinical waste.

Disposable curtains used in treatment rooms were visibly clean and were marked with the date they were last changed. They had been changed within the last six months.

Personal protective equipment such as gloves and plastic aprons were available in treatment rooms and we saw that staff visiting patients in their own homes carried a supply with them.

We observed staff washing their hands before and after a procedure with a patient.
Infection control practice was generally good; however, we observed one nurse did not adhere fully to aseptic technique when redressing a wound.

Staff told us that infection control audits including handwashing were carried out regularly; however, they were not aware of how this information was shared in order to improve practice.

The trust provided an infection, prevention and control report for Whitby and this showed an overall compliance of 87.1%. This report was from September 2017 and was for the whole hospital. There was no compliance target for infection, prevention and control audit attached to the report.

The report showed 100% compliance for questions such as adherence to 'bare below the elbow' policy, hand gel being available and all staff being observed washing their hands at the entrance of areas.

## Environment and equipment

Staff across the services worked from two base sites, Whitby Hospital and Pocklington health centre (which was based in a general practitioner (GP) practice). Staff had access to offices for their teams and computer access to trust systems. We saw hand gel dispensers available on entrance to the staff departments.

Staff were issued with individual laptops to enable mobile working and ensure access to systems was available. Staff told us that WI-FI access could be a challenge at Whitby hospital in office areas.

Manual handling training was available from the Pocklington base and trainers would attend Whitby hospital to provide this training. There were staff that had completed train the trainer courses and could deliver this training.

The treatment rooms at the Beckside Centre were on the first floor of the building. A lift was available for patients who were not able to use the stairs. Treatment rooms were spacious and well maintained with sealed floors for effective cleaning.

There was a separate waiting area for patients; however, there were no reception staff available for patients to check in with, or to answer any queries.

All electrical equipment we inspected had been checked and safety tested. The next service date was recorded on equipment to ensure that they were maintained in line with manufacturers' recommendations.

We saw equipment had been provided for patients in their homes. Equipment such as mattresses for pressure relief were sourced from an external supplier. Staff told us equipment for bariatric patients could be ordered but if it was expensive, it needed to be approved by a manager first.

## Assessing and responding to patient risk

The service had recently introduced a joint assessment framework which was an assessment carried out on the first visit to patients. Therapy services completed a prioritisation matrix for new patients, which staff documented whether the patient was routine or required urgent assessment. This was documented on the front sheet and a target date for the appointment was highlighted on the front sheet.

Therapy services had access to electronic templates for assessments and risk assessments, for example balance assessments and upper limb assessments. However, there had been some challenges with implementing the electronic templates initially in therapy services. Staff told us of examples where they had worked with patients to develop a plan of care and that these would be patient centred. Community nursing were able to describe nutritional assessments they could use in the community.

Community nursing did not have scheduled formal handovers between shifts, however managers told us staff handed over from the out of hours shift information to the staff on the early rota. Referrals into community nursing were not triaged upon receipt of the referral. Administrative staff received referrals and added these to the community nursing team's caseload. Community nursing would then be able to review who was on their caseload and told us they would prioritise referrals at this point, for example if there were palliative care patients. Staff could refer patients to other services and to the general practitioner if required.

If there was deterioration in a patient's condition staff would contact the patient's GP to discuss their concern. Out of hours, staff would contact the 111 service or 999 depending on the level of concern. Staff told us that prior to April 2017, they had access to a senior nurse for advice on the late shift but this was no longer available.

The service did not use any specific recognised tools for monitoring deteriorating patients. Community staff we spoke to were aware of the key risks to patients. For example, risks of falls and pressure damage to skin.

The community nursing teams completed risk assessments for patients as part of the core patient assessment on the electronic records system. Risk assessments were carried out to identify patients at risk of falls, pressures ulcers and malnutrition.

All patients received pressure risk assessment using the Walsall community risk score. Staff told us they had excellent advice and support from the tissue viability nurse in managing both patients at risk of developing a pressure sore and those with an existing ulcer.

Staff were aware of what action to take to protect patients from these risks and we saw this clearly documented in the notes. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage risks to patients.

If staff were off at short notice and patient visits needed to be cancelled, a triage tool was used to plan and prioritise workload. Out of hour's community nursing staff attended visits in pairs.

## Staffing

As of 31 May 2017, the trust reported a vacancy rate of 9.7% in community health services for adults. The teams and staff groups with vacancies at 31 May 2017 are detailed in the table below:

| Team | Staff group | Total number of substantive staff | Total % vacancies overall (excluding seconded staff) |
|---|---|---|---|
| **WHITBY THERAPY SERVICES** | Healthcare Assistant | 2 | 50.0% |
| **OT ROTATIONAL SERVICE** | Allied health professionals | 4 | 25.0% |
| **WHITBY COMMUNITY NURSES** | Healthcare Assistant | 12.45 | 22.6% |
| **WHITBY COMMUNITY NURSES** | Nursing and midwifery registered | 18.4 | 14.5% |
| **HEALTH TRAINERS** | Other (including admin and clerical) | 13.2 | 5.5% |
| **WEST WOLDS COMMUNITY NURSES** | Healthcare Assistant | 1 | -3.0% |

*Figures reflect staffing and vacancies at the most recent month, May 2017

Between 1 June 2016 and 31 May 2017, the trust reported an overall turnover rate of 6.7% in community health services for adults, however a number of teams were de-commissioned in March 2017. The below table reflects that this occurred by the high number of staff who were identified as leavers but the trust confirmed they transferred to another provider.

The table below includes the annual turnover rates for the teams that were still provided at 31 May 2017.

| Team | Staff group | Total number of substantive staff (mean WTE) | Total number of substantive staff leavers in the last 12 months | Total % of staff leavers in the last 12 months |
|---|---|---|---|---|
| **338 MSK - ER (Team) (273949)** | Qualified Allied Health Professionals (Qualified AHPs) | 11.77 | 14.12 | 120% |
| **338 West Wolds District Nurses (Team) (274502)** | Support to doctors and nursing staff | 2.47 | 1.53 | 62% |
| **338 West Wolds District Nurses (Team) (274502)** | Qualified nursing & health visiting staff (Qualified nurses) | 6.65 | 3.85 | 58% |
| **338 West Wolds District Nurses (Team) (274502)** | Qualified nursing & health visiting staff (Qualified nurses) | 5.43 | 2.80 | 52% |
| **338 Alfred Bean Outpatients (Team) (274254)** | Qualified nursing & health visiting staff (Qualified nurses) | 1.22 | 0.53 | 44% |
| **338 Whitby Community Nurses (Team) (275002)** | Qualified nursing & health visiting staff (Qualified nurses) | 15.69 | 5.60 | 36% |
| **338 Health Trainers (Team) (274050)** | Support to doctors and nursing staff | 5.83 | 2.06 | 35% |
| **338 Whitby Therapy Services (Team) (275040)** | Qualified Allied Health Professionals (Qualified AHPs) | 4.43 | 0.50 | 11% |
| **338 Whitby Community Nurses (Team) (275002)** | Support to doctors and nursing staff | 9.97 | 0.85 | 9% |
| **338 Health Trainers (Team) (274050)** | Support to doctors and nursing staff | 1.00 | 0.00 | 0% |
| **338 Health Trainers (Team) (274050)** | NHS infrastructure support | 0.20 | 0.00 | 0% |
| **338 Alfred Bean Medical Records (Team) (274281)** | Support to doctors and nursing staff | 5.60 | 0.00 | 0% |
| **338 Alfred Bean Outpatients (Team) (274254)** | Support to doctors and nursing staff | 1.79 | 0.00 | 0% |
| **338 West Wolds NCT OT (Team) (273929)** | Qualified Allied Health Professionals (Qualified AHPs) | 1.00 | 0.00 | 0% |
| **338 West Wolds NCT OT (Team) (273929)** | Support to ST&T staff | 0.48 | 0.00 | 0% |
| **338 Whitby Cardiac / Heart Failure (Team) (275007)** | Qualified nursing & health visiting staff (Qualified nurses) | 0.80 | 0.00 | 0% |
| **338 Whitby Therapy Services (Team) (275040)** | Support to doctors and nursing staff | 2.17 | 0.00 | 0% |
| **338 Whitby Therapy Services (Team) (275040)** | Qualified Allied Health Professionals (Qualified AHPs) | 4.08 | 0.00 | 0% |
| **338 Whitby Therapy Services (Team) (275040)** | Support to ST&T staff | 1.00 | 0.00 | 0% |

Between 1 June 2016 and 31 May 2017, the trust reported an overall sickness rate of 5.4% in community health services for adults. As of 31 May 2017, the trust reported an overall sickness rate of ranging from 0-16% in community health services for adults.

| Team | Staff group | Total number of substantive staff* | Total % permanent staff sickness overall* |
|---|---|---|---|
| **338 Whitby Cardiac / Heart Failure (Team) (275007)** | Qualified nursing & health visiting staff (Qualified nurses) | 24.80 | 16.1% |
| **338 West Wolds District Nurses (Team) (274502)** | Qualified nursing & health visiting staff (Qualified nurses) | 171.33 | 14.5% |
| **338 Whitby Therapy Services (Team) (275040)** | Qualified Allied Health Professionals (Qualified AHPs) | 134.75 | 14.4% |
| **338 West Wolds District Nurses (Team) (274502)** | Support to doctors and nursing staff | 55.80 | 10.8% |
| **338 Whitby Community Nurses (Team) (275002)** | Qualified nursing & health visiting staff (Qualified nurses) | 512.60 | 8.7% |
| **338 Whitby Community Nurses (Team) (275002)** | Support to doctors and nursing staff | 297.60 | 1.1% |
| **338 Health Trainers (Team) (274050)** | NHS infrastructure support | 6.20 | 0.0% |
| **338 Health Trainers (Team) (274050)** | Support to doctors and nursing staff | 117.80 | 0.0% |
| **338 Health Trainers (Team) (274050)** | Support to doctors and nursing staff | 31.00 | 0.0% |
| **338 Health Trainers (Team) (274050)** | Support to doctors and nursing staff | 80.60 | 0.0% |
| **338 Alfred Bean Outpatients (Team) (274254)** | Qualified nursing & health visiting staff (Qualified nurses) | 31.00 | 0.0% |
| **338 Alfred Bean Outpatients (Team) (274254)** | Support to doctors and nursing staff | 55.80 | 0.0% |
| **338 MSK - ER (Team) (273949)** | Qualified Allied Health Professionals (Qualified AHPs) | 62.00 | 0.0% |
| **338 West Wolds District Nurses (Team) (274502)** | Qualified nursing & health visiting staff (Qualified nurses) | 111.60 | 0.0% |
| **338 West Wolds NCT OT (Team) (273929)** | Qualified Allied Health Professionals (Qualified AHPs) | 31.00 | 0.0% |
| **338 West Wolds NCT OT (Team) (273929)** | Support to ST&T staff | 14.88 | 0.0% |
| **338 Whitby Therapy Services (Team) (275040)** | Qualified Allied Health Professionals (Qualified AHPs) | 127.10 | 0.0% |
| **338 Whitby Therapy Services (Team) (275040)** | Support to doctors and nursing staff | 62.00 | 0.0% |
| **338 Whitby Therapy Services (Team) (275040)** | Support to ST&T staff | 31.00 | 0.0% |

*Figures reflect staffing and vacancies at the most recent month, May 2017

Between 1 June 2016 and 31 May 2017, community health services for adults reported an overall bank usage of 1929 shifts for qualified nursing staff. No shifts were filled by agency staff, however 278 shifts were unable to be filled by bank or agency staff.

| Total Shifts Filled by Bank Staff | Total shifts Filled by Agency Staff | Total shifts NOT filled by bank or agency staff |
|---|---|---|
| **1929** | 0 | 278 |

Between 1 June 2016 and 31 May 2017, community health services for adults reported an overall bank usage of 1629 shifts for healthcare assistants. No shifts were filled by agency staff, however 277 shifts were unable to be filled by bank or agency staff.

| Total Shifts Filled by Bank Staff | Total shifts Filled by Agency Staff | Total shifts NOT filled by bank or agency staff |
|---|---|---|
| **1629** | 0 | 277 |

The trust have highlighted that no medical locums have been used by the core service between 1 June 2016 and 31 May 2017.

During the reporting period of 1 July 2016 and 1July 2017, this core services reported that there were no cases where staff have been either suspended or placed under supervision.
Staff told us staffing levels at the Whitby NCS felt low. Managers organised work rotas in the services visited. Staff told us caseloads varied, however were manageable. There were four caseloads that held around 60 to 70 patients.

Therapy services had caseloads of between 20 and 50 patients per caseload for each staff member. Caseloads were displayed on the electronic patient system and new patients were added to staff caseloads through the system.

There were 13 staff in the therapy services team at Whitby neighbourhood care service. Therapy services were a mixture of occupational therapists, physiotherapists and therapy assistants. Across Whitby NCS community nursing services, there was one whole time equivalent registered nurse vacancy, one part time registered nurse vacancy and one part time healthcare assistant vacancy. The community nursing service had one band two healthcare assistant, ten band three healthcare assistants, 16 band five registered nurses, four band six registered nurses and one community matron.

The health trainers performance report for August 2017 showed there were no current whole time equivalent established posts vacant.

At the time of our inspection in the Pocklington based team, nurse staffing levels were up to establishment with the exception of one band 5 nurse vacancy (1.0 wte). This post had been appointed to and was due to commence in November 2017. The nursing establishment was two band 6 nurses (1.4wte), six band 5 nurses (4.9wte) and two band 3 health care assistants (1.8wte).

The Pocklington based therapy team establishment was one band 7 physiotherapist (0.65wte), one band 6 physiotherapist (1.0wte), two band 6 occupational therapists (1.6wte), one band 4

physiotherapy assistant (0.9wte) and one band 3 occupational therapy assistant (0.6wte). There were no vacancies.

In addition, there was one band 7 team leader (1.0wte) for the Pocklington neighbourhood care service.
Issues with long-term sickness were putting pressure on the team. Providing nurse cover until 10pm was also challenging as this had been shared between three neighbourhood care teams prior to the transfer of services to another provider in April 2017. The team manager told us that they used regular bank staff to cover and the current nursing staff worked additional hours. Staff told us they tried to help each other out within the team when possible.

In order to provide a service from 8am to 10pm, community nurses worked on a shift basis. Shifts were from 8am – 4pm, 10am – 6pm and 2pm -10pm. A minimum of one registered nurse and one health care assistant were on duty from 6pm -10pm.

The team manager told us that due to the geographical isolation of the team, any cover for staff absence had to be found within the team or by using bank staff. Prior to the transfer of the remaining neighbourhood care teams to another provider, cross cover had been available from other teams. The manager acknowledged this was a challenge.

The Pocklington neighbourhood care service were attached to one GP practice, The Pocklington Group Practice, which served a population of approximately 14,000. This included the residents of three residential homes. Nurse caseloads varied depending on the complexity of patients. For example, one nurse had a caseload of 160 patients and another nurse had 26 complex patients. Additional time was allowed for visits to new patients and those receiving palliative care.

We observed a nurse handover and found this was methodical and thorough. We saw that actions resulting from the handover were documented accurately.

## Quality of records

We looked at the records for eight patients at Whitby Hospital during our inspection. Records were found to have the appropriate sections on the electronic record system completed, however there was one record that did not have the ‘goal’ section complete. Records included care plans and the joint assessment framework questions, which were completed during first visits to patients. Some templates had different areas complete, however managers told us this was because certain sections were completed only when relevant and dependant on the patient need and risk.

Electronic records included risk assessments and different services had assessment templates appropriate to their services, for example, therapy services had assessments they could complete on the electronic system.

The service carried out a monthly record audit where they selected and audited 10 records in community nursing. Results from July 2017 from Whitby showed overall compliance of 25.3%; however, this did not refer specifically to community health services for adults. Therapy services had previously completed record audits; however, this had not been completed in the previous six months. Managers told us they had a planned meeting to address auditing records.

Staff used their laptops to complete records. However some staff completed patient records when they returned from the community visits and not during visits, particularly when they were unable to access the systems remotely. This was raised during the last inspection.

Community nursing would update records at the local general practitioner (GP) practice if they were unable to access the system remotely whilst on visits.

Staff told us they had access to GP information from the Pocklington base; however some patient information was not as accessible for community nursing and therapy services from Whitby hospital. Staff told us they would contact the GP when information was required and there was an out of hours GP for advice if required. Managers told us lack of a full holistic assessment was a risk to the service.

Records completed on the electronic system offline would update once the system re-established connection.

Patient records were held securely on an electronic record system. All staff had laptops and could work remotely if they were able to get a signal. Staff could also download patients' notes at their office, prior to visiting the patient at home. Paper copies of prescription charts were kept at patients' homes.

We looked at five community nursing patient records (Pocklington neighbourhood care service) and found that care plans were in place and risk assessments had been thoroughly completed in all but one record. This was pointed out to the team leader who immediately spoke to the member of staff responsible and asked them to update the care plan.

The service carried out a monthly documentation audit using a sample of ten records per month. Any issues were flagged and shared with the care group and with staff at team meetings. The team manager told us that individual staff were given feedback if an issue was identified with their documentation. We requested record audits from the service; however the trust only provided us with a Whitby hospital record audit.

The electronic system used by the Pocklington neighbourhood care service by for recording patient information was different to the one used by the GPs. However, in order to allow sharing of information staff had read only access to the GPs records and vice versa.

## Medicines

There was one medicines cupboard at the Whitby hospital community nursing base which held a small number of medicines. Most medicines checked were found to be in date; however we found three medicines out of date. When staff were informed of this, they were removed immediately. There was no formal stock rotation or expiry check of items in the medicines cupboard. Staff did not carry medicines and only kept a small number of items in the medicines cupboard which were rarely used.

During our inspection, we found the medicine cupboard keys were not securely stored and locked away. We informed managers of this and they locked the keys away immediately and told us they had ordered a key lock cupboard to securely store the keys.

An emergency pack was available in case of adverse reactions and staff told us they were ordering more to increase stock levels.

Staff in the Pocklington neighbourhood care service and the musklo-skeletal physiotherapy did not prescribe or administer any medicines.

Wound dressings were stored in a lockable storeroom in the NCS office. We checked the use by date on 10 randomly selected dressings and found they were all well within date.
Creams and lotions for single patient use were stored in the treatment room. We saw that these were within their expiry date but the date of opening had not been recorded on the label.

## Safety performance

The service submitted monthly data to the NHS Safety Thermometer. Incidents reported would be sent to the selected manager electronically and these would be reviewed. Staff told us grade three and above pressure ulcers would be reported through the incident reporting system.

## Incident reporting, learning and improvement

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events'.
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in Community health services for adults, which met the reporting criteria, set by NHS England between, 1 June 2016 and 31 May 2017. Of these, the most common type of incident reported were apparent/actual/suspected self-inflicted harm and pressure ulcers both accounting for 40% of the core service serious incidents reported.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The number of serious incidents reported during this inspection is not comparable to the serious incidents reported at the last inspection.

| Incident Type | Number of Incidents |
|---|---|
| Apparent/actual/suspected self-inflicted harm meeting SI criteria | 2 |
| Pressure ulcer meeting SI criteria | 2 |
| Medication incident meeting SI criteria | 1 |
| **Core Service Total** | **5** |

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.
In the last 12 months, there have been no prevention of future death reports sent to Humber NHS Foundation Trust.

The services visited used a trust wide incident reporting systems and staff told us they had access to this through the computer systems. Staff were able to describe how they report incidents through the electronic reporting system. Incidents were forwarded to the relevant manager to investigate.

Incidents were recorded on the incident reporting system and would be assigned to the team manager to investigate. Senior managers told us they also received copies of the incident, discussed incidents at governance meetings and that feedback to staff from incidents could be reporting through their electronic reporting system.

Learning from incidents through the Whitby community health services for adults had not been fully embedded. Staff told us learning from incidents would be discussed informally, however because there had been a lack of team meetings in community nursing where staff told us these would be shared in the previous six months, there was no formal system for sharing learning from incidents. Managers in therapy services told us learning from incidents would not be currently documented on team meeting minutes; however the trust had provided a formal agenda for team meetings which was being implemented. Some staff told us they had received feedback from incidents when they occurred.

Managers told us incidents were discussed at the locality level governance and business meetings where required. Managers also received copies of incidents that had occurred within their teams and told us they would share action plans from incident investigations with teams as required. Managers told us they were trying to change the culture around reporting incidents.

All staff we spoke with understood their responsibilities to raise concerns and to record safety incidents. They understood how to report incidents using the electronic reporting system. Staff at Pocklington neighbourhood care service told us they received feedback from incidents either at team meetings or individually from their line manager.

The Pocklington neighbourhood care service had reported two serious incidents in the last 12 months, one incident related to a medication error and one involved pressure lesions. These incidents had been thoroughly investigated and an action plan formed to prevent a reoccurrence. The action plan included staff training and competencies in tissue viability, fall assessment and documentation.

All pressure ulcers grade three and above were investigated using root cause analysis. The tissue viability nurse was involved with the investigation and would make a decision on whether the pressure ulcer had been preventable. While we did not see the root cause analysis during our inspection, the trust did provide an action plan for a serious incident regarding a pressure ulcer. This included the issue, action required and accountable person along with timescales for completion. For example, recommendations included improve record keeping standards and ensure staff have implemented the correct procedures for tissue viability management.

The team manager of Pocklington neighbourhood care service was attending a lessons learnt conference a few days after the inspection.

Staff we spoke with had a good awareness of the duty of candour. Staff told us they acted in accordance with the duty of candour and would apologise to patients if they caused them harm. Staff said they were encouraged to be open and honest if they made a mistake.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

## Is the service effective?

### Evidence-based care and treatment

The trust have participated in three clinical audits in relation to this core service as part of their Clinical Audit Programme.

The trust clinical network organised the audits relevant to different areas within community health services for adults. There were no current ongoing audits during our inspection, however record audits were being completed.

Managers told us they were developing an audit plan and that the clinical network at the trust drives audits for the community. Managers told us a heart failure audit using telehealth was planned for the future.

| Audit name / title | Audit scope | Type of audit (clinical, financial, environment etc.) | Date completed | Key Successes | Key concerns |
|---|---|---|---|---|---|
| **NICE QS15 Statement 12** | All teams using electronic system | Local clinical audit | 15/11/2016 | Increase in compliance from 29% to 47% from Dec 2014 to Dec2015. Reaudit Sept 2016 improved to 52% | Progress in increased compliance slow |
| **MHAD273 National Diabetes Foot Care Audit** | Community services | National audit | 2nd report published 07/03/2017. 3rd report due 01/08/17 | 52% met NICE guidelines for HbA1c Higher performance than national data for: proportion seen within 2 days, 12 & 24 week outcomes (100%v92%), those alive and ulcer free at 12 & 24 weeks | Proportion having persistent ulceration at 12 & 24 weeks was higher in the Trust compared to national benchmark |

We saw staff providing evidenced based holistic care. Staff took time to ensure that patients receive a holistic assessment, which meet all their needs.

New National Institute for Health and Care Excellence (NICE) guidelines were discussed at a bi-monthly clinical network meeting.

The musculoskeletal physiotherapist was planning to attend meetings of the hand therapy network.

We did not find any evidence of involvement in local and national clinical audits or benchmarking in order to improve the quality of care for patients.

Staff were able to access trust policies and procedures on the staff intranet. We checked five polices relevant to community health service for adults and found they were all in date.

## Nutrition and hydration

Community nurses used a nationally recognised risk assessment tool, the Malnutrition Universal Screening Tool (MUST) to assess patients at risk of malnutrition. Patients requiring additional support with nutrition and hydration were referred to the dietitian.

## Pain relief

We observed staff assessing patients' pain levels and we saw that this was documented in their notes.

Staff were caring and responsive to patients experiencing pain. The musculoskeletal physiotherapist quickly assisted a patient into another position when she saw he was experiencing pain and discomfort.

## Patient outcomes

We found limited evidence of patient outcome data available across the services. The service performance report showed referral data for the services which enabled managers to monitor referrals.
The trust provided us with two audits, A NICE QS15 Statement 12 which was a local clinical audit and a national diabetes foot care audit.
The NICE local audit completed showed an Increase in compliance from 29% to 47% from December 2014 to December 2015 and a re-audit in September 2016 improved to 52%; however, progress in increased compliance was slow.
The national diabetes foot care audit showed 52% met NICE guidelines for HbA1c higher performance than national data for: proportion seen within 2 days, 12 & 24 week outcomes (100%v92%), those alive and ulcer free at 12 & 24 weeks. However the audit showed the proportion having persistent ulceration at 12 & 24 weeks was higher in the trust compared to the national benchmark.

## Competent staff

The trust has a policy which articulates the standards for clinical supervision for all staff working within the trust. Between 1 June 2016 and 31 May 2017, the average clinical supervision rate for the core service was 92% against the trust's target of 100%.

| Team | Clinical Supervision Target | Clinical Supervision Delivered | Clinical supervision rate (%) |
|---|---|---|---|
| Health Trainers | 100% | 24 | 86% |
| Hull and ER LD OT service (comm.&inpatient) | 100% | 20 | 100% |
| Whitby Heart Failure | 100% | 0 | 0% |
| Whitby Therapy Team | 100% | 12 | 92% |
| **Core Service Total** | 100% | **70** | **92%** |

Between 1 April 2016 and 31 March 2017, 36% of permanent non-medical staff within the community health services for adults core service had received an appraisal compared to the trust target of 85%.

| Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|
| **81** | 29 | 36% |

The trust have not submitted any medical staff appraisal data for this core service in the reporting period from 1 April 2016 to 31 March 2017.
Compliance with appraisals was 100% in the Pocklington neighbourhood care service for June and July 2017. All staff we spoke with confirmed they had completed their appraisal within the last year.

Appraisals in the Whitby neighbourhood care service had not been kept up to date consistently prior to our inspection, however managers were addressing this during our inspection and staff were receiving appraisals. There were 32 staff that required an appraisal at Whitby neighbourhood care service and senior nurses told us around 10 of these staff had received up to date appraisals with a plan to have completed all appraisals by end of October 2017.

The health trainers' performance report from August 2017 showed appraisal completion rates to be 71.4% against a target of 85%.

Staff received managerial supervision and clinical supervision every six to eight weeks. Therapy services had one to one management supervision with staff every two months.

The team manager at Pocklington neighbourhood care service told us that band 5 community nurses and band 3 health care assistants had their competencies assessed every six months by the band 6 nurse, using the Leicester Clinical Assessment Tool.

Staff were able to attend study days to ensure they kept up to date with practice. The musculoskeletal physiotherapist had recently attended a hand therapy study day.

Therapy staff told us that when the remainder of the therapy staff transferred over to a different provider in April 2017, they were worried about losing their clinical supervision. However, new arrangements for supervision had been put in place to ensure that this continued. This included the musculoskeletal physiotherapist joining the neighbourhood care service therapy team linking in with the therapists in the Whitby NCS for peer supervision. There were plans to establish a musculoskeletal supervision group with three first contact practitioners who were due to join the organisation.

The team manager was in the process of arranging some bespoke training on catheter care for nursing staff in the team.

Managers told us they worked with a local NHS trust for specialist nursing services and were developing link roles for staff to enable staff to develop further through specialist interest.
Some staff had attended training in addition to mandatory training. For example assistant practitioner courses. There were four staff in community nursing who were nurse prescribers.

## Multidisciplinary working and coordinated pathways

Staff we spoke with told us there was effective multi-disciplinary team working between community nursing, occupational therapists and physiotherapists across the services. Staff were able to offer joint visits where necessary.

There had been limited engagement between the teams at Whitby community and Pocklington Community health services; however this was changing during our inspection with further joint working taking place.

Referrals to community nursing came from a variety of areas, for example general practitioner referrals and hospital discharge referrals. Therapy services accepted referrals from other healthcare professionals.

Therapy assistants worked between the different therapy services and were able to assist the physiotherapy team and the occupational teams to provide support to the services.

Staff in community nursing would sometimes attend ward discharge meetings to understand which patients may require community nursing. Joint visits could be organised between tissue viability and community nursing if appropriate for patients. The clinical lead for the service attended pressure ulcer forum meetings. Staff told us they worked with the community mental health nurses if required.

Pocklington neighbourhood care service was a multidisciplinary team of nurses, health care assistants and therapists. The team were located together in one office, which helped facilitate communication and close working.

Staff referred patients to other services such as speech and language therapy, dietetics and podiatry.

The trust had recently recruited a specialist bowel and bladder nurse who would work across the Pocklington and Whitby neighbourhood care service.

Therapists in the Pocklington neighbourhood care service worked in partnership with the local authority and the GP practice to provide an intermediate care service that aimed to prevent unnecessary hospital admissions. The service was provided in an intermediate care hub (three beds) within a local care home. Patients at risk of hospital admission or those needing rehabilitation before returning home from hospital were admitted to the hub. A weekly MDT was held which included the long terms conditions nurse, therapists GP, social worker, community nurse and practice nurse. At this meeting, patient progress and goals were reviewed.

### Health promotion

Staff we spoke with told us they would refer patients to other services such as dietitians and general practitioners. Staff told us they consider health promotion when on visits, for example they could provide information on smoking cessation.
Staff were able to refer patients to health trainers for advice and motivation on improving their health by making lifestyle changes. Health trainers offered personal support and motivation to adults on healthy eating, losing weight, physical activity and giving up smoking.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff told us mental capacity was considered as part of the trusted assessor assessment document which was completed on first visits to patients.

During visits with staff we saw staff gain consent as required. Consent was verbally obtained and would be documented in patient notes as required.

Staff told us they had received Mental Capacity Act (2005) training and that Deprivation of Liberty Safeguards training was included in this. Staff worked with a patient's GP where mental capacity assessments were required.

A template was available in the electronic record system for staff to record the results of a test to assess patient's mental capacity. Staff told us they completed this if they had concerns about a patient's capacity.

Staff gained patient consent for sharing their information with other health care professionals and we observed all staff gaining verbal consent prior to providing care.

## Is the service caring?

### Compassionate care

During visits, we saw staff provide support and were responsive to patient needs. Staff provided compassionate care and treatment to patients. Staff took time to interact with patients and did not have set timeframe for appointments, which enabled staff to spend the required time to support patients and provide care.

Staff took into account patients' dignity and privacy during patient visits and were aware of ensuring privacy and dignity was maintained when visiting patients. Staff showed encouragement when interacting with patients. The Pocklington performance report from August 2017 showed that 100% of respondents said they were given enough privacy when talking to staff between April 2017 and August 2017.

Patients we spoke with all said they were extremely happy with the care they received and felt they were always treated with compassion.

We observed staff introducing themselves by name to patients and speaking to them with courtesy and respect.

In the treatment room, a curtain was pulled across to allow patients privacy when undressing and dressing during assessment and treatment.

### Emotional support

Staff did not use any particular anxiety assessments during visits, however staff told us they do ask about patient mood and could refer as necessary. Staff told us they could visit patients with two community nurses if the patient was anxious or required additional support. Staff provided patients with as much time as they required during visits. Staff also provided additional time to learning disability patients to ensure they received the appropriate care and support.

We observed staff giving support to patients and carers in making difficult decisions about their care.

Staff gave information and advice to patients and carers on voluntary services such as the British Red Cross, Dementia UK and carers support groups.

### Understanding and involvement of patients and those close to them

We attended seven community nursing visits from Whitby hospital and three therapy community visits. Staff provided patients with contact details and community nursing were available 24 hours.

Staff in therapy services told us they discussed with patients their goals for therapy and supported patients as required. Patient records had sections for patient goals to be documented and discussed as part of their therapy. Patient goals were documented in patient notes along with a review date and outcome score. Staff could sign post patients to other services if required.

Staff in therapy services developed individual plans of care with patients and agreed on programmes of therapy with patients. Staff provided additional time as needed to support patients. We saw that staff communicated clearly with patients so that they understood their care and treatment and the options available to them. Staff explained clearly and gave patients and relatives the opportunity to ask questions.

The Pocklington performance report from August 2017 showed that between April 2017 and August 2017, 100% of respondents were given enough time to talk about their care.

## Is the service responsive?

### Planning and delivering services which meet people's needs

Service planning was carried out alongside clinical commissioning groups and the services that community health services for adults. Therapy services operated between the hours of 08:30 and 17:00, Monday to Friday. Community nursing for adults were a 24 hour service, seven days a week. There was one registered nurse and one healthcare assistant for out of hour's community nursing based at Whitby hospital.

Managers told us they attended a transformational group that was led by commissioners and attended business meetings and contract meetings with clinical commissioning groups.

Services were managed by team leads in the services and the community nursing service at Whitby had recently introduced a new clinical lead role. The schedule for patient visits was documented on the electronic patient system and showed which patients had visits planned and when.

The services operated in areas surrounding Whitby and Pocklington. There was a business continuity plan in place and staff told us that during bad weather, a more appropriate vehicle was available for use during visits. The service had a map on display in the base site at Whitby showing the region that was used for planning visits during bad weather. Managers told us they would prioritise patient visits during times when visits could be a challenge.

The Pocklington neighbourhood care service provided services from 8am to 10pm seven days a week. Outside of these hours, an evening nursing service was available which was provided by a different organisation based in Beverley. Patients were handed over between the two services by phone and staff could communicate by using a task on the electronic records system.

All referrals came in via a single point of contact. This service was available 365 days a year, from 8.30am – 4.30pm. Outside of these hours, calls were diverted to the duty phone carried by the nurse on duty.

We saw that staff were responsive to urgent referrals. A referral to set up a syringe driver for a patient receiving palliative care was prioritised and actioned immediately.

## Meeting the needs of people in vulnerable circumstances

The service had recently recruited to a continence specialist nurse post to provide additional care and treatment to continence patients. This service was starting in September 2017.
Staff were able to refer patients for a mental health assessment through a single point of access.
Staff provided patients with written information in addition to verbal explanations.

## Access to the right care at the right time

The trust has identified the below services in the table as measured on 'referral to initial assessment'.

The trust have not submitted any assessment to treatment data in their information submission as this is not recorded.

The number of days from referral to initial assessment during this inspection is comparable to that reported at the time of the last inspection in April 2016.

| Name of hospital site or location | Name of in-patient ward or unit | Service Type | Days from referral to initial assessment | |
|---|---|---|---|---|
| | | | National Target | Actual (mean days) |
| **Willerby Hill** | Health Trainers | Health Trainers | *none set* | 0 |
| **Willerby Hill** | NHS Healthcheck | Health Trainers | *none set* | 0 |
| **Willerby Hill** | Stop Smoking Service | Health Trainers | *none set* | 0 |
| **Willerby Hill** | MSK Level 1 Outpatients Pocklington | MSK | *none set* | 23 |
| **Willerby Hill** | MSK Level 1 Physio Direct Pocklington | MSK | *none set* | 3 |
| **Whitby Hospital** | Heart Failure Specialist Nursing Whitby | Neighbourhood Care | *none set* | 6 |
| **Willerby Hill** | NCS District Nursing Pocklington | Neighbourhood Care | *none set* | 2 |
| **Whitby Hospital** | NCS District Nursing Whitby | Neighbourhood Care | *none set* | 1 |
| **Willerby Hill** | NCS Occupational Therapy Pocklington | Neighbourhood Care | *none set* | 10 |
| **Whitby Hospital** | NCS Occupational Therapy Whitby | Neighbourhood Care | *none set* | 13 |
| **Willerby Hill** | NCS Physiotherapy Pocklington | Neighbourhood Care | *none set* | 18 |
| **Whitby Hospital** | NCS Physiotherapy Whitby | Neighbourhood Care | *none set* | 21 |

Staff and managers in community nursing told us there were no waiting lists at the service and referrals were assigned to a community nurse by the administrative team and staff would attend to the patient as required once placed on their caseload. Staff told us they could generally attend to patient visits as soon as they were referred to community nursing. Where there was a delay in attending a patient visit, staff told us they would inform the patients if they were delayed.
There were longer waits, past 18 weeks in therapy services at the Whitby neighbourhood care team. These waits for new referrals were between 22 and 26 weeks.

Managers told us they were taking action to try and address this, for example, staff were checking through the waiting list and contacting patients to assess whether they still required the appointment and whether there had been any changes in the condition. Managers told us they were also looking at internal efficiency to address waiting lists, increasing some staff skill set to complete assessments and the service had considered other services such as the musklo-skeletal service to assist where appropriate. This was not on the risk register for the service.

Routine waiting times in therapy services at Pocklington were eight weeks and the fast response from the service was two to four hours.

The target time for responding to referrals for preventing admission was four hours. Performance of this against the trust target was not part of the performance report supplied by the trust. There were 37 patients on the waiting list for continence assessments. The longest waiting time was 14 weeks. Staff told us the waiting list was being validated and patients would be seen as soon as the new bladder and bowel nurse commenced in post.

At the time of our visit there were 16 patients waiting for an OT assessment. The longest wait was seven weeks. There were 28 patients waiting for a physiotherapy assessment, the longest wait was nine weeks.

Patient visits and clinic appointments were recorded on an appointments ledger in the electronic system. If visits or clinic appointments needed to be changed or cancelled, patients were informed by phone.

### Learning from complaints and concerns

Community adult services received 34 complaints between 1 June 2016 and 31 May 2017. The main complaints themes were regarding access and discharge with 14 complaints and assessment of needs and planning of care with 11 complaints.

Community health services for adults received 45 compliments between 1 June 2016 and 31 May 2017, which accounted for 17% of all compliments received by the trust as a whole. Information on how to make a complaint was available in treatment rooms and in the patient waiting area.

Staff told us they received very few complaints. Compliments were recorded on a log within the electronic reporting system. Learning from complaints was not included as part of the team meeting minutes the trust provided.

## Is the service well led?

### Leadership

Overall leadership for the services was provided by a locality director responsible for community health services across the trust. There was a service manager with responsibility for Whitby community services and Pocklington neighbourhood care services. Each location had a lead therapy manager and community nursing had a senior nurse lead at each site who reported to the service manager for community services.

There had been recent changes to leadership across community services. A new clinical lead post had been added to the community nursing team at Whitby hospital and there was a senior nurse within community nursing at Whitby. Senior Managers told us they had recruited to the clinical lead post to assist in governance, bring advanced clinical skills and develop and lead practice at team level.

The team manager of the Pocklington NCS had been in post since April 2017 and had moved over from another team when the remaining services moved to another provider. The team manager said she had regular supervision meetings with her line manager and felt well supported.

Staff at Pocklington NCS told us that their local team manager was helpful, approachable and had brought the team together. Staff said they felt remote from the trust senior leadership team and had never met them.

## Vision and Strategy

The trust had an overall vision and strategy. Managers told us of the vision and strategy of moving services forward across Whitby and aimed for integrated health and social care, which included the third sector to ensure people were safe and well at home; however, staff were not always aware of the vision or strategy for the services. Managers told us they were working with social services in using the same systems and processes. Staff were aware of the trust values of caring and learning.

There was a service specification for Whitby Therapy services and there was a service specification for Pocklington neighbourhood care team; however, this needed to be updated due to recent service changes. The overall service specification version one was created in November 2015 and described the service vision, integrated service model, neighbourhood care services and local key performance indicators for example.

Trust vision and values were displayed in the reception area and on notice boards in staff offices.

## Culture

Staff across Whitby community services told us there was a lack of communication from senior managers and the trust with different teams in community health services for adults during changes across the services. For example, staff told us there had been no consultation or communication on a new clinical lead role until it had been advertised. Managers told us this had been discussed at team meetings.

We asked staff about feeling part of the wider trust and responses to this varied across different services and locations, for example staff working across Whitby community services did not always feel part of the trust. This had been raised at a previous inspection.

The trust provided us with the trust staff survey for 2016 and this showed that for community health services and older people, only 27% of staff reported good communication between senior management and staff and 67% of staff felt able to make contributions at work.

Staff told us morale varied and was low across services because of the recent changes. Managers told us of the varied morale in community health services and monitored morale through attending meetings and speaking with staff.

Staff told us teamwork between the teams was good and there was openness and honesty in teams. Staff we spoke with were proud of the services they provided to patients.

Staff were aware of lone working at the service. There had been concern raised regarding out of hours offices at Whitby hospital and managers had implemented a new system for signing in and out during out of hours and moved offices to be located on the ward areas. This had recently been introduced before our inspection.

Staff in therapy services told us they had a lone worker communication book. Therapy services worked 08:30 to 17:00, Monday to Friday.

There were systems in place to keep staff safe. For example, staff had been given a torch and a personal alarm and went out in pairs after dark or if there was a known risk. There was a notice board in the office, which listed the names of staff who were working that day. Staff ticked next to their names to show that they had gone home.

There had been mapping exercises completed regarding new services over the previous 12 months to involve staff in the changes.

Staff across the Pocklington services felt able to raise concerns and felt these were listened to and acted upon.

Although staff had been faced with new challenges since the transfer of neighbouring teams to another provider, there was a positive attitude to finding solutions and overcoming these challenges.

Staff and managers told us they were proud of their team and the care they gave to patients.

## Governance

Managers told us of the trust governance arrangements and how risks would be escalated through various meetings as required. However, governance systems were not fully embedded at team level within the services we inspected.

Staff told us learning from incidents and risks to the service would be discussed at team meetings, however these had only been implemented a week prior to our inspection and had been less frequent previously. This did not provide assurance around governance systems at team level.

There was a monthly business meeting across the services where representatives from human resources, finance and performance attended. Trust governance structures fed into the care groups and then down to the locality groups. The locality group level included business meetings and governance meetings, which then provided information to the team meetings.

The Whitby locality governance group meeting from August 2017 showed that performance and management was part of the agenda along with statutory and mandatory training for example. Minutes from the September 2017, Whitby locality governance group meeting showed locality management and best practice and innovation were part of this agenda.

The Whitby clinical network group meeting minutes from June 2017 showed that terms of reference, audit plan and updates were part of the agenda for the meeting.

There were challenges with waiting lists in the therapy services team at Whitby hospital and staff were taking some action to address this, however there was no formal action plan to address waiting list issues for therapy services. This did not provide assurance that risks regarding waiting lists were regularly assessed and monitored.

The team manager of the Pocklington NCS told us that interaction with the NCS at Whitby was difficult because of the time it took to travel between the two locations. However, links between the teams were starting to form.

## Management of risk, issues and performance

The local team risk register for community nursing at Whitby hospital had been created in September 2017 and when reviewed did not have all sections completed, for example review dates. Managers told us they had recently changed from using the overall trust risk register to establishing a risk register for teams within the community services directorate. Managers were able to add items to the risk register.

Risks included on the risk register for example, included low staffing levels and turnover of staff and continence waiting lists. We requested the risk registers and the community risk register provided had all sections completed, along with review dates and risk ratings. Delay in access to assessment and treatment due to waiting lists in Whitby physiotherapy services was on the risk register supplied by the trust.

The care group risk register was used to escalate risks to the trust board and that risks were captured at trust board level, care group level and more recently at local team level through the recently introduced risk register. Managers acknowledged this was new and required further work. Managers told us risk registers would be reviewed monthly.

There was an agenda document, which had processes for meetings and escalation of concerns. This had been implemented across the service in 2016, however had not been embedded at Whitby community services. Managers told us that having recently started regular formal team meetings at Whitby community services, risks would be escalated from these to the business meetings.

Senior managers told us the main three risks to the service were providing full holistic assessments to patients, staff competency and staff culture and engagement. Whilst providing full holistic assessments was on the risk register, developing staff skills and staff culture and engagement were not on the risk register. Managers told us they had an action plan for holistic assessments and that they were upskilling staff and had organised bespoke training. The service provided a Whitby neighbourhood care service action plan that had been updated in September 2017. This showed for example, to have a clear understanding and achievement of the expected standard of full and holistic assessment and to develop the skills and knowledge of the team.

The service manager received quarterly service reports, which detailed performance in several areas including staff absence, compliance with appraisals, face to face contacts, friends and family test results, prevent admission data and compliance with mandatory and statutory training. Budget performance was also included in this report. We received the performance report for Pocklington NCS but not Whitby community services.

The service provided us with a health trainer's performance report for August 2017 and included workforce information such as sickness absence, staff turnover, staff training compliance and number of complaints received for example.

We did not find evidence of a robust programme of clinical and internal audit to monitor quality. For example, there was no community services audit programme.

There was a local risk register for the Pocklington NCS, however this had been recently introduced and did not reflect the risks identified to us by staff during this inspection. Staff we spoke with were

not able to tell us how risks were escalated up to senior management. The team manager told us that training in risk management was needed.

The Pocklington NCS held team meetings every six to eight weeks, which was attended by nursing and therapy staff. There was a standard agenda which included items such as incidents/themes, statutory and mandatory training update, staff safety, safety alerts and risks.

## Information management

Managers had access to monthly performance reports to enable monitoring of performance indicators within the services.

Staff had access to patient records system through their laptops. These were used to assist in mobile working across the services. Incident reporting was electronic and staff complete incident forms through their computers.

## Engagement

Regular team meetings in community nursing at Whitby hospital had only recently been introduced in September 2017 and this had increased engagement; however team meetings before this were less frequent. Team meetings in therapy services at Whitby hospital were weekly and managers told us every four weeks the team meeting was longer where the team would share additional information.

We requested team meetings minutes from across the service. Minutes from the Pocklington neighbourhood care team meeting in July 2017 showed that mandatory training and staffing were on the agenda. We received one set of team meeting minutes from Whitby Hospital for July 2017 and this showed that mandatory training, staffing, infection control, policies and procedures and the incident reporting system was on the agenda. Therapy team meeting minutes from Whitby Hospital community services from August 2017 showed that waiting lists and triage were on the agenda.

Staff and managers we spoke with were not aware of any active programmes to engage the public in services. However managers told us they had recently communicated with the external voluntary and charity organisations. The trust did carry out friends and family test surveys. Results from the West Wolds neighbourhood care services for September 2017 showed that 100% of respondents were extremely likely or likely to recommend the community services. The friends and family test for Whitby community services for August 2017 showed that 100% of respondents were extremely likely or likely to recommend the service.

Community nursing staff told us they took feedback cards out to patients to assist in gaining feedback on the services.

The health trainer service provided support, guidance and motivation to adults across the east riding of Yorkshire who wants to make a change to their lifestyle.

The trust participated in the Friends and Family Test. The results were collated monthly and shared with team leaders in the quarterly service report. However, additional patient comments were not shared with the team manager or staff within the team; therefore, there was no opportunity for staff to use patient feedback to improve their services. Managers told us they also received information regarding the service from complaints and the patient advice and liaison

service. Managers told us the trust had recruited to a post to improve patient engagement as it had recognised patient engagement needed improving.

A physiotherapist from the Pocklington neighbourhood care service had presented a ‘patient story’ to the trust board on the morning of our visit.

Staff told us that when the surrounding teams had moved over to another provider in April 2017 they had initially felt isolated and morale was low. However, they said morale had improved and they were focused on finding solutions to the challenges they faced.

Nursing staff told us they tried to help each other out within the team when possible.
Senior managers told us they had held a year end listening event in March 2017 and formed an action plan from this. One action was to hold a monthly drop in clinic for staff at Whitby Hospital to provide staff with the opportunity to talk to managers. Manager told us they had increased the presence of managers at Whitby Hospital and carried out engagement meetings with staff for the refurbishment of Whitby hospital.

## Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to a team the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The teams within this core service have not participated in any accreditation schemes.

A new continence nurse role had recently been created to increase the specialist knowledge for continence care to patients.

The service was rolling out an inspection tool across the different services. This was in progress during our inspection.

The service provided us with a community services care group quality improvement plan for 2017/2018. This detailed the improvement required, when this will be done and progress updates. This detailed planned improvements for example, supervision structures. There was a patient safety improvement area showing planned improvements such as the safety huddle model. The patient and carer section of the quality improvement plan showed plans for developing a carer engagement strategy. The training, development and skills gap analysis showed an improvement action required for skills and gap analysis. The culture and staff engagement had a planned improvement to respond to the latest staff survey to address any areas of concern.
The multi-agency intermediate care team won an award for their partnership working.

# Mental health services

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

## Facts and data about this service

Humber NHS Foundation Trust provides inpatient acute and intensive care services for adults of working age with mental health conditions that 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 patients who are experiencing an acute mental illness and crisis. It has 10 beds and treats both men and women. The ward is based on Castle Hill Hospital site to the north of Hull.
- Newbridges provides care and treatment to men who are experiencing an acute mental illness and crisis. It has 18 beds and treats only men. The ward is a standalone unit located in east Hull.
- Westlands provides care and treatment to women who are experiencing an acute mental illness and crisis. It has 18 beds and treats only women. The ward is a standalone unit located in west Hull.

The trust also has a psychiatric intensive care service for people who present higher levels of risk and require greater observation and support. It has 14 beds and treats both men and women. 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 April 2016 we rated the caring key question as good, the safe key question inadequate and the effective, responsive and well led key questions as requires improvement so we re-inspected all five key questions.

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, asked a range of other organisations for information and sought feedback from patients at focus groups. We visited the five wards between 12 and 14 September 2017.

| Location site name | Ward name | Number of beds |
|---|---|---|
| **Miranda House** | Avondale Assessment Unit | 14 |
| **Miranda House** | Psychiatric Intensive Care (PICU) | 14 |
| **Newbridges** | Newbridges | 18 |
| **Westlands** | Westlands | 18 |
| **Mill View** | Mill View Court | 10 |

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

# Is the service safe?

## Safe and clean care environments

### Safety of the ward layout

Acute and psychiatric intensive care wards provided patients with a clean and comfortable environment. All patients and carers told us that when there was an incident that resulted in untidiness, staff cleared this up quickly.

The ward layouts meant that there were blind spots where staff could not observe patients and there were ligature risks throughout the building. Following the 2016 inspection we asked the provider to ensure and document effective controls in place to mitigate against ligature risks. Staff lessened risks with convex mirrors to improve observation of blind spots and the wards had comprehensive environmental ligature risk assessments. We reviewed ligature audits during the inspection and saw that the risks on the ward were identified; this had improved since the last inspection.

There were ligature risks on five wards within this core service. The trust had undertaken recent ligature risk assessments at five locations.

All of the wards presented a high level of ligature risk due to doors and soap dispensers being red rated. Staff also carried out observations of patients depending on the patients' risk and level of supportive engagement. The key purpose of supportive engagement and observation is to provide regular contact with patients during temporary periods of distress when they are at risk of harm to themselves and or others.
We saw that staff carried out engagement and recorded it in the patients' care records. Observation levels were also recorded on the communication board in the staff office. However there were not always enough staff on the wards to keep the patients safe. For example, in August Westlands and the psychiatric intensive care unit recorded four occasions where there were not enough staff to cover general and increased engagement levels. We saw that although ligature risk assessment had improved, low staffing levels had the potential to impact on patient safety. Staff on Westlands told us they felt isolated as they were a standalone unit.

Avondale, the psychiatric intensive care unit and Mill View Court provided mixed sex accommodation to patients. Although the three wards had separate male and female corridors, they also provided 'swing beds' to allow for additional opposite gender admissions if necessary. Bedrooms were en-suite on Mill View Court however female patients on Mill View Court and Avondale would have to pass male bedrooms to access female only lounges. On Avondale unit we asked staff how they ensured the safety of patients when males were admitted to the 'swing beds' in the female corridor. We were told that they risk assessed patients to determine their suitability and locked the access to the female section to prevent male access. We previously asked the provider to ensure that there was dedicated, female only space on Mill View Court; patients now had access to a female only lounge, but this was off a shared gender corridor. When patients of the opposite gender were admitted onto the wards staff recorded these as incidents. Over the 12 month period from 1 June 2016 and 31 May 2017 there were zero mixed sex accommodation breaches within this core service.

All staff carried personal alarms that they regularly checked to ensure they worked properly. On Westlands when a member of staff's alarm failed during an incident with a patient this was recorded and raised with the health and safety link on the ward. On Newbridges, Westlands and psychiatric intensive care unit the patients told us they felt safe on the wards, however on Mill View Court and Avondale patients did not. Following the 2016 inspection we recommended the provider ensure that there were appropriate systems in place for patients to summon assistance from staff, including in patient bedrooms. One patient on Avondale was offered a personal alarm.

**Maintenance, cleanliness and infection control**

Acute and psychiatric intensive care ward environments were clean and well maintained; domestic staff carried out and recorded daily cleaning tasks. However some furnishings were worn and posed potential infection control issues; for example, on Westlands, the laminate edging on dining room tables was exposed. There was graffiti on the notice boards at Newbridges.
Staff carried hand gel and there were hand gel dispensers at the entrances to the units. Wards were completing hand hygiene assessments of staff and cleaning equipment guidance was available.
Patient-led assessments of the care environment assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. The locations scored similar to similar trusts for two of the four aspects overall – cleanliness and disability. The locations received a score worse than other similar trusts for condition appearance and maintenance scoring 90.34% compared to 94.5% nationally.

There were four locations that scored worse than similar trusts for the condition appearance and maintenance aspect of the care environment.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Newbridges** | Acute/ PICU | 99.66% | 91.01% | N/A | 91.57% |
| **Mill View** | Acute/ PICU and Wards for older people | 99.02% | 93.63% | 84.66% | 82.27% |
| **Miranda House** | Acute/ PICU | 97.84% | 89.63% | N/A | 81.80% |
| **Westlands** | Acute/ PICU | 96.69% | 86.71% | N/A | 88.57% |
| **Trust overall** | | 99.16% | 90.34% | 81.49% | 82.92% |
| **England average (Mental health and learning disabilities)** | | **97.8%** | **94.5%** | **82.9%** | **84.5%** |

### Seclusion rooms

With the exception of Mill View Court, all wards had a seclusion room. During the inspection there were no patients formally secluded and we viewed all rooms. Seclusion rooms allowed for two way communication via a hatch and had clocks with the correct time. Seclusion rooms had access to natural light and blinds could be operated externally by staff to increase or minimise light as required. Seclusion rooms were not en-suite which was highlighted as an issue during the last inspection in 2016. In the event that a patient could not use the bathroom facilities due to safety risks, they were provided with urine bottles and bowls which were then collected from the seclusion room when it was deemed safe. Staff told us that where possible patients were supported to use the toilet facilities and that three members of staff trained in management of actual or potential aggression would escort the patient. Anti-ligature bedding was in all seclusion rooms. There were plans to refurbish the seclusion room on the psychiatric intensive care unit; however these did not incorporate changing the adjacent bathroom to an en-suite. There is an expectation that refurbishment of seclusion facilities should create en-suite facilities where possible.

### Clinic room and equipment

We checked all clinic rooms and equipment. Clinic rooms had examination couches and equipment for physical health examinations. We found that the medicines cabinets were orderly, well stocked and in date and medicines fridge temperatures were being monitored. Following the 2016 inspection we asked the provider to ensure that refrigeration temperatures were checked daily on all wards, in line with Trust policy and national guidance; this had been resolved.

On Westlands, clinic checks were not allocated to a specific staff member which resulted in checks not always being completed. We asked a member of staff how clinic stock was ordered and were told that one member of staff ordered items on a monthly basis. Controlled drugs were given to patients in the clinic room and the door was locked. Staff told us that one patient had grabbed the sharps bin when there was not another member of staff to help medications round

due to high levels of activity on the ward. They also told us that the incident was promptly responded to quickly and effectively.
On Newbridges the frequency that controlled drugs were checked was unclear.

## Safe staffing

### Nursing staff

With the exception of psychiatric intensive care unit, all nursing staff worked across three daily shifts.

- Early - 07:00 to 15:00
- Late - 12:00 to 20:00
- Night - 19:30 to 07:30

The staffing establishment for nursing staff is displayed below. Additional staff could also be requested to cover patient engagements.

| | Early | | Late | | Night | |
|---|---|---|---|---|---|---|
| | Qualified Nurses | Healthcare Assistants | Qualified Nurses | Healthcare Assistants | Qualified Nurses | Healthcare Assistants |
| **Avondale** | 2 | 3 | 2 | 3 | 2 | 2 |
| **Mill View Court** | 2 | 2 | 2 | 3 | 1 | 3 |
| **Newbridges** | 2 | 4 | 2 | 4 | 2 | 3 |
| **Westlands** | 2 | 4 | 2 | 4 | 2 | 3 |

On the psychiatric intensive care unit staff worked across two shifts.

- Long Days - 06:40 to 19:20
- Night - 18:40 to 07:20

| | Long Day | | Night | |
|---|---|---|---|---|
| | Qualified Nurses | Healthcare Assistants | Qualified Nurses | Healthcare Assistants |
| **Psychiatric intensive care unit** | 2 | 3 | 2 | 3 |

There were additional staff on the wards during normal business hours, for example, modern matrons, the service manager, consultants, junior doctors, charge nurses, occupational therapists, psychologists and activity workers. The trust provided staffing data from May 2017.

| Staff role | Avondale (WTE) | Mill View Court (WTE) | Newbridges (WTE) | Psychiatric Intensive Care Unit (WTE) | Westlands (WTE) |
|---|---|---|---|---|---|
| Charge Nurse/Ward manager | 1 | 1 | 1 | 1 | 1 |
| Deputy Charge Nurses | 3 | 2 | 3 | 2 | 3 |
| Staff Nurses | 11 | 9.8 | 11 | 10 | 10.8 |
| Healthcare Assistants | 12 | 13.4 | 19.6 | 15 | 13 |
| Social Worker | 0 | 0.2 | 0.4 | 0 | 0.4 |
| Occupational Therapist | 0 | 1 | 1 | 1 | 1 |
| Assistant Practitioner OT | 0 | 0 | 1 | 0 | 1 |
| Activity Co-ordinator | 2 | 1 | 1 | 1 | 1 |
| Psychologist | 1.5 | 0.5 | 0.6 | 0.45 | 0.6 |
| Psychiatrist | 1 | 1 | 1 | 1 | 1 |
| Ward Clerk/Admin | 1 | 2 | 2 | 1 | 2 |
| Handyman | 0 | 0 | 1 | 1 | 1 |
| Speciality Doctor | 0 | 0 | 0 | 0.8 | 0 |

We reviewed 4 months of staff fill rate data provided by the trust. The fill rate is the actual number of hours worked divided by hours planned and indicates when shifts filled have been met. Newbridges and the psychiatric intensive care unit both had two months where staffing levels were rated red against the safer staffing planned levels and all other wards, with the exception of Mill View Court, had instances where they were identified as amber against the safe staffing levels.

| | | Nurse | | Healthcare Assistants | |
|---|---|---|---|---|---|
| Ward | Month | Day | Night | Day | Night |
| Avondale | Apr-17 | 89.0% | 95.7% | 96.0% | 117.8% |
| Avondale | May-17 | 84.7% | 95.1% | 92.2% | 121.6% |
| Avondale | Jun-17 | 95.8% | 99.3% | 92.6% | 133.3% |
| Avondale | Jul-17 | 97.5% | 99.4% | 87.1% | 122.8% |
| Mill View Court | Apr-17 | 97.9% | 109.7% | 97.2% | 104.9% |
| Mill View Court | May-17 | 97.6% | 100.3% | 96.0% | 98.9% |
| Mill View Court | Jun-17 | 94.7% | 103.4% | 98.3% | 97.0% |
| Mill View Court | Jul-17 | 103.0% | 103.8% | 94.5% | 105.3% |
| Newbridges | Apr-17 | 73.6% | 66.1% | 95.8% | 123.6% |
| Newbridges | May-17 | 76.8% | 105.2% | 101.2% | 101.2% |
| Newbridges | Jun-17 | 82.9% | 100.0% | 90.1% | 108.6% |
| Newbridges | Jul-17 | 95.1% | 100.0% | 93.4% | 98.9% |
| Psychiatric intensive care units | Apr-17 | 75.6% | 100.1% | 124.9% | 144.1% |
| Psychiatric intensive care units | May-17 | 73.9% | 96.4% | 139.2% | 162.5% |
| Psychiatric intensive care units | Jun-17 | 71.6% | 98.4% | 131.8% | 151.6% |
| Psychiatric intensive care units | Jul-17 | 95.1% | 83.3% | 142.2% | 173.3% |
| Westlands | Apr-17 | 104.7% | 97.0% | 83.9% | 97.0% |
| Westlands | May-17 | 94.3% | 102.2% | 101.3% | 109.9% |
| Westlands | Jun-17 | 82.1% | 92.5% | 95.4% | 96.8% |
| Westlands | Jul-17 | 86.2% | 90.5% | 104.2% | 94.8% |

The wards used a centralised e-rostering system to manage staffing. The wards relied on bank and agency staff and regular staff worked additional hours and overtime to meet safe staffing levels. Charge nurses and ward managers were able to adjust daily staffing levels to take account of patient need, but felt that some staff on shift were inexperienced.

When agency and bank staff were used, managers tried to request staff already familiar with the ward but this was not always possible. All bank and agency staff received an induction to the wards. Induction packs emphasised the importance of potential ligatures and supportive engagement and had a section for speaking up and raising concerns. However no contact telephone numbers were provided in this section.

Agency registered nurses were also given a fact sheet to carry regarding restrictive practices such as seclusion, restraint and rapid tranquilisation.

Staff were visible on the wards and a qualified nurse, though not always present in communal areas, was available on shifts. However staff told us that there had been occasions where the qualified nurses on shift were inexperienced. Patients were offered one to one time at the start of every shift and that this was recorded on a whiteboard in the staff offices.

After the last inspection we asked the provider to ensure that there were sufficient staff to ensure patients were able to have sufficient one to one time with nursing staff. Patients told us that this had improved.

Staff, patients and families told us that leave and activities were frequently cancelled. Staff told us that this was because of staff shortages, increased ward engagements and annual leave. We saw discussion of cancelled activities in patient community meeting minutes. On Westlands and Avondale the charge nurses told us that they tried to facilitate activities and leave between 13:00 and 15:00 when a larger number of staff were on shift. We requested details of activities and leave that were cancelled. The trust told us that there were no instances of cancelled leave and did not provide information on the monitoring of cancelled activities.

Nursing staff on Westlands, Mill View Court and Avondale told us there was not enough staff on shifts, particularly nights, and they ‘keep their fingers crossed’. They also told us that qualified staff were frequently agency staff who were unfamiliar with the wards. One staff member from Mill View told us that there were shifts offered to bank and agency staff every day. Staff on Newbridges also told us that they were frequently transferred to cover other wards to cover staffing. Staff at the psychiatric intensive care unit told us that they worry about the safety of the ward. We saw that staff had recorded 4 incidents of unsafe staffing levels for both Westlands and the psychiatric intensive care unit in August and saw evidence of complaints from patients on Westlands and Mill View Court regarding staffing levels, cancelled leave and unavailability of staff.

**Medical staff**

There was adequate medical cover day and night and a doctor could attend the wards in an emergency. Each ward had a consultant psychiatrist and the psychiatric intensive care unit had a speciality doctor. Junior doctors supported the wards. The consultant psychiatrists had an on call rota to support the wards out of normal working hours. We saw a complaint relating to medical cover for Newbridges where a family member felt that the ward psychiatrist had not scheduled enough time with their family member and a patient on Westlands told us they found it difficult to

see their doctor. We also saw that an episode of seclusion was forwarded to the day team to review as there was not enough cover to end the seclusion at night. Medical staff felt there was a lot of pressure in their roles and cited patient numbers and a lack of cover as their main concerns.

**Definition**

Substantive – how many staff in post currently.

Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| Substantive staff figures | Date | Core service | Trust target |
|---|---|---|---|
| Total number of substantive staff | At 31 May 2017 | 166 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 16 | N/A |
| Average WTE* leavers over 12 months (%) | 1 December 2016 – 31 May 2017 | 11% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) (WTE*) | At 31 May 2017 | 0.4 | N/A |
| Total vacancies overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 0.2%<br>Monthly core service range 11% over established to 0.2% vacancy | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 5%<br>Range 4% to 8% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 70<br>Range 70 to 72 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 91<br>Range 61 to 91 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 7.3<br>Range 6 to 18 vacancy | N/A |
| Number of WTE vacancies nursing assistants | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 29<br>Range 3 over-established to 29 vacancy | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 10%<br>Range 9% to 25% vacancy | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017 | 32% | Not provided |

| | | | |
|---|---|---|---|
| | 1 June 2016 – 31 May 2017 | Range 4% over-establishment to 32% vacancy | |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 1054 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 918 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 448 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 2389 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 318 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 281 | N/A |

*WholeTime Equivalent

The sickness rate for this core service was 5% between 1 June 2016 and 31 May 2017.
This core service had 16 (11%) staff leavers between 1 June 2016 and 31 May 2017.
This core service has reported a vacancy rate of 0.2% as of 31 May 2017.

The trust provided updated agency use ward level figures following the inspection. Between the period 1st August 2016 to 31st July 2017, Newbridges had the highest number of shifts filled by bank and agency to cover sickness, absence or vacancies at 1350 shifts, followed by Westlands at 1177 and Avondale at 1069. The same three wards also had the highest numbers of shifts not filled to cover sickness, absence or vacancies; the highest shifts being Westlands at 240, followed by Avondale at 212 and Newbridges at 193.

The trust provided data at ward level following the inspection. Newbridges, Mill View Court and Westlands had the highest sickness rates of 6.7%, 6.8% and 4.8% respectively. The same wards also had the highest staff turnover rates; Newbridges – 20%, Mill View Court 19.5% and Westlands 14.8%

The trust reported the following nursing vacancies per ward.

| | Avondale | Mill View Court | Newbridges | Psychiatric intensive care unit | Westlands |
|---|---|---|---|---|---|
| Number of vacancies: registered nurses (WTE) | 1 | 1 | 3 | 0 | 3 |
| Number of vacancies: healthcare assistants or equivalent (WTE) | 0 | 2 | 0 | 0 | 4.8 |

**Mandatory training**

The trust had set mandatory training required by all staff dependent on role.
Overall as of 31 March 2017, staff in this service had undertaken 87% of the various elements of training that the trust had set as mandatory. This was better than the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% target in fire safety training.

Safeguarding adults and information governance training had the highest training compliance with 99%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 73% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate of 74%. The staff in this service had not achieved the CQC 75% training target in 10 courses. These courses are indicated in the table below.

Mental Health Act training had the highest training compliance with 90%. Basic life support scored the lowest out of all the training courses with 46% however staff had not been required to complete these courses in previous years.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Information Governance | 99% | *62%* |
| Safeguarding Adults | 99% | *72%* |
| Mental Capacity Act | 98% | *72%* |
| Conflict Resolution | 92% | *67%* |
| COSHH | 89% | 81% |
| Prevent | 89% | 85% |
| Health and Safety | 88% | 86% |
| Safeguarding Children | 88% | *70%* |
| Display Screen Equipment | 85% | *68%* |
| Moving and Handling | 84% | *70%* |
| Equality and Diversity | 81% | 76% |
| Infection Prevention and Control | 80% | *73%* |
| Fire Safety | 61% | *59%* |
| Mental Health Act | Not provided | 90% |
| Basic Life Support | Not provided | *46%* |
| Immediate Life Support | Not provided | 81% |
| MAPA | Not provided | 79% |
| Paediatric Basic Life Support | Not provided | Not provided |
| Core service total % | 87% | *73%* |

On 22 September 2017, following our inspection, we requested updated training figures for life support training. Acute services averaged 64% completion for basic life support training and 74% for immediate life support training. Individual ward rates are detailed below. Life support training is important where staff use rapid tranquilisation on patients. The rapid tranquilisation policy states

that the nurse in charge must ensure there was immediate access to an immediate life support trained member of staff on shift however this was not identified on the ward rotas or staffing boards.

Following our focused follow up inspection in 2017 we issued a requirement notice to ensure that all qualified staff were up to date with immediate life support training. This was not resolved at this inspection.

| Training Course | Avondale | Mill View Court | Newbridges | Psychiatric intensive care unit | Westlands |
|---|---|---|---|---|---|
| Immediate Life Support (ILS) | 90% | 90% | 77% | 62% | 54% |
| Adult Basic Life Support (BLS) | 62% | 69% | 69% | 57% | 65% |

The trust also provided additional training figures for management of actual or potential aggression of 87% and Mental Health Act training figures of 92% as of August 2017. Westlands was the only ward below the 75% target training for Mental Health Act at 69%; however the charge nurse told us that training had been scheduled for staff. Acute and psychiatric intensive care wards averaged 72% for fire safety training. Newbridges and the psychiatric intensive care unit had fire safety figures of 66% and 53% respectively, both below the target.

We reviewed fire safety files and requested dates of fire dates and drills. Staff completed fire alarm log books, dates of equipment checks and audits; fire incident reports were seen for false alarms. Charge nurses were responsible for completing weekly and monthly checks and contact details were available of the central fire safety team for escalation of any issues identified. Fire drills were being completed.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

We reviewed 26 care and treatment records that included risk assessments. The trust had revised its risk assessment practice and was no longer using the recognised Galatean Risk and Safety Tool. Acute and psychiatric intensive care wards were preparing to use an alternative tool called the electronic functional analysis of care environments risk assessment tool at the end of September. However, the electronic system did not fully support staff to complete the tool and needed upgrading. As an interim measure staff completed a clinical risk review and a safety plan. Staff had completed risk assessments on admission for the 26 records we reviewed. Care plans and risk assessments were also updated following any incidents and were discussed at multidisciplinary team meetings and handovers. Safety plans were completed by the patients on paper and transferred to the electronic records system.

**Management of patient risk**

Staff were aware of patients at risk and we saw that engagement levels were increased following incidents. When patients returned from leave, staff searched patients for banned articles where they had reason to do so, and with patients' permission. However one member of staff told us that they did not always record this on the system in line with trust policy. Staff said that they had received search training however training figures varied across the wards.

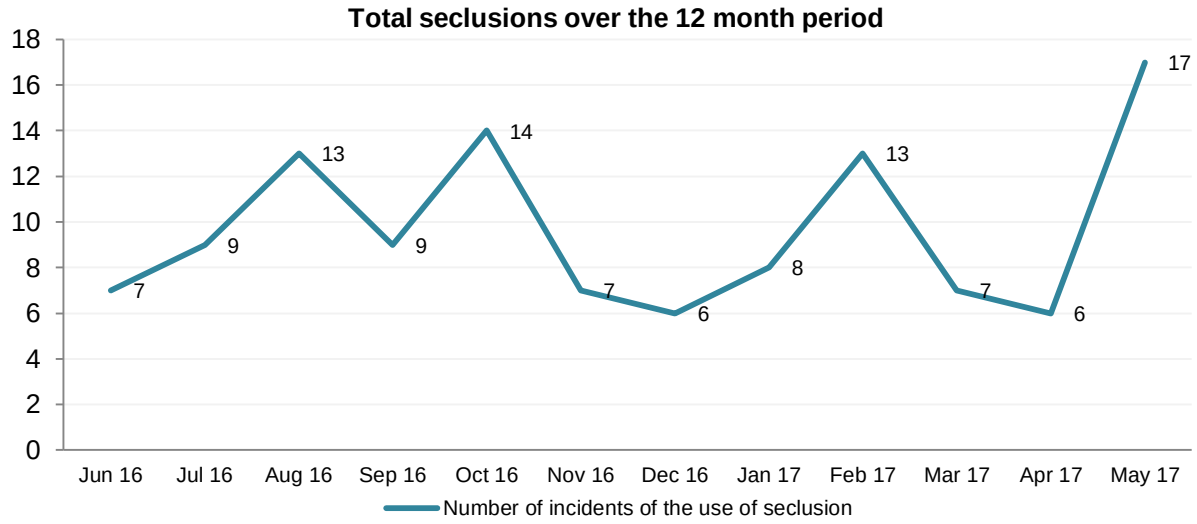
- Avondale – 100%
- Mill View Court – 84%
- Psychiatric Intensive Care Unit – 50%
- Newbridges – 66%
- Westlands – 94%

All wards had ligature cutters as attempted ligature incidents were common on the wards due to the patient group's suicidal ideations; these were clearly marked and were easily accessible.
All wards had a designated smoking area in the gardens and staff offered help to patients to stop smoking if they wished. We saw in care notes that smoking cessation aids had been offered to patients.
We struggled to find notices informing informal patients of their rights to leave on the wards. We fed this back to the charge nurse on Mill View Court and they directed us to an unclear laminated sign on the exit door. Informal patients on Mill View Court told us that they felt unable to leave. On Avondale the charge nurse told us that there was a sign on a Mental Health Act notice board instead of by the door.

**Use of restrictive interventions**

There were no patients secluded on any of the wards when we inspected. Staff understood the definition of seclusion and understood that restraint was a last resort. Staff and patients described how they tried to manage incidents with de-escalation and only used low level of restraint when de-escalation failed. Mill View Court had decommissioned their seclusion room at the end of November 2016. Staff from other wards told us that this had resulted in an increase of higher risk patients being transferred to the other wards. We also saw that one ward had recorded an inappropriate transfer of a patient from Mill View Court following an incident.
At the inspection in 2016 patients did not have clear seclusion exit plans and seclusion was not always ended appropriately. We reviewed six seclusion records and saw that this had improved. Seclusion records detailed the reason for seclusion, details of medication and details of debriefs completed with patients following seclusion. Staff followed the patients' care plan and seclusion was terminated quickly and effectively in all but one case. One record highlighted the difficulty of having a multidisciplinary review at night so the independent review was deferred for three hours until day shift staff started. The multidisciplinary team reviewed patients care plans and with the exception of one record, nursing reviews were being completed in line with the trust policy. Staff told us that a briefing note had been sent out by the director of nursing regarding the procedure for entering reviews.

Over the 12 months, a total of 116 seclusion incidents were reported. There was an increase in the use of seclusion in May 2017, where there were a total of 17 instances.




There have been no instances of long term segregation over the 12 month reporting period. This is lower than the four reported at the time of the last inspection.
This core service had 305 incidents of restraint (on 183 different service users) and 116 incidents of seclusion between 1 June 2016 and 31 May 2017. Over the 12 months, there was an increase in the use of restraint in February and May 2017, where there were a total of 36 incidents.

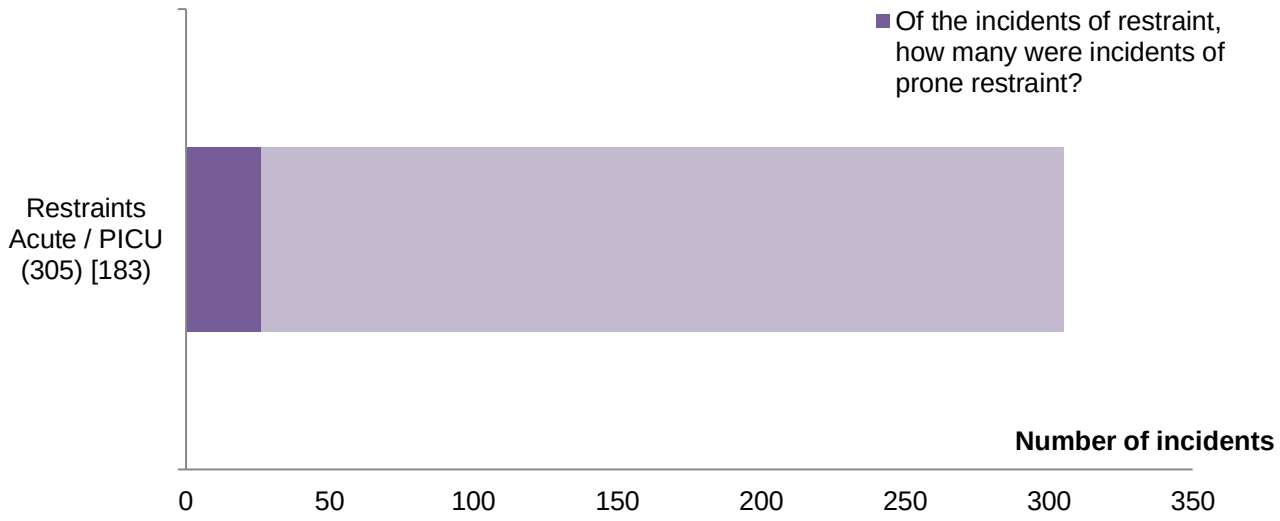
The below table focuses on the last 12 months' worth of data: 1 June 2016 to 31 May 2017.

| Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|
| 116 | 305 | 183 | 26 (9%) | 56 (18%) |

There were 26 incidents of prone restraint which accounted for 9% of the restraint incidents. Incidents resulting in rapid tranquilisation for this core services seem to have been fluctuating, with the highest numbers in May 2017.

There have been no instances of mechanical restraint over the reporting period.

**Number of incidents of restraint and prone restraint for this core service over the 12 months**




Please note the figures in square brackets after the total number of restraints, are the number of different service users restraint was used on during this time period.

The table below shows the episodes of restraint including prone restraint and seclusion between the period 1 June 2016 and 31 May 2017. The highest numbers of restraints were recorded on Westlands, followed by Avondale. Westlands had the highest numbers of different service users being restrained and incidents of rapid tranquilisation. Avondale had the highest number of prone restraints.

| Ward | Number of incidents of use of restraint | Number of different service users restraint was used on | Number of incidents of use of prone restraint | Number of incidents resulting in the use of rapid tranquilisation - only Intra-Muscular (IM) delivery not oral |
|---|---|---|---|---|
| **Avondale** | 68 | 37 | 11 | 8 |
| **Mill View Court** | 36 | 22 | 1 | 4 |
| **Newbridges** | 48 | 29 | 6 | 7 |
| **Psychiatric intensive care unit** | 60 | 45 | 6 | 6 |
| **Westlands** | 93 | 50 | 2 | 31 |

Charge nurses and matrons from the acute and psychiatric intensive care wards participated in the provider's restrictive interventions reduction programme. We saw meeting minutes that discussed restrictive practices such as restraint, seclusion and patient searches. The group met every two months to review restrictive practices and completed an action tracker to log progress. Following the 2016 inspection we asked that the provider review restrictive practices and blanket restrictions

on the wards, including access to bedroom keys and mobile telephone chargers; this had improved since the last inspection.

The completion of physical health checks following rapid tranquilisation was an issue identified in the last inspection. We saw that staff were now completing physical health checks in line with trust policy. Patients were supported to use formal side-effect rating tools for reporting and monitoring side effects in order that these could be managed effectively. The NEWS (National Early Warning Score) tool was used to assess patients' clinical condition, alerting the clinical team to any medical deterioration. The trust completed monthly audits of rapid tranquilisation. The audit findings were reviewed and shared at board level. The most recent audit found good adherence to post dose physical health monitoring but identified post incident debrief as an area for improvement. Plans were in place to share these findings in order to bring about improvement. We similarly, saw that nurses completed records of patients' physical health monitoring and incident reporting in accordance with trust policy

## Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff on the wards had a good understanding and knowledge of safeguarding policies and procedures. Staff recorded potential safeguarding incidents in a log in the staff office that was reviewed by a centralised safeguarding team. Where an incident needed referral to a local authority this was recorded in the folder.

| Training course | This core service | Trustwide mandatory training total % |
|---|---|---|
| Safeguarding Adults | 99% | 99% |
| Safeguarding Children | 88% | 81% |

We saw that staff recorded safeguarding concerns in patient records and saw safeguarding referrals that protected patients from harassment and discrimination both internal and external to the wards. When children visited the wards there were processes in place to keep them safe. Most wards had family visiting rooms away from the main patient areas and those that were on the inpatient wards had doors that locked from the inside to keep children and visitors safe.
Staff described using Prevent, a UK wide government counter-terrorism strategy, to safeguard patients and to protect and divert people away from terrorist activity.

### Staff access to essential information

The trust had moved to a 'paper light' approach to information in May of this year; acute and psychiatric intensive care wards moved to an electronic care record system as part of a trust wide roll out. Mental Health Act documentation and signed records of care plans were kept in two

separate folders in the staff office. We reviewed 26 care records and found an inconsistent approach to recording information. We saw no clear protocol for recording information. For example, some wards recorded all multidisciplinary team meeting minutes in the nursing notes, while others recorded the same information in the multidisciplinary team meeting section of the system. While the system allowed staff to search on notes entered by role, there was no way to search quickly for key pieces of information within these entries. Staff told us that paper Mental Health Act documentation and signed records of care plans were to be scanned onto the system after being signed but this was not always the case.

Information recorded from previous admissions was available via the electronic records system, for example risk assessments conducted on Avondale assessment unit were then visible to staff when patients transferred to another acute ward. For patients that had been admitted prior to the new electronic care records system, staff told us that they found it difficult to access patient records as these had been archived and needed to be requested.

Staff told us that the electronic care record system was slow to load and they felt that this impacted on being able to log patient engagements on the system. The electronic system did not allow for easy access to blood results. Doctors had a separate login to the physical health hospital system to collect results, or they would phone for results. Doctors on the wards told us that blood results were not easily accessible. Some junior doctors transcribed blood results into the medic notes to improve the availability of information.

Agency staff were given temporary access cards to the electronic care record system. We asked the trust what training agency staff received in relation to the electronic record system but no response was received. We saw entries on the system, completed by substantive staff, on behalf of agency staff.

We found that staff were reliant on information received at shift handovers as a result of the formal systems in place access to patient information.

**Medicines management**

We looked at 49 prescription charts and associated authorities across the four acute adult wards and 12 on the psychiatric intensive care unit because we had identified issues with rapid tranquilisation at the last inspection. The prescription charts were up to date and clearly presented to show the treatment people had received. A pharmacy technician visited Avondale three days a week to support medicines reconciliation; ensuring doctors had a complete list of patients' current medicines on admission. Specialist mental health pharmacists provided clinical support, reviewed prescription charts and completed medicines related audits. The junior doctors and nurses we spoke with gave positive feedback about the pharmacist support and their prompt response to any medicines related queries. Pharmacists were part of the ward multidisciplinary team and were available to speak with patients on request. The trusts had access to a range of medicines information sources for patients. These were available in a number of different languages.

A recent trust clinical audit of the monitoring of physical parameters in antipsychotic therapy had noted some areas for improvement; these were shared with the relevant care groups. At our inspection, we found it difficult to find patients' electrocardiograms (heart trace) and blood results. Nurses, a junior doctor and a pharmacist confirmed that they similarly found it difficult to find these results because they were not consistently entered in the same place on the electronic system.

Staff showed us a new form that the trust was implementing to capture all this information in one place but we did not see any of these in use. We were concerned to find that two patients on Westlands ward had identical electrocardiograms. We brought this to the attention of the junior doctor in order that the electrocardiograms could be repeated and the incident investigated. Records showed appropriate monitoring of patient prescribed high dose antipsychotics.

During the 2016 we recommended that the trust ensure that appropriate medicines management systems were in place on all wards in line with Trust policy. We found this had been addressed.

### Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.
Between 1 June 2016 and 31 May 2017 there were 3 STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

| Type of incident reported | Total |
|---|---|
| **Apparent/actual/suspected self-inflicted harm meeting SI criteria** | 1 |
| **Failure to obtain appropriate bed for child who needed it** | 1 |
| **Sub-optimal care of the deteriorating patient meeting SI criteria** | 1 |
| **Total** | **3** |

Humber NHS Foundation Trust have not been involved in any external case reviews in the last 12 months that relate to this core service.

## Reporting incidents and learning from when things go wrong

Staff had a clear understanding of what constituted an incident and how to report it. We reviewed incident data from the month of August that included verbal and physical aggression, self harm, damage to property, low staffing levels and inappropriate admissions. Incidents were discussed and shared at team meetings and handovers, and staff received weekly 'blue light' email alerts from the trust regarding all services in the trust. We saw Avondale team away day minutes that discussed incidents but we saw no record of additional dates for team meetings. On Avondale we saw that staff had met to discuss a serious incident following an assault of a member of staff and one member of staff from Newbridges described a recent scenario where the charge nurse had

arranged a debrief following a former patient's death. Wards also held reflective practice groups, although attendance was not always possible due to low staffing levels and ward activity. Staff did say that they could contact the psychology team for additional support. We saw examples that changes were being made following incidents. We saw that all wards had multiple types of ligature cutters following a delay in removing a ligature.

A duty of candour prompt was incorporated into the incident reporting system and actioned where necessary. Staff knew about their responsibility under the duty of candour and shared information with relevant parties. The Duty of Candour is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Humber NHS Foundation Trust.

## Is the service effective?

### Assessment of needs and planning of care

We examined 26 care records that varied in quality and personalisation. Although safety plans for risk assessments were completed in the patient's voice, we saw that care plans were written in a more clinical manner. Staff recorded protective factors, triggers, thoughts and behaviours in care plans and some care plans detailed the patient's nursing preferences, for example, not to be nursed by males. We saw that a translator was arranged for a patient so that the care plan could be completed and understood by the patient. Patients' rights were recorded but not always in the same place. After the 2016 inspection we asked that the provider ensure that all patients were actively involved in the development of care plans. While we saw that there was patient involvement and improvement, particularly in safety plans, 12 care plans across the wards, excluding the psychiatric intensive care unit, appeared to be generic in content.

On Newbridges the charge nurse told us that they had identified a physical health need for a patient with communication needs but we did not see this reflected in the patient's care plan. All care records evidenced physical health monitoring. Patients were offered health improvement profiles, and where patients declined staff recorded it in nursing notes and the communication boards in the staff offices. Staff used the National Early Warning Score (NEWS) to assess and score vital signs for patients; where patients declined, they also recorded it in the nursing notes. We also saw evidence of the Malnutrition Universal Screening Tool (MUST) and Waterlow risk assessments being completed. On the psychiatric intensive care unit there were individualised care plans that included detailed plans of physical health and infection control issues. After the last inspection we asked that the provider ensure that appropriate levels of physical health monitoring were in place for all patients, including those with long-term conditions; this had improved since the last inspection.

## Best practice in treatment and care

Staff assessed patients' needs following their admission to the ward and took account of any existing assessments and care plans from the transferring ward. Patients were referred to specialists when needed.

Wards responded to patients' needs such as eating disorders, substance misuse, diabetes, and weight management and they offered advice and access to schemes such as smoking cessation. However we did not see specific care plans relating to these needs.

The service allocated patients to care clusters to support care. Clusters were used to evaluate the patients' mental health, presentation and diagnosis to identify a package of care with input from the multidisciplinary team. The mental health clustering tool incorporates the Health of the Nation Outcome Scale. The Health of the Nation Outcome Scale is the most widely used routine clinical outcome measure used by mental health services in England. Patients were also assessed using the Model of Human Occupation, a practice model designed to provide theory along with practical tools and strategies for occupational therapy and related rehabilitation practice.

The trust reviewed National Institute for Health and Care Excellence against patients' diagnoses to identify the intervention required and any gaps in treatment. Staff followed National Institute for Health and Care Excellence best practice guidance such as Guidance 10, the management of violence and aggression.

This core service participated in 15 clinical audits as part of their clinical audit programme 2016 – 2017.

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| **NICE QS15 Statement 12** | Local clinical audit | 15/11/2016 | Monitoring via the IG Committee need for regular audits to support services achieving increased compliance. Numerous services using SystmOne have transferred to another provider so requirement to reassess compliance Planned for Q3 2017/18. Care Groups to develop action plans for improvement |
| **MHAD298 Substance use disorders amongst inpatients in PICU in 2015** | Service evaluation | 22/06/2017 | No action plan was required given service evaluation |
| **SI 2014-24579 Audit of Borderline Personality Disorder** | Local clinical audit as a result of an SI | 01/07/2016 | Benchmarked practice against NICE guidelines, informed learning into the development of the personality disorder pathway which commenced September 2016 - now complete.<br><br>Review of guidelines also initiated:<br><br>Co-production of Suicide and Self Harm (SASH) Training with Service User - delivered by Service User and SASH leads<br><br>Roll out of Knowledge and Understanding Framework Training for Personality Disorders across mental health services<br><br>Training for DBT and MBT also commissioned<br><br>Commenced the appointment of 4 x Specialist Care Co-ordinators for Personality Disorders and a process initiated for the commissioning of a new specialist service. |
| **SI 2015-29528 Audit of immediate discharge letters to be completed within 24 hour period of discharge** | Local clinical audit as a result of an SI | 11/08/2016 | New template developed to support improved implementation through IT system |
| **SI 2015-23632 CPA Audit** | Local clinical audit as a result of an SI | 12/08/2016 | Review assessment documentation to strengthen Capacity Assessment, capturing patient views, involvement of service user in MDT, development of training - sharing of plans with service users. To re-visit teams involved in original audit 6 months from formulation of individual action plans to re-audit due Autumn 2017 |

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| **SI 2015-17021 Audit of S17 Leave forms** | Local clinical audit as a result of an SI | 01/09/2016 | Action plan developed and due to be reported on 29th July 2017 |
| **MH5 Audit of documentation of Essential elements in Liaison Consultant Psychiatrists 'written case notes and letters** | Local clinical audit | 01/10/2016 | All action completed as per action plan |
| **SI-2015-29569 Case note Audit** | Local clinical audit as a result of an SI | 07/10/2016 | No action plan required as audit closed SI action plan item as complete |
| **MH2 Monitoring of physical parameters in antipsychotic therapy** | Local clinical audit | 19/12/2016 | Health Improvement Profile Adjunct created in January 2017 and added to pro forma.<br><br>Patients to be monitored yearly via health improvement clinic. Re-audit to be undertaken early 2018. |
| **MH8 Audit of the appropriate monitoring of prolactin levels and symptoms of hyperprolactinaemia in patients on Anti-Psychotics as per NICE guidance** | Local clinical audit of NICE guidance | 22/12/2016 | Action plan developed and progress being monitored by Clinical Network |
| **MH11 'Hello my name is…' an evaluation of current practice within inpatient services** | Service evaluation | 07/03/2017 | Approach being reviewed and discussed via Acute Care Forum and Clinical Network, Adult Mental Health Services |
| **MH7 Re-audit of Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines** | Local clinical audit | 10/03/2017 | Action on plan completed - new audit tool being developed for Reaudit March 2018.<br><br>ECT Policy revision |

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| **SI 2014-24579 Audit against the policy & procedures related to prone restraint and the management of self-ligature and the use of ligature cutters.** | Local clinical audit as a result of an SI | 01/04/2017 | Extensive work plan through the Restrictive Practices Group, supported by ligature audits, peer review inpatient mock inspections and a programme of work which reviews all individual reports of prone restraints.<br><br>Review of Datix reporting reviewed along with policy documents supporting best practice |
| **Audit of clinical equipment on inpatient units** | Local clinical audit | 25/05/2017 | Action plan being developed. Presentation of audit due through medical devices meeting. |
| **MHA7 Section 132 in PICU & Avondale** | Local clinical audit for Mental Health Act | 31/05/2017 | Action planned developed and supported by the Mental Health Legislation Team which supported training and the introduction of forms and advice & support following the introduction of the electronic system (Lorenzo) within Adult Mental Health Inpatient Units.<br><br>Peer review mock inspections assessing progress<br><br>Modern Matron monitor electronic records including application of Act and recording of rights |

The trust was in the process of implementing an app to create and monitor ward audits and improve the service. We saw copies of trial audits for acute and psychiatric intensive care wards as the audits hadn't been completely rolled out. Staff also completed care records audits, infection control audits and seclusion audits.

## Skilled staff to deliver care

Acute and psychiatric intensive care wards had range of suitably skilled healthcare professionals that supported patients. These included psychiatrists, psychologists, pharmacists, occupational therapists, activity workers, dual diagnosis nurses, social workers, nurses and support workers.

All new staff completed a three day trust induction and had a local induction to the ward. Staff completed appraisals and supervisions according to a team matrix but low staffing levels meant that staff had difficulty arranging their individual supervision every four weeks. The trust monitored supervision rates. Newbridges was the only ward to have exceeded the 80% target rate for supervision. Annual leave, clinical activity, staff working opposite shifts and staff shortage were all logged as reasons for non-compliance.

- Avondale 25%
- Westlands 39%
- Mill View Court 46%
- Psychiatric Intensive Care Unit 52%

Following the 2016 inspection, we recommended that the provider should ensure that staff receive supervision and appraisals in line with trust policy. This had not been fully resolved during this inspection.
Staff also had access to reflective practice and formulation meetings however these were often cancelled due to ward activity. Staff told us that they had team meetings when ward activity allowed. The most recent team meeting was in July on Mill View Court where the director of nursing, quality and patient experience also attended.

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for non-medical staff within this core service was 77%.

The teams failing to achieve the trust's appraisal target were Mill View Court – adult team with an appraisal rate of 72%, Newbridge residential unit with 75% and Westlands unit nursing team at 47%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 55% reported at the last inspection.

| | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 95 | 73 | 77% |
| **Trust wide** | 1399 | **1063** | 76% |

Appraisal figures for qualified nurses were lower than trust target on four of the five wards as of 31 March 2017; the lowest being the psychiatric intensive care unit at 58% and Westlands ward at 64%.

| Ward | Role | Appraisal Rate |
|---|---|---|
| **Avondale** | Qualified Nurses | 73% |
| **Avondale** | Qualified Allied Health Professionals | No figures available |
| **Mill View Court** | Qualified Nurses | 92% |
| **Newbridges** | Qualified Allied Health Professionals | 100% |
| **Newbridges** | Qualified Nurses | 73% |
| **Psychiatric intensive care unit** | Qualified Allied Health Professionals | 100% |
| **Psychiatric intensive care unit** | Qualified Nurses | 58% |
| **Westlands** | Qualified Allied Health Professionals | 100% |
| **Westlands** | Qualified Nurses | 64% |

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for medical staff within this core service was 78%.

| | Total number of permanent medical staff requiring an appraisal | Total number of permanent medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 64 | 50 | 78% |
| **Trust wide** | 1440 | **1063** | 74% |

Between 1 June 2016 and 31 May 2017 the clinical supervision rate across all six teams for nursing and therapy staff in this core service was 70% against the trust's target of 100%.
The trust was unable to provide clinical supervision data for medical staff.
The rate of clinical supervision reported during this inspection was the same as the 70% reported at the last inspection.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Core service total** | 100% | 3129 | 70% |
| **Trust Total** | 100% | 3244 | 69% |

Staff told us they could access specialist training and gave examples of self harm training and attending university courses. We asked the trust for details of specialist training figures but none were submitted.

## Multidisciplinary and inter-agency team work

Wards held regular multidisciplinary meetings. Avondale, Mill View Court, Newbridges and Westlands had daily report out meetings where the full multidisciplinary team attended each day, excluding Wednesdays. The psychiatric intensive care unit had weekly multidisciplinary team meetings.

The wards had effective working relationships with other relevant teams such as liaising with drug and alcohol services and social services.

We observed one handover on Avondale where shift coordinators logged tasks per shift. Staff respectfully discussed all of the patients, the carers' needs, safeguardings, and reasons for admission; formal assessment tools were completed. On Mill View Court we observed another handover where the full multidisciplinary team was not available due to staffing issues. A record of the discussion could not be entered directly onto the electronic record keeping system as there were not enough staff in attendance. Staff found it difficult to recall patients' full names as the handover sheet used initials. However, we did see a full discussion of risks, engagement levels, detention status and patient presentations. One activity worker told us that when they arrived on shift, they always received a handover, even when they were the only member of staff starting the

shift. We reviewed two sets of handwritten handover notes for Westlands. We saw a lack of reflection regarding patient restraints and ligatures, and tasks required by the next shift were minimally recorded. They discussed patients on leave but had no indication of when the patient was to be contacted. We saw little continuity from the previous handover notes.

Staff on all wards described a fully integrated multidisciplinary team that worked well and considered everyone's views. We saw that charge nurses supported each other across the wards.

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

Staff were knowledgeable in the application of the Mental Health Act. They knew how to access the Mental Health Act policies and Code of Practice and they contacted the trust's Mental Health Act legislation team for additional support. The legislation team completed audits and disseminated this information across the trust. All staff including administrative staff and health care assistants were aware of the patients' detention status and rights and we saw copies of the Code of Practice in staff offices.

Patients had access to independent mental health advocates. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. The wards displayed information about the advocacy service on their Mental Health Act notice boards and charge nurses confirmed that advocates regularly visited the wards. Patients confirmed that they knew how to contact their independent mental health advocate and met with their advocate on the wards.

Staff recorded when they explained rights to patients in their care records and the majority of patients we spoke to on the wards confirmed that they understood why they were on the wards. However, we did see that when patients' sections were changed, this was not always reflected in their care plans. When one patient was held on a 5.2 section we saw no justification in the records detailing why they could not stay informal or what placed them at risk.

We looked at 49 prescription charts and associated authorities across the four acute adult wards and twelve on the psychiatric intensive care unit. With the exception of one record, the relevant legal authorities for treatment were in place. This record was brought to the attention of ward staff in order that it could be promptly addressed. However, nurses could not easily check that the relevant authorities were in place on Mill View and Westlands wards as doctors did not always fully complete the prescription chart to include the patient's Mental Health Act status. Additionally, on Westlands ward nurses could not check the authorities at the time of medicines administration because copies were not kept with the prescription charts.

The services discussed and recorded Section 117 aftercare at care program approach meetings. This was clearly recorded in the meeting minutes and in discharge summaries. Following the 2016 inspection we recommended that all discharged patients who required treatment and support from community care teams had a care package in place prior to discharge. We saw that wards worked hard to involve community care teams to resolve this issue.

Acute and psychiatric intensive care wards had separate folders that contained patients' detention paperwork. Patients were able to have leave however patients and families also told us that leave

was regularly cancelled. Cancelled or expired leave forms were not always crossed through; this could result in leave being given in error.

As of 31 May 2017, 100% of staff had completed their Mental Health Act training on Avondale, Mill View Court and the psychiatric intensive care unit. On Newbridges, 93% of staff had completed the training. Westlands was the only ward below the 75% target training for Mental Health Act at 69%; however the charge nurses told us that training had been scheduled for staff.

We struggled to find notices informing informal patients of their rights to leave on the wards.

For the current financial year between 1 April 2017 and 21 June 2017, 90% of the workforce had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all staff. This is role specific training and renewed every three years.

## Good practice in applying the Mental Capacity Act

Staff were knowledgeable in the application of the Mental Capacity Act. They knew how to access the Mental Capacity Act policies and who to get extra help from in the trust.

As of 31 May 2017, 98% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. Following the last 2016 inspection we recommended that staff receive the full range of mandatory training, including Mental Capacity Act training. This had been resolved for the Mental Capacity Act at this inspection.

Staff understood the principles of the Mental Capacity Act and were able to give us examples of how they had assessed people's capacity. The trust had a mental health legislation lead that staff could refer to for advice and support.

We saw that staff sought patients' consent prior to sharing information and staff told us that they assumed capacity. Where capacity was questioned staff completed a decision capacity assessment of the patients, for example, in relation to a patient receiving medication. Following the last 2016 inspection, we asked that the provider ensure that capacity assessments were completed for patients lacking capacity; this had improved since the last inspection.

Although staff recorded consent for medications, staff on Westlands could not find a record of consent to treatment recorded on the electronic record system. The trust provided minutes from the Mental Health Act steering group which confirmed that this had been highlighted as an issue and consequently the trust were updating the electronic record system to record capacity to consent to treatment throughout a patient's admission. Medical staff were updated via email and sent a copy of the paper version of the form.

With the involvement of the multidisciplinary team, best interests meetings were arranged for patients that lacked capacity. Staff involved the Court of Protection to protect patients that lacked capacity when difficult decisions had to be made about patients' care and welfare. When reviewing patient care plans we saw that communication notes, safety plans, clinical risk records and multidisciplinary notes on the electronic record system noted changes in capacity.

Humber NHS foundation trust told us that one Deprivation of Liberty Safeguard (DoLS) application was made to the local authority between 1 June 2016 and 31 May 2017 for this core service. This is higher than the zero reported at the last inspection.

| | Number of DoLS applications made by month | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Total |
| **Applications made** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| **Applications approved** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

We observed kind and respectful interactions between staff and patients on the wards and found staff to be knowledgeable about patients' needs. Patients and carers described staff as genuinely caring, respectful and working for the best interests of the patients. However, two patients at Mill View Court said that staff had told them they were 'childish' and some patients didn't feel listened to.

On Newbridges and the psychiatric intensive care unit patients and carers told us they felt safe on the wards, however on Mill View Court, Westlands and Avondale patients did not. One patient from Westlands told us that they had been assaulted by another patient as there were not enough staff to prevent it. Families and carers said they mostly felt safe on the wards and where there had been incidents of violence and aggression, staff had responded immediately.

Patients, carers and families on all wards told us that activities and leave were cancelled due to short staffing and annual leave. This was visible in community meeting notes. The trust recorded no cancelled leave for the service. On the psychiatric intensive care unit, patients were uncomfortable with agency staff at night. One patient described an agency member of staff sleeping when they were meant to be keeping the patient safe on one to one observations. We saw this reported as an incident on the trust's incident reporting system.

Patients on all wards told us that the ward staff supported them in attending services for physical health or specialist appointments, for example weight management and blood pressure; staff also provided patients with literature on healthy living.

Staff were aware of the need to maintain confidentiality of information about patients and took care to cover visible information in the staff office when staff were not present or when the doors were open. In staff offices where confidential patient information was displayed, there were blinds over information boards, doors and windows to ensure patient information was not visible to others.

The 2016 Patient-led assessments of the care environment assessments score for privacy, dignity and wellbeing at four core service locations was worse than similar organisations.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Westlands** | Acute/ PICU | 86.62% |
| **Newbridges** | Acute/ PICU | 86.29% |
| **Miranda House** | Acute/ PICU | 85.34% |
| **Mill View** | Acute/ PICU and Wards for older people | 84.04% |
| **Trust overall** | | **85.31%** |
| **England average (mental health and learning disabilities)** | | **89.7%** |

## Involvement in care

### Involvement of patients

Staff orientated patients to the wards on admission and provided them with information about the wards and keyworkers, expectations, rights and medications.

Patients were involved in care planning and risk assessments. Patients were offered a copy of their care plans. Patient's safety plans were completed in their own words; this was in contrast with the care plans and clinical risk plans that we saw.

The majority of patients told us that they understood their care and treatment and the reason for admission. We saw evidence in care plans that staff had revisited points that patients were unclear about.

Staff could access interpreters, including sign language interpreters. On Newbridges interpreters had been used for patients that had difficulty understanding English, and consequently their rights and treatment plan. However, for another patient with learning difficulties, we saw no care plan referencing the patient's additional needs or details of how best to communicate.

Patients were not involved in decisions about the service such as staff recruitment, although the charge nurses said that patients had been previously.

Patients were able to feed back on the service they received in a consistent manner. Community meeting minutes from the wards recorded patients' thoughts on aspects of ward life that included discussion of patient suggestions, activities and access to advocacy. Patients on the psychiatric intensive care unit suggested more group outings which were to be facilitated on alternating weeks when there was an assigned activity coordinator. We saw that escorted leave was unavailable due to staffing levels and that there were reduced activities on the ward due to annual leave. Patients on Mill View Court told us they were not aware of the last community meeting until after it had taken place. We requested community meeting minutes for the acute and psychiatric intensive care wards; community meetings were held weekly with the exception of Avondale which had daily meetings.

Wards had 'you said, we did' boards on the walls of communal areas. On Mill View Court we saw that this information had been last updated in 2016 and on Avondale ward we saw that the same actions and responses appeared the next month, with a different date of action.
Staff ensured that patients had access to advocacy services and information about the services was displayed. Patients and staff told us that there were good links with the advocacy service and that they attended the wards regularly.

### Involvement of families and carers

Families and carers also received an information pack and were invited to reception meetings to help orientate them to the wards. Carers attended care programme approach meetings with their loved ones and nursing staff and doctors phoned them with updates. Families and carers were involved in care planning and risk assessments.

Of the eight carers we spoke with, only one family member had been offered a carer's assessment. On Newbridges carers' information packs included details of carers' assessments. A carer's assessment is an opportunity to discuss the support or services that might be needed. Carers did receive a referral form in their information packs to 'Rethink' the mental health support charity.

The wards sought feedback from carers and families; they completed friends and family questionnaires and all wards had a carer's champion.

## Is the service responsive?

### Access and discharge

#### Bed management

The trust provided information regarding average bed occupancies for all wards in this core service between 1 June 2016 and 31 May 2017.

| Ward name | Average bed occupancy range (01 June 2016 and 31 May 2017) (current inspection) |
|---|---|
| **Avondale Unit** | 85% - 95% |
| **Mill View Court** | 100% - 109% |
| **Newbridges** | 98% - 114% |
| **Psychiatric Intensive Care Unit** | 80% - 100% |
| **Westlands Unit** | 97% - 104% |

The Royal College of Psychiatrists recommends bed occupancy rates of 85% or less, saying that lowered bed occupancy rates enables local timely admissions and provides optimal support for patients. During the inspection patients were admitted to beds of other patients that were on leave, also known as leave beds. This meant the wards were operating at greater than the recommended 85% bed occupancy. When we inspected Avondale, Newbridges and Westlands all had admitted additional patients to leave beds. Staff told us that patients on leave would have to stay on leave. When a patient went on leave, staff identified the bed on the bed management system and dependent on the patients' status and duration of leave, they rated them as red, amber, or green. The trust aimed to have a male and female admission bed available but used leave beds in order of their rating.

The wards monitored bed occupancy rates and reported on ward performance monthly. We reviewed four months data supplied by the trust. Mill View Court, Westlands and Newbridges all admitted patients to leave beds and even when patients were on leave the bed occupancy rates had been flagged, in amber, for further attention as they were greater than the 85% recommendation. Following the 2016 inspection we recommended that the provider ensure that bed occupancy levels were maintained at such a level that allows patients on leave to return to the ward. This was not resolved during this inspection.

| Ward | Occupied Bed Days | April | May | June | July |
|---|---|---|---|---|---|
| Avondale | Excluding leave | 86.2% | 91.7% | 79.3% | 96.8% |
| | Including leave | 73.1% | 78.3% | 61.7% | 82.5% |
| Mill View Court | Excluding leave | 106.7% | 103.9% | 102.0% | 104.5% |
| | Including leave | 95.7% | 95.2% | 85.3% | 90.3% |
| Newbridges | Excluding leave | 110.9% | 105.4% | 108.9% | 108.4% |
| | Including leave | 99.8% | 92.5% | 95.0% | 99.3% |
| Psychiatric intensive care unit | Excluding leave | 86.2% | 94.2% | 89.5% | 89.2% |
| | Including leave | 85.7% | 93.5% | 84.0% | 83.2% |
| Westlands | Excluding leave | 100.6% | 100.2% | 95.0% | 103.2% |
| | Including leave | 98.0% | 94.6% | 86.5% | 88.0% |

When there were no beds available staff admitted to sofas and mattresses until a bed became available. Staff recorded these as incidents on the trust's incident management system. In August, Newbridges, Mill Court View and Avondale each recorded one instance of admitting to a sofa when no bed was available and the patients couldn't be managed safely in the community. The trust recorded six instances between March 2017 and August 2017, three of which were on Newbridges. One member of staff on Newbridges and another from Avondale felt that the service was not clear on the purpose of admissions. Charge nurses told us that they were not always able to refuse admissions when they felt it necessary. Previously, on call managers were from any service within the trust, for example community or learning disability services. Staff told us that the on call managers did not have sufficient specific knowledge about the acute and psychiatric intensive care wards and would inappropriately admit patients when they were full instead of finding alternative placements. In response to this the wards had developed a rota whereby one charge nurse from the acute care group would work weekend day shifts to provide more ward oversight.

Beds were not always available in the psychiatric intensive care unit and staff gave examples of when patients were transferred to another hospital out of area. The trust told us that four patients had required an out of area transfer to psychiatric intensive care units between April and September 2017.

When patients were moved between wards, we could see a clinical reason for this. However some staff told us that patients were sometimes moved from Mill View Court because they could not manage without a seclusion room. Subsequently they felt that when a patient arrived at a ward with seclusion facilities, having calmed down during the journey, then seclusion would not be appropriate.

The trust provided information for average length of stay for the period 1 June 2016 to 31 May 2017.

| | Average length of stay range (previous inspection) | Average length of stay range (current inspection) |
|---|---|---|
| **Core service total** | 9 - 78 | 5.2 – 90.3 |
| **Trust total** | 8 – 384.5 | 0 - 386.5 |

This core service reported no out of area placements between 1 June 2016 and 31 May 2017.
This core service reported 132 readmissions within 28 days between 1 May 2016 and 30 April 2017. Seventy-two readmissions (55%) were readmissions to the same ward as discharge. Fifty-nine of the readmissions to the same ward (82%) as discharged came from Avondale.

Thirty-four of these were planned readmissions. The trust told us that patients readmitted frequently had complex diagnoses combined with significant social care needs and although discharge planning addressed these issues, patients were care planned to return for a short admission when in crisis.

The average of days between discharge and readmission was 11 days.
There were three instances patients were readmitted the day after being discharged.

| Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|
| **132** | 72 | 55% | 0 - 28 | 11 |

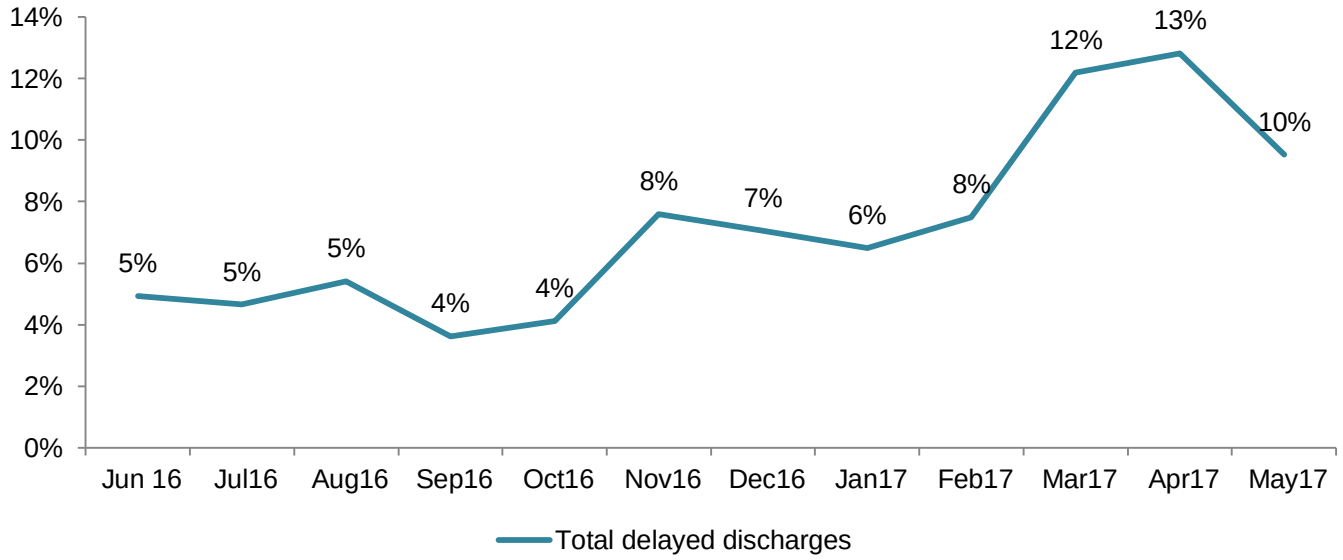
### Discharge and transfers of care

There was good evidence that staff planned for patients' discharge and discharge plans were visible in all of the patient records we viewed. Patients had care programme approach meetings with care coordinators, families and the multidisciplinary team. They gave examples of working with families, social services and drug and alcohol services. Staff members described scenarios where patients relapsed with substance misuse issues in the community or when on leave and were then readmitted at a later date. Staff also raised their concerns about discharging vulnerable patients to homeless shelters but felt under pressure to discharge patients. We saw that staff supported patients when they were transferred between the services for example from the Avondale assessment unit to Newbridges.

Between 1 June 2016 and 31 May 2017, there were 983 discharges within this core service. This amounts to 55%% of the total discharges from the trust overall. Five-hundred and thirty-five of these came from Avondale (54% of discharges within this core service).
The graph below shows the trend of delayed discharges across the 12 month period. The graph suggests a spike in April 2017.

Between 1 June 2016 and 31 May 2017 46% of the delayed discharges were identified as being from Newbridges. We asked the trust for further information regarding this increase. The trust

were aware of the increase in delayed transfers of care and explained that a lack of available patient accommodation was the primary issue; for example, social housing, care homes or suitable step down units.




The trust has identified no services as measured on 'referral to initial assessment' and 'assessment to treatment' within this core service.

## Facilities that promote comfort, dignity and privacy

All wards had single bedrooms for patients. Some patients chose to personalise their bedrooms and all bedrooms had a small lockable safe to keep their possessions safe. Patients could also keep larger items in a secured cupboard on the wards.

Mill View Court was the only ward where all bedrooms had en-suite facilities; all wards had communal bathrooms, which provided shower and bathing facilities for patients.
The range of facilities varied across the wards. All wards had a clinic room to examine patients, rooms where they could meet with visitors and access to a phone to make phone calls in private. All wards either had, or were moving to an electronic fob access for patients to directly access bedrooms. During our inspection improvement work was being completed on Westlands and the psychiatric intensive care unit. On Westlands following on from the new keyfob access there was also a refurbishment of the activities for daily living kitchen. On the psychiatric intensive care unit the keyfob access was being installed on the male bedrooms. To keep patients safe, staff locked the doors where the work was being completed and we saw that when a patient needed access to their room, staff escorted the patient to get their belongings.

Patients had access to drinks and snacks on the wards 24 hours a day and access to outside space. The male garden on the psychiatric intensive care unit was bleak with no features other than a smoking shelter and goal post painted on a wall. Patients had access to activities but on Avondale we saw that there was no separate activity room.

Wards had separate lounges for both genders on mixed sex wards as well as mixed lounges if that was the patients' preference. We saw that wards had pool tables, table tennis and the psychiatric intensive care unit had a gym for patients that had been risk assessed and inducted. Newbridges had a separate multi-faith room.

The 2016 Patient-led assessments of the care environment assessments score for ward food at two locations scored comparable to similar trusts. There were two location(s) including Newbridges (70.59%) that scored worse when compared to other similar trusts for ward food. However when we spoke to six patients on Newbridges they described the food on the ward as good although the choices for vegetarians could be improved. On the psychiatric intensive care unit kitchen staff attended the patient community meetings on a quarterly basis to get direct feedback on quality.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Miranda house** | Acute/ PICU | 93.80% |
| **Millview** | Acute/ PICU and Wards for older people | 89.54% |
| **Westlands** | Acute/ PICU | 82.98% |
| **Newbridges** | Acute/ PICU | 70.59% |
| **Trust overall** | | **94.75%** |
| **England average (mental health and learning disabilities)** | | **91.9%** |

## Patients' engagement with the wider community

Staff supported patients to remain in contact with their families and to maintain relationships with other people who were important to them such as their friends. Family details were in patients' care records and families visited wards and attended meetings. Staff also told us that one family was bringing their pet to the ward as it was listed as one of their loved ones' protective factors.

## Meeting the needs of all people who use the service

The service could accommodate patients and visitors with mobility issues. On Newbridges and Westlands, patient bedrooms were on the first floor however there was a lift on both of the wards for access.

Staff were respectful of people's cultural and spiritual needs. They supported external visits to places of worship and arranged for the chaplain or different faith representatives to visit if leave was not possible. Food appropriate to patients' religious preference was ordered in for patients on the wards and we saw that the service provided vegetarian, kosher and halal meals. Mill View Court had a folder in the staff office that held key information about different religions. One patient on Newbridges felt that staff could be better informed of different spiritual holidays and festivals.

Staff told us that information leaflets relating to patient rights and treatments could be downloaded from the trust intranet in non-English and easy read formats.

## Listening to and learning from concerns and complaints

This core service received 34 complaints between 1 June 2016 and 31 May 2017.

Avondale had the highest number of complaints during this period at 18, five of which related to poor communication and three of which related to admissions and discharge.

The wards displayed information on how to complain on notice boards and in the patient welcome packs. Patients felt confident to complain either directly to staff or to the patient advice and liaison service and told us that they were listened to. One patient on Westlands told us that they had complained to the patient advice and liaison service three weeks prior but they had not been contacted.

When a formal complaint was raised via the patient advice and liaison service, ward managers investigated the complaint and updated the patient advice and liaison service with the outcome, detailing how they had addressed the complaint with the complainant. We saw that families, patients and advocates had raised complaints about the wards. On Avondale we saw that staff had discussed complaint outcomes at a team away day in July and staff said that complaints were discussed with patients at community meetings on the psychiatric intensive care unit, Westlands and Newbridges. Mill View Court and the psychiatric intensive care unit provided team meeting minutes; neither recorded having discussed any complaints. No further evidence of formal discussions could be confirmed for Avondale, Newbridges or Westlands as these were not provided by the trust. Following the 2016 inspection we recommended that the provider ensure there were robust processes in place to review and learn from incidents and complaints. While there was a clear framework for electronic updates, this had not consistently fed through to ward practice and there was little evidence of complaints being discussed.

This core service received 10 compliments during the last 12 months from 1 June 2016 to 31 May 2017 which accounted for 4% of all compliments received by the trust as a whole.

## Is the service well led?

### Leadership

Leaders on acute and psychiatric intensive care wards had the skills, knowledge and experience to perform their roles. On Westlands unit, two experienced charge nurses had started within the last month; one from Mill View Court and the other from Hawthorne Court, the rehabilitation unit. Charge nurses described a programme to support band 5 nurses to progress to band 6 and the senior leadership team told us that they supported band 3 staff to move into assistant practitioner roles.

The charge nurses and ward managers were fully aware and informed of the challenges within their wards and had a good understanding of their services and the challenges they faced. Charge nurses, modern matrons and service managers were visible on the wards, although staff felt that the senior leadership team were not as visible.

### Vision and strategy

The trust's vision is: 'We aim to be a leading provider of integrated health services, recognised for the care compassion and commitment of our staff and known as a great employer and a valued partner.'
The trust values are:

- Caring - Caring for People while ensuring they are always at the heart of everything we do
- Learning - Learning and using proven research as a basis for delivering safe, effective, integrated care, and
- Growing - Growing our reputation for being a provider of high-quality services and a great place to work.

Ward level staff were unclear of the visons and values of the trust, but could tell us that they were available on the intranet; ward leaders could describe them and told us that the values were a standing agenda item at meetings but we only saw this reflected in Westlands meetings. We were told that the senior leadership team developed the values without input from staff. The service informed patients about the vision and values by displaying information around the wards. The senior leadership team said that they empowered staff to input to the service and held sessions with staff to gather feedback and suggestions; staff could also feedback via the acute care forum. Staff had been supported to create an internal self harm prevention training program when they had identified that a standard external training program was unsuitable; this training was then rolled out throughout the trust.

## Culture

Staff morale varied, but the majority felt respected, supported and valued by their immediate leaders on the wards. However staff also felt that there was a disconnect between the staff at ward level and the senior leadership team. They found them reactive and some staff told us they had little confidence in the senior leadership teams' abilities. Following the 2016 inspection we recommended that the provider should ensure that staff felt appropriately supported by senior management within the organisation. While we were aware of initiatives to meet with staff such as attending team meetings, this had not been fully resolved by this inspection.

Ward leaders were very proud of their staff and spoke of their teams' resilience and pride in care given. They understood the pressures on staff. Staff were also proud to work at the service and teamwork was demonstrated in the support the staff gave each other regardless of role. Staffing levels and patient needs were the greatest concerns for staff.

The leadership team, up to care group director level, had a clear future vision for the service and monitored budgets and resources. The service hoped to create a standalone acute unit so that outlying wards like Westlands and Newbridges were supported. They felt this would help to address some of the staffing issues and improve the service. Staff on the wards knew of the changes and felt it would be of benefit.

There was a mixed awareness of the role of the Speak Up Guardian and there were mixed views as to whether staff could raise concerns without retribution. Induction packs on Westlands and the psychiatric intensive care unit named the trust's Speak Up Guardian, although no email or telephone number was provided. All induction packs had a section providing staff with people or organisations to contact internally and externally for support, for example, the nurse in charge, placement officers for students and the patient advice and liaison service.

The ward relied on bank and agency staff to cover staff sickness and maintain safe staffing levels. The overall sickness rate for the ward was comparable with the trust average.

The trust supported the health and wellbeing of staff by offering an occupational health service which provided support to staff.

The trust recognised contributions of staff by holding annual staff awards and employee of the month schemes. The senior leadership team told us that some staff preferred acknowledgement at a local level and ward leaders provided this.

Managers dealt with poor staff performance via the annual staff appraisal process. It was not possible to view individual staff personnel files for evidence of their appraisal conversation because the trust held these files centrally. The appraisal process included the performance appraisal of staff and allowed for personal development planning and review. Qualified nurses' appraisal rates were below trust target on all wards except Mill View Court.

## Governance

The senior leadership team and ward leaders had worked hard to make improvements to issues identified at the previous 2016 inspections regarding seclusion, physical health and rapid tranquilisation. The trust had also implemented many recommendations identified in the reports such as discharge planning and fridge temperature monitoring. There was an improvement in patient involvement in care plans, however this had not been fully resolved. Issues relating to the Mental Health Act Code of Practice same sex guidance at Mill View Court and Avondale were partially resolved, however the services were limited by the environment and admissions.

There were recommendations and actions identified at the April 2016 and December 2016 follow up inspections that were not completed and additional issues relating to staffing levels that were impacting on the wards.

Actual staffing on the wards was frequently lower than the planned establishment and staff access to team meetings, appraisal, supervision and training varied by ward and role. The trust were aware of the staffing issues and had recruitment plans and staff development programs in place. The trust did not collect and review cancelled activities data as a result of staffing issues. There were issues with bed management. This was monitored and reported on however it was impacting on staff morale and patient activities. The service had effective mechanisms in place to monitor ward performance, including staffing, discharges, readmission and bed occupancy.

There was a clear framework based on the trust values of what must be discussed at ward level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However access to the team meetings varied across the wards and there was little evidence of this discussion occurring. The trust updated staff with learning for all wards via email bulletins.

The wards were implementing a new audit tool to further improve the data that was collected and had policies in place to support staff. Where issues were identified in audits staff acted quickly to resolve them.

Staff understood the arrangements for working with other teams, both internally and external to the provider, to meet the needs of the patients. Staff worked with other wards in the core service and with external organisations such as drug and alcohol services, local authorities and commissioners.

The introduction of the 'paper light' and electronic record system was not fully embedded. The service had not highlighted this as a risk in advance of the inspection, however did add it to the trust risk register.

There was a strong focus on discharge planning and ward leaders and the senior leadership team knew where blockages to discharge were.

Infection control was a priority and there was evidence that this was being monitored and reviewed.

Staff were knowledgeable in the application of the Mental Health Act and Mental Capacity Act; the governance system in place had identified an issue with recording consent and this was being rectified at an organisational level.

## Management of risk, issues and performance

Although there was a Mental Health Adult's care group risk register, there was no risk register at ward level. Items could be added to the trust's overall risk register by completing a form which was discussed with the senior leadership team.

No risks were related specifically to this core service.

The senior leadership was aware of the risks to the acute and psychiatric intensive care wards and their concerns matched those of staff at service level, for example staffing challenges relating to retention and recruitment; staffing was identified as a risk on the Mental Health Adult's risk register. During the inspection concerns around information technology were added. We saw no items relating to admissions to leave beds or sofas on the register although this was monitored via ward performance reports.

When developments to the service were suggested, these were reviewed at the cross service care forum. Staff told us that they felt the environment compromised patient care, but these were managed via ligature audits until new premises could be sought. The service had also completed a local standard operational policy which contained a business continuity plan to maintain services when adverse events occur.

## Information management

The service used a number of tools and audits to collect data from each ward and used this data to monitor quality and risks within the Mental Health Adult's care group. For example, the trust was in the process of implementing an app to create and monitor ward audits. Charge nurses and ward managers were able to access software to support the monitoring of staffing levels.

Staff could access the physical equipment and information technology needed to do their work, but a consistent use of the electronic record system was not yet fully embedded. Staff found the system slow and cumbersome. However the electronic record system did support the transfer of patient information when patients moved wards and we saw that agency staff were given key cards to access the electronic record system. The wards were "paper light" and kept all documentation securely and easily accessible for all staff. Patient information boards for staff were hidden from view.

The service made notifications to external bodies as required.

## Engagement

The service updated staff via the intranet and email bulletins. Staff were also updated at team meetings, however these were not consistently scheduled due to ward activity. We saw staffing information, such as staff sickness, displayed on notice boards on the wards. The wards sought feedback from carers and families; they completed friends and family questionnaires and all wards had a carer's champion.

Patients told us that they were able to feedback at community meetings and directly to staff but we saw no evidence of patients being involved in making decisions about changes to the service. The trust worked closely with external stakeholders such as commissioners, NHS Improvement and Health Education England; they also attended transforming care meetings to discuss risk, issues and improvements to the services.

## Learning, continuous improvement and innovation

Staff contributed to service improvements and suggested opportunities for innovation such as the creation of bespoke self harm training. Staff had opportunities to contribute to research and we saw examples of this. The trust employed a research nurse that worked with inpatient mental health services on studies to support retention and recruitment, carer involvement and audits relating to national clinical guidance. The nurse was completing their PhD thesis on professional decision making in ending episodes of seclusion.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. Westlands had applied for accreditation for inpatient mental health services but were not accredited due to issues with training and the ward environment, the seclusion room facilities and the ward layout.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **AIMS - WA (Working Age Units)** | Not provided | Not provided |
| **AIMS - PICU (Psychiatric Intensive Care Units)** | PICU | September 2016 |
| **AIMS - AT (Assessment and triage wards)** | Avondale | February 2016 |

# Long stay/rehabilitation mental health wards for working age adults

## Facts and data about this service

Humber NHS Foundation Trust provides one long stay, rehabilitation mental health ward for adults of working age who live in Hull and East Riding. The trust closed one long-stay rehabilitation ward called St Andrews Place following our previous inspection in April 2016.

Hawthorne Court is an 18-bed rehabilitation and recovery inpatient unit with controlled access and exit via an airlock. It provides a specialist assessment, care, treatment and rehabilitation service for adults experiencing severe and enduring mental illness. The ward has two floors with bedrooms and a self-contained flat located on the first floor.

The ward admits male and female patients, informally or detained for treatment under the Mental Health Act (1983).

## Is the service safe?

### Safe and clean environment

#### Safety of the ward layout

There were some ligature anchor points on the ward. A ligature anchor point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. However, patients on the ward were engaged in rehabilitation and preparing to return to the community, which meant they were usually not at high risk of self-harm. There was a comprehensive, up to date environmental ligature risk assessment in place. If patients' risk did increase then staff could use this risk assessment to ensure that patients were observed when using areas of the ward that included ligature anchor points.

The ward layout also meant that there were blind spots where staff could not observe patients. The ward acted to keep patients safe with convex mirrors to improve observation of blind spots. Staff carried out observations of patients depending on the patients' risk and level of supportive engagement. When we inspected the ward, staff carried out general levels of supportive engagement with all 18 patients and recorded their engagement with patients every four hours.

Staff held handover meetings three times per day and held discussions about patient risks and their required engagement levels. Nurses increased the level of engagement quickly if patients were at increased risk. Staff understood that engagement meant having a conversation with a patient rather than just observing patient whereabouts. This meant staff had an awareness of risk to each individual patient and could manage ligature risks effectively.

Over the 12-month period from 1 June 2016 and 31 May 2017, the trust reported no same sex accommodation breaches for the long stay and rehabilitation service. At this inspection, we found that the ward complied with Department of Health guidance on same sex accommodation. Staff achieved this by arranging bedrooms for men and women along separate corridors. Patients used communal bathrooms on each corridor, as the bedrooms were not ensuite. Staff managed access to the self-contained flat that ensured it met the Department of Health guidelines. The ward

followed good practice and provided female only and male only lounges as well as communal areas where all patients could be together on the ground floor.

All staff carried personal alarms that they regularly checked to ensure they worked properly. The alarms were programmed to panels throughout the ward. This meant that when staff triggered their alarm, they identified the area easily and responded quickly. Patients told us they felt safe on the ward.

Staff followed cleaning and maintenance systems that kept patients safe.

The service was clean throughout with good standards of hygiene and infection control. Cleaning records were up to date and completed regularly. There were effective systems in place to reduce the risk and spread of infection, with hand gel dispensers placed around the ward. Domestic staff were present and cleaning on the ward during our inspection. However, we observed a pile of bed linen placed directly on the corridor floor that was not in keeping with good infection control standards.

The score for the patient led assessment of the care environment was better than the England average and the trust average for all four aspects of care.

Please refer to the table below for details of how the ward scored overall.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **HAWTHORNE COURT** | Mental Health Only | 98% | 95% | N/A | 87% |
| **Trust overall** | | **99%** | **90%** | **81%** | **83%** |
| **England average (Mental health and learning disabilities)** | | **98%** | **93%** | **75%** | **78%** |

### Seclusion room

The ward did not have a seclusion room and staff did not seclude patients in other areas of the ward.

### Clinic room and equipment

The clinic room was clean, tidy, well organised, and spacious. Staff undertook regular comprehensive checks of equipment, controlled drugs and stock medication to ensure everything was in working order and in date. However, we found that staff had not documented checks for resuscitation equipment on four occasions in August 2017.

The clinic contained an electronically monitored medication fridge that ensured temperature ranges remained within an acceptable range.

## Safe staffing

### Nursing staff

There was not always sufficient numbers of staff on the ward and it was unclear if staff on duty were up to date with life support training.

Nurses and healthcare assistants worked across three daily shifts. The establishment level for the early and late shifts was two qualified nurses and three healthcare assistants. The night shift was one qualified nurse and two healthcare assistants. The ward relied on bank and agency staff and regular staff worked additional hours and overtime to maintain safe staffing levels. On both days of our inspection, the staffing level was lower than the establishment. The rota for one month before our inspection showed that this happened regularly on day shifts. Staff felt staffing levels had worsened over the past few months and were concerned about the impact this had on delivering good care to patients. During the two days of our inspection, the trust contacted the ward several times to request staff to move to other wards. Staff told us this happened daily and sometimes staff moved to work on other wards. The service managers explained this happened because staff moved to work on wards with higher risks.

Patients told us that there was enough staff around and available when they needed them. We observed staff were available for patients to support their leave arrangements, planned activities, and supportive engagement. Staff and patients planned daily leaves and activities together every morning. Staff used the three-hour handover period to ensure patients planned leave and activities took place. Staff and patients said that leave was rarely cancelled because of staff shortages. We saw evidence that staff displayed a response to patient feedback about cancelled activities in August because of staff shortages.

The trust reported on the ward staffing levels. Please refer to the information and table below for details about staffing on the ward.

This core service reported an overall vacancy rate of 23% for registered nurses and 6% for nursing assistants.
Between 1 June 2016 and 31 May 2017, bank staff filled 486 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 22 shifts. Thirty-nine shifts were unable to be filled by either bank or agency staff.

Between 1 June 2016 and 31 May 2017, 114 shifts were filled by bank staff to cover sickness, absence, or vacancy for nursing assistants.

In the same time period, agency staff covered 53 shifts. One shift was unable to be filled by either bank or agency staff.

The sickness rate for this core service ranged between 4% and 16% between 1 June 2016 and 31 May 2017.

This core service had five (17%) staff leavers between 1 June 2016 and 31 May 2017. This is higher than the 9.9% reported at the last inspection.

This core service has reported a vacancy rate of 4% as of 31 May 2017.

The trust did not have any data relating to staff fill rates for this core service.
Substantive means how many staff in post currently.

Establishment means substantive plus vacancies, e.g. how many the trust wants or thinks they need in post.

| Substantive staff figures | Date | Core Service | Trust target |
|---|---|---|---|
| Total number of substantive staff (WTE*) | At 31 May 2017 | 34.2 | N/A |
| Total number of substantive staff leavers | 1 June 2016 – 31 May 2017 | 5 | N/A |
| Average leavers over 12 months (%) (WTE*) | 1 June 2016 – 31 May 2017 | 17% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) (WTE*) | 1 June 2016 – 31 May17 | 1.3 over-established | N/A |
| Total vacancies overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 4% over-subscribed<br><br>Range 7% over-established to 22% vacancy | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 6%<br><br>Range 4% to 16% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 13.4<br><br>Consistent at 13.4 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 13.8<br><br>Range 6.8 to 13.8 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 3 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 2.8<br><br>Range 5.19 over-established to 2.8 | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 23% | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 18% over-established<br><br>Range 59% over-established to 20% | Not provided |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 486 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 22 | N/A |

| | | | |
|---|---|---|---|
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 39 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 114 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 53 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 1 | N/A |

*Whole Time Equivalent

**Medical staff**

The availability of the psychiatrist had improved since our last inspection. The psychiatrist covered the ward over three days per week. The psychiatrist had enough time to see individual patients at their recovery meetings every three weeks and to support team decisions about patients' risks and levels of supportive engagement. The staff used the trust on-call and out of hours arrangements to ensure that the ward always had access to medical staff when required.

**Mandatory training**

The managers could not provide assurances that all staff on duty were adequately trained. Mandatory training rates for basic and emergency life support were low and the staff rotas did not identify how many staff were trained in life support on each shift. This meant there might not be enough adequately trained staff on duty at all times. The ward was isolated from other wards in the trust, which meant other staff were not available to respond. Staff called the emergency services if required.

Overall as of 31 March 2017, staff in this service had undertaken 87% of the various elements of training that the trust had set as mandatory. This was better than the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% training target for one course which was fire safety with 65%.

Information governance and Mental Capacity Act training had the highest training compliance with 100%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 79% of the various elements of training that the trust had set as mandatory. This was higher than the overall trust average mandatory training rate of 74%. The staff in this service had not achieved the CQC 75% training target in five courses. These courses are indicated in the table below.

Mental health act and conflict resolution had the highest training compliance within the core service with 100%. Basic life support (56%) and Information governance (61%) achieved the lowest compliance of all applicable mandatory training courses.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Health and Safety | 85% | 88% |
| Information Governance | 100% | 61% |
| Mental Capacity Act | 100% | 85% |
| Mental Health Act | Not provided | 100% |
| Basic Life Support | Not provided | 56% |
| Conflict Resolution | 88% | 100% |
| COSHH | 88% | 82% |
| Display Screen Equipment | 91% | 79% |
| Equality and Diversity | 76% | 82% |
| Fire Safety | **65%** | 64% |
| Immediate Life Support | Not provided | 83% |
| Infection Prevention and Control | 76% | 85% |
| MAPA | Not provided | 91% |
| Moving and Handling | 88% | 79% |
| Prevent | 88% | 88% |
| Safeguarding Adults | 97% | 73% |
| Safeguarding Children | 88% | 73% |
| **Grand Total** | **87%** | **79%** |

All staff had oversight of their mandatory training performance and booked onto the courses they needed to complete. Staff had not met the trust target for some training. This included information governance, basic life support, fire safety, and safeguarding adults and children. All training was booked for the following month. The manager explained that basic life support training was booked previously but cancelled by the trainer.

## Assessing and managing risk to patients and staff

Staff did not carry out comprehensive risk assessments and develop risk management plans that supported patients' safety. We reviewed six care records that included paper and electronic records and found that staff did not complete a recognised risk assessment tool for all six patients. Staff said that nurses no longer completed the electronic Galatean risk and safety tool. This was because the ward was preparing to use an alternative tool called the electronic functional analysis of care environments risk assessment tool. However, the wards electronic system did not fully support staff to complete the tool and needed upgrading. In the meantime, staff used historic information from the Galatean risk and safety tool and completed safety plans. However, we identified four patient records that did not have evidence of an up to date risk assessment or safety plan. This meant that patients' safety could be at risk.

We observed one handover where staff discussed individual patient risks. This was part of the standard agenda for every handover meeting. However, staff followed their own agenda and there

was no evidence that staff referred to patient records at every handover meeting. This meant that staff did not communicate consistent information about patient risks.

Staff used supportive engagement as a means of positive risk taking and if staff increased levels of engagement, they made team decisions to review and reduce the level as soon as possible.

Patients moved freely around most of the building, however some areas were always locked and staff explained they restricted access to male and female areas for patient safety. Staff had temporarily locked the phone cubicle whilst awaiting repair and kept the lift doors locked until needed. These meant patients could not routinely use the lift unless supervised by staff. This was because the lift opened into the air lock area on the ward. We found that staff kept the visitors room locked because they wanted to keep the carer's room and resources tidy and available for visitors. The door displayed a notice with set visiting times. Staff told us they opened the door for visitors and that visiting arrangements were flexible.

The ward followed the trust policy for searching of patients. This was a revised policy and all staff on the ward received training. The ward kept equipment used for searching patients in the visitors' room. Staff did not routinely search patients or their belongings unless they had a reasonable belief that a patient had a restricted item. Staff gave patients information about restricted items and searching in patients' welcome packs. Staff told us they sought patient consent and ensured that they searched patients in a private room. Staff documented care plans for searching patients based on individual risks.

The ward had a designated smoking area in the garden and staff offered help to patients to stop smoking if they wished to.

The ward displayed a clear notice at the entrance that informed all patients how they could leave the ward. Patients knew how they could leave, and we observed how staff supported patients to leave the ward both escorted and unescorted according to their status under the Mental Health Act and leave arrangements.

The ward did not have a seclusion room. Staff understood the definition of seclusion and understood that restraint was a last resort. Staff described how they tried to manage a recent incident with de-escalation and only used low level of restraint when de-escalation failed.

Staff used prone restraint rarely. Staff described one incident when prone restraint happened with one patient that occurred when the patient and staff fell to the floor during restraint. Staff used an electronic incident reporting system to report their use of all restraint. This allowed senior managers to investigate and identify any themes emerging from the use of restraint.

The trust reported no incidents that involved the use of rapid tranquillisation at Hawthorne Court. This happens when staff administer an injection to patients who are very agitated and disturbed. However, we reviewed one incident where staff used low-level restraint and gave an intra-muscular injection to help calm the patient. Staff did not report this as rapid tranquillisation, which was not in keeping with the trust policy. The medical staff reviewed the patient after 1 hour and 20 minutes and we could not find any evidence that staff completed physical health observations according to the trust policy.

The ward participated in the trust restrictive intervention reduction programme and displayed information about their pledge to reduce restrictive interventions for patients and visitors. Senior staff representatives attended the trust reducing restrictive practice group and fed back information to ward staff at regular team business meetings.

The long stay and rehabilitation service had nine incidents of restraint, no incidents of seclusion and no long-term segregation incidents between 1 June 2016 and 31 May 2017. Over the 12 months, there was a decrease in the incidents of restraint since the last inspection with data from November 2015. There were two incidents of prone restraint which accounted for 22% of the restraint incidents. There were no incidents of rapid tranquilisation or mechanical restraint for this service in the recent data. The number of restraint incidents, prone restraints and seclusions reported during this inspection is lower than the reported at the time of the last inspection.

Please refer to the table below for information about the use of seclusion, long-term segregation, restraint and rapid tranquillisation in this service.

| Seclusions | Long term segregation | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| 0 | 0 | 9 | 13 | 2 (22%) | 0 |

## Safeguarding

The mandatory training compliance for adult and child safeguarding was below the trust target of 75%. However, staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. The ward had an identified safeguarding link nurse and gave examples about how they raised safeguarding issues that involved working with other agencies. We saw evidence that staff raised safeguarding incidents through the electronic system and we observed staff discuss safeguarding issues at their meetings.

The ward had a visiting room but staff did not arrange child visiting in this room. The room was situated within the communal are of the ward and did not include any child friendly furniture or equipment. Staff arranged child visiting on an individual basis with patients to ensure the arrangements were safe.

The trust did not provide a breakdown of information about safeguarding referrals for the long stay and rehabilitation service. The trust has had no external case reviews commenced or published in the last 12 months that relate to this service.

### Staff access to essential information

Staff coordinated paper records and electronic systems for recording all aspects of patients ‘care and treatment. All information was stored securely in locked facilities and accessible to all staff. However, when agency staff recorded in the patients’ electronic notes, the system did not generate an electronic signature. This meant that staff could not easily identify who had made the record, which is important for good standards of record keeping.

**Medicines management**

The ward had safe systems and processes for the management of the medicines on the ward. Staff ensured that medicines and medicine keys were kept securely. The ward pharmacist visited weekly to attend the ward and patient meetings and reviewed the medication charts and all medicines on the ward. The pharmacist carried out checks on medicines reconciliation and identified any issues that required further attention such as missed signatures and reviews due for "as required medications". The ward had appropriate arrangements for the management of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Nurses stored medicines that required refrigeration appropriately and monitored and checked fridge temperatures daily.

Staff fully completed medicine administration records and patients received their medicines as they had been prescribed and in accordance with the Mental Health Act.

Staff ensured that the effects of medication on patients' physical health was reviewed as required such as regular blood tests. No patients received high doses of anti-psychotic medication at the time of our inspection. These are medicines that require additional physical health checks.

Three patients were at different levels of self-medication, and staff supported patients to gain independence to take their own medications safely. Patients understood about their medications and had opportunity to discuss their choices with staff.

**Track record on safety**

Staff told us about one serious incident that happened on the ward in the 12 months leading up to our inspection. The completed report detailed the investigation and actions taken. The manager shared this information and lessons learned with staff. Staff spoke about the lessons learned which included ensuring that all staff had full training in the management of actual or potential aggression. At the time of the inspection, staff training was above 95%, which meant that staff had taken action in response to the incident.

Providers must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified.

Between 1 June 2016 and 31 May 2017 there were two Strategic Information Executive System incidents reported by this core service. Of the total number of incidents reported, one was a suspected suicide whilst the other was disruptive/aggressive behaviour resulting in a prone restraint.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

There was no data received for the long stay and rehabilitation service in the previous inspection. Please refer to the table below for details about serious incidents.

| Type of incident reported | Total |
|---|---|
| Disruptive/ aggressive/ violent behaviour meeting SI criteria | 1 |
| Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| **Total** | **2** |

### Reporting incidents and learning from when things go wrong

Staff had a clear understanding of what constituted an incident and how to report it.
We reviewed the past three-month's incident documentation that included reports of a range of incidents that should be reported. This included verbal and physical aggression, damage to property and low staffing.

Duty of candour was included in the incident reporting system as a prompt and actioned where necessary. Staff knew about their responsibility under the duty of candour and shared information with all relevant external bodies, the patient, and their families.

Staff told us they learnt outcomes from incidents electronically through feedback from incident reports, "blue light reports" from the trust, and at team meetings, staff de-briefs and supervision. The ward also held reflective practice sessions which helped staff to think about their practice.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made by local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last two years, there have been no 'prevention of future death' reports sent to the trust related to this long stay and rehabilitation service.

## Is the service effective?

### Assessment of needs and planning of care

Staff fully assessed patients' needs before and following their admission to the ward and took account of any existing assessments and care plans from the transferring ward. This included patients' mental, physical health and social care needs. We looked at six care records and all six had evidence that staff completed and regularly updated comprehensive and individualised recovery focused plans. Staff made this improvement following our previous inspection in April 2016. However, at this inspection, in five of the six care plans we reviewed staff did not document that they offered the patient a copy of their care plan. Only two patients told us they had copies of their care plan.

### Best practice in treatment and care

The multidisciplinary team provided a range of care and treatment interventions that followed best practice guidance for rehabilitation wards. This included assessments by the occupational

therapist that used a recognised assessment tool called the model of human occupation screening tool. Staff supported patients in a range of activities and therapies depending on their needs. This included support to access training and work opportunities in the community.

We looked at 18 prescription records and found evidence of good practice. The psychiatrist followed National Institute for Health and Care Excellence best practice guidance and prescribed medication within British National Formulary limits. The psychiatrist reduced ant-psychotic medication as soon as possible and no patients received more than one anti-psychotic medication. The pharmacist regularly checked that prescribing and relevant physical checks were in keeping with best practice.

The psychologist offered psychological therapies to patients such as cognitive behavioural therapy and mindfulness. The psychologist also facilitated reflective practice and formulation sessions with staff, which supported them with the work they did with patients.

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Nurses and support staff considered and addressed patients' physical health needs and ensured patients accessed specialist advice if needed. Staff focused on helping patients with their daily living and social skills alongside health promotion activities such as physical exercise, smoking cessation and healthy eating.

Nurses used the national early warning scores to monitor patients' physical health. National early warning scores monitor heart and breathing rate, blood pressure, level of consciousness, oxygen saturation, and temperature. Patients confirmed that they had physical observations taken weekly or more frequently if staff had concerns.

Staff used a variety of evidence-based tools to assess and record severity and outcomes such as the clustering tool, the brief psychiatric rating scale and the Beck depression inventory.

The trust provided data that said the long stay and rehabilitation service participated in no clinical audits specific to the service. However, staff carried out a range of audits such as compliance with the Mental Health Act and Mental Capacity Act, and defensible documentation. Staff also carried out regular checks of equipment and medicines to make sure they were safe to use.

## Skilled staff to deliver care

A range of suitably skilled healthcare professionals provided input to the service and supported patients. These included a psychiatrist, pharmacist, psychologist, occupational therapist and assistant, nurses and support workers. The social worker post was vacant and the manager had arranged interviews for the post. The ward employed one nurse with a learning disability qualification and some staff received training to take blood and electrocardiogram recordings.

All new staff had a local induction to the ward and had access to appraisal and supervision. Staff completed appraisals and supervisions according to a team matrix but low staffing levels meant that staff had difficulty arranging their individual supervision every four weeks. The manager did not have oversight of staff supervision compliance. However, all staff had a range of opportunities to receive peer supervision that supported them in their work. The reflective practice and formulation meetings were well attended and documented as evidence that staff received peer support.

The trust's target rate for appraisal compliance is 85%. As at 1 April 2016 to 31 March 2017, the overall appraisal rates for non-medical staff within this core service was 88%. The rate of appraisal compliance for non-medical staff reported during this inspection is similar than the 93% reported at the last inspection. There was no data provided for medical staff for the long stay and rehabilitation service.

Between 1 June 2016 and 31 May 2017 the average compliance rate for supervision in the long stay and rehabilitation service was 78% against the trust's target of 100%. This was higher than the trust overall compliance.

Please refer to the table below for details of the staff compliance with appraisals and supervision.

| Team | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| 338 Hawthorne Court Ward (Team) (NHS infrastructure support) | 1 | 1 | 100% |
| 338 Hawthorne Court Ward (Team) (Other qualified ST&T) | 1 | 0 | 0% |
| 338 Hawthorne Court Ward (Team) (Qualified AHPs) | 2 | 1 | 50% |
| 338 Hawthorne Court Ward (Team) (Qualified nurses) | 14 | 12 | 86% |
| 338 Hawthorne Court Ward (Team) (Support to doctors and nursing staff) | 15 | 15 | 100% |
| 338 Hawthorne Court Ward (Team) (Support to doctors and nursing staff) | 1 | 1 | 100% |
| Trust wide | 34 | 30 | 88% |

| | Clinical supervision target | Clinical supervision required | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|---|
| Core service total | 100% | 112 | 87 | 78% |
| **Trust Total** | **100%** | | | **69%** |

The manager encouraged and supported staff to undertake specialist training that enhanced skills within the team and professional development. All unregistered staff had access to the National Vocational Qualification level 3 in health and social care and the nursing associate training scheme. Some staff had received "train the trainer" training to cascade new learning and some had lead roles within the team depending on their interests, skills and training. This included a physical health lead and a safeguarding lead. A number of staff had completed a two-hour workshop for suicide prevention training.

The ward manager felt supported to manage performance within their teams, which included supporting staff on long-term absence. No staff were currently being performance managed.

The ward did not have any volunteers or plans to use volunteers to support the ward.

The ward had good arrangements with the GP service to review patients' physical health conditions once per month on the ward. Staff also supported patients to access their local GP in the community for long-term physical health conditions such as diabetes.

## Multidisciplinary and interagency team work

The multidisciplinary team held a weekly recovery meeting. A range of healthcare professionals reviewed all patients every three weeks. The ward had made changes to the way the meeting was organised that ensured staff fully supported and involved patients and their families at their recovery meetings. We observed one recovery meeting and all patients we spoke with told us about their recovery meetings. This was an improvement from our last inspection in April 2016 when staff held recovery meetings without inviting any patients.

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Ward staff had a range of opportunities to share information about patients including three handovers every day, fortnightly team business meetings and peer supervision sessions. The team business meetings were well attended and administration staff recorded important information against a set agenda.

We observed one handover, where staff discussed patients' current care and risks. This ensured that staff coming on duty were up to date with all aspects of patient care and treatment. However, staff did not keep a permanent record of the handover discussion and did not use a standardised format. Two daily handovers occurred for 15 minutes each and one for 30 minutes to discuss all 18 patients. Staff told us they prepared their own documentation for the handover and handovers often occurred for longer than planned. This meant the manager was not assured of the quality and consistency of information that staff handed over and important information could be missed.

The service had established good working relationships with external services such as community mental health teams, and local authority teams. Staff invited care coordinators to care programme approach reviews although they did not always attend. Staff provided up to twice-weekly contact for six weeks to discharged patients. Staff then reviewed the plan with the patient and the community team. This helped support the patient to have a successful discharge and built on good relationships with community services.

Staff had very good relationships with the local general hospital. This was important because patients attended the hospital for specialist appointments and sometimes needed additional support from staff. We saw one example where all staff worked well together to help one patient feel confident to attend their physical health appointment.

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

Staff were knowledgeable in the application of the Mental Health Act. They knew how to access the Mental Health Act policies and Code of Practice and who to get extra help from in the trust.

Patients had easy access to independent mental health advocates. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. Seven patients received support from an advocate at the time of our inspection and the ward displayed information about the advocacy service on their Mental Health Act notice board. Patients confirmed that they knew how to contact the independent mental health advocate and met with their advocate regularly. The advocate visited during our inspection to support one patient.

Staff regularly explained to patients their rights under section 132 and recorded their understanding. We saw a notice board that clearly displayed information about patients' legal status and rights under the Mental Health Act.

The ward had 13 patients detained under the Mental Health Act at the time of the inspection. The ward had taken action following the previous Mental Health Act Reviewer visit that ensured the system for recording and auditing section 17 leave was thorough. Patients were aware of how much leave they could take and used it. Staff encouraged patients to discuss any leave requests they might have at the daily morning meeting. This meant staff could ensure that patients accessed their leave.

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The ward made requests for an opinion from a second opinion appointment doctor when necessary. Staff kept copies of the patients' detention papers in order and the pharmacist checked treatment cards on a weekly basis to make sure that all treatment was authorised correctly.

The ward displayed a notice for informal patients that told them they could leave the ward. Patients told us they knew how they could leave and how staff supported them with their requests.

The ward participated in the trust Mental Health Act audit requirements. The manager received quarterly feedback from the trust and discussed the findings at team meetings.

As of 31 May 2017, 100% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. No data for this training was supplied in the previous inspection.

## Good practice in applying the Mental Capacity Act

Staff were knowledgeable in the application of the Mental Capacity Act. They knew how to access the Mental Capacity Act policies and who to get extra help from in the trust.

Staff we spoke to understood the principles of the Mental Capacity Act and were able to give us examples of how they had assessed people's capacity. We saw evidence of four completed capacity assessments and best interest decisions. However, staff documented for one patient that they lacked capacity to manage their cigarettes and we could not find any evidence that staff documented a best interest decision that supported the current care plan. This meant that staff did not record their decision-making consistently in keeping with good practice when applying the Mental Capacity Act.

Staff took part in the trust audit of adherence to the Mental Capacity Act via an electronic survey. At the time of our inspection, this audit was online for staff to complete.

As of 31 May 2017, 85% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. No data for this training was supplied in the previous inspection.

The trust reported that two Deprivation of Liberty Safeguard applications were made to the Local Authority between 1 June 2016 and 31 May 2017, which were pertinent to this core service. Neither of the applications were approved. CQC received no notification of Deprivation of Liberty Safeguard applications from the trust during the same period, which is consistent with

requirements (providers must notify CQC of authorised Deprivation of Liberty Safeguards applications. No data for this metric was provided during the last inspection.

Please refer to the table below for details of Deprivation of Liberty Safeguard applications.

| Number of DoLS applications made by month | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Total |
| **Applications made** | | | | 1 | | 1 | | | | | | | 2 |
| **Applications approved** | | | | **0** | | **0** | | | | | | | **0** |

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

We observed respectful and compassionate interactions between staff and patients and their families. Staff took time to help patients understand and manage their care and treatment during one to one time, recovery meetings and care plan discussions. This included explaining how patients and their families could access other services such as the local authority and the patients' advice and liaison service.

All the patients we spoke with reported that staff treated them well and that staff were kind, helpful and supportive. Patients felt that staff respected their privacy and always had time to talk to them. One patient felt staff had saved their life and that everyone worked together to help their recovery.

Staff were aware of the need to maintain confidentiality of information about patients and took care to cover visible information in the staff office when staff were not present. The office window had privacy screening to prevent others seeing information, however the glass door panel did not. This meant that when staff were in the office, others could look through the panel and see confidential information contained on visual display boards.

The 2016 Patient led Assessment of Care Environment score for privacy, dignity, and wellbeing scored 86% which is comparable to similar organisations and the trust average.
Please refer to the table below for details of the Patient Led Assessment of Care Environment score.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **HAWTHORNE COURT** | Mental Health Only | 86% |
| **Trust overall** | | **85%** |
| **England average (mental health and learning disabilities)** | | **84%** |

## Involvement in care

Staff offered patients visits to the ward before they were admitted and provided patients with a tour and a welcome book to help orient them to the ward and explain the care and treatment provided.

Staff had recently updated the welcome book which was awaiting final publication before staff could use it with patients.

Staff fully involved patients and their families in their care plans and recovery meetings. Patients we spoke with told us about their care and treatment plans and we observed one recovery meeting with a patient and their family in attendance. Not all patients told us that staff offered copies of their care plan. Only one of the six care plans we reviewed had evidence that staff documented they offered patients a copy of their care plan.

Staff used the interpreting service to help patients with communication needs to understand their care and treatment needs.

Staff encouraged patients to give feedback on the service in a variety of ways. All patients were invited to attend the daily morning meeting where patients could voice their comments. The ward displayed a 'You said we did' feedback from the monthly user group and minutes of the last meeting and date of the next meeting. Patients confirmed they felt listened to by staff and that staff responded to their requests where possible. We saw that staff had explained why a recent activity was cancelled due to being short-staffed. Patients also left messages about their experience on the ward recovery tree which was on display on the ward.

Staff gathered information about any advance decisions during the referral process. Staff also asked a patient to complete an assessment form that took their views into account. However, this form did not ask specifically about advance decisions and we saw that both the referral form and the patient assessment form were out of date. Both forms had a review date for April 2014.

Staff ensured that all patients had access to advocacy service and we saw information displayed about advocacy services. Patients and staff told us that there were good links with the advocacy service.

**Involvement of families and carers**

Patients' families and carers were encouraged to be part of their relative's care with consent from the patient. This included attending recovery meetings and care programme review meetings. Staff referred carers to the local authority for carers assessments and had an identified carers lead on the ward. We saw an information board and information leaflets available for carers on the ward. Staff kept up to date and well organised carers' information in the visitors' room. The carer feedback was very positive about how the service involved and supported carers.

# Is the service responsive?

## Access and discharge

The trust provided information regarding average bed occupancies for one ward in this core service between 1 June 2016 and 31 May 2017. Hawthorne Court reported average bed occupancies ranging between 93% to 103%% over this period. This is similar to the previous inspection in December 2015.

| Ward name | Average bed occupancy range (01 June 16 - 31 May 17) (previous inspection) | Average bed occupancy range (1 June 16 - 31 May 17) (current inspection) |
|---|---|---|
| **Hawthorne Court** | 93% – 103% | 97% |

The trust provided information for average length of stay for the period 1 June 2016 to 31 May 2017. The information for this core service suggests that one ward in the core service presented a longer length of stay (123 day average) for this period to the trust average of 91 days. When compared to the information provided at the time of the previous inspection, it appears that the average length of stay has increased since then.

Please refer to the table below for details about the average length of stay in this service.

| | Average length of stay range (1 January 2015 to 31 December 2015) (previous inspection) | Average length of stay range (1 June 16 - 31 May 17)) (current inspection) |
|---|---|---|
| **Core service total** | 358 | 123 day average (range: 31 – 142 days) |
| **Trust total** | | 91 days |

This core service reported no out area placements between 1 June 2016 and 31 May 2017. This core service reported three readmissions within 28 days between 1 June 2016 and 31 May 2017.The average number of days between discharge and readmission was 23 days. None were readmissions to the same ward.

The number of readmissions within 28 days has increased between the two periods and the average time between discharge and readmission has increased from no readmission prior to the last inspection.

Please refer to the table below for information about admissions.

| Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|
| **3** | 0 | 0% | 19 to 27 | 23 |

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The ward admitted patients from the trust's adult acute mental health inpatient wards and recently admitted two patients who had been placed out of area who required rehabilitation.

The ward admitted patients with an identified need for rehabilitation and recovery. This was an improvement from our previous inspection in April 2016. At the inspection in April 2016, we found that staff admitted patients directly to the ward because of bed pressures on the adult acute

mental health inpatient wards. This meant that not all patients were appropriate for the ward environment. Some staff felt the ward continued to admit patients who were too unwell to participate in their rehabilitation. However, the team held weekly meetings to discuss all referrals and carried out pre-admission assessments to make sure that the ward could meet patients' needs. If patients became too unwell and the ward could not meet their needs, then staff referred patients back to more appropriate environments. Staff remained focused on patients' rehabilitation and recovery and managers had carried out a review of the service that included plans to improve the rehabilitation model.

Staff did not admit patients into leave beds, which meant that when patients left the ward on leave their bed was always available for them when they returned.

The trust provided information that between 1 June 2016 and 31 May 2017 there were 25 discharges within this core service. This amounts to less than 1% of the total discharges from the trust overall (3598).
The rate of delayed discharges was relatively stable throughout the period.
No data was provided in the previous inspection.
The core service did not provide any data for referral to assessment to treatment times.

Staff and patients discussed discharge arrangements at the recovery meetings and care programme approach meetings. Staff arranged discharge times at a time that was convenient to patients, and their families. All patients were discharged with a risk and relapse plan developed with the community team before they were discharged from the ward. The ward staff supported patient discharge with a six-week plan that included home visits and liaison with the community services. This helped prevent the risk of relapse and repeated admission to the hospital. Staff identified that they wanted to be able to carry out more outreach work with patients. However the trust had not confirmed the future service model and plans to develop the outreach service were on hold.

## Facilities that promote comfort, dignity and privacy

All patients used an individualised electronic key fob to access their own bedrooms. Some patients chose to personalise their bedrooms and all bedrooms provided a lockable safe for patients to keep their possessions safe.

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Staff and patients had access to a range of rooms and equipment to support patients' treatment and rehabilitation needs. This included a spacious clinic room, a well-equipped games room and art room, a multi-faith room, kitchen area, and communal areas. Individual patients occupied the self-contained flat for up to three weeks as part of their assessment. The flat comprised separate bedroom, bathing, lounge and kitchen areas. The flat was located upstairs between the female and male accommodation and visitors were not allowed in the flat. The ward had a locked visitors' room that displayed a notice with set visiting times. Staff told us that visiting times were flexible and they locked the room to keep it tidy because it contained carers' information. The room contained the ward search equipment and staff told us how they managed access to this equipment when the room was occupied.

Patients had access to quiet rooms and a garden at all times on the ground floor. The garden was well maintained, with facilities to support patient activities and a designated smoking area. Throughout the inspection, patients and staff accessed these facilities.

The ward had a working public phone that was enclosed within a cubicle and allowed for privacy. Staff had locked the cubicle temporarily whilst awaiting a repair. However, staff displayed a notice that informed patients to ask staff to unlock the door. Patients used their own mobile phones to make phone calls in private and could access the ward phone to make calls to other professionals and agencies involved in their care. To protect the confidentiality and dignity of patients, the service gave patients information that requested them not to take photographs with their mobile phones. The room where patients accessed a computer was no longer in use but patients could access a computer in the ward office with staff support.

Patients told us that the food was of good quality and accessed snacks and drinks at all times. Catering staff offered patients a daily choice of meals from a menu that rotated every three weeks. The ward had set mealtimes and staff observed patients in the dining room whilst patients ate. Staff told us that the trust policy did not allow them to eat with patients at mealtimes but they were able to join in with communal activities such as barbecues and cooking sessions.
The 2016 Patient Led Assessment Care Environment score for ward food at Hawthorne Court was100%. This scored better than similar trusts and better than the trust average of 95%. Please refer to the table below for details of the Patient Led Assessment Care Environment score for ward food at Hawthorne Court.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **HAWTHORNE COURT** | Both mental health and learning disabilities provided from the same site by the same provider | 100% |
| **Trust overall** | | **95%** |
| **England average (mental health and learning disabilities)** | | **89%** |

## Patients' engagement with the wider community

Staff ensured that patients had access to opportunities in the local community such as training and work skills. This included volunteering opportunities and enrolment on training courses at a local college and the trust recovery college. Patients told us about the opportunities that staff had discussed with them as part of their discharge planning.

Staff supported patients to remain in contact with their families and to maintain relationships with other people who were important to them such as their friends. Staff invited relatives and carers to an initial contact meeting to meet the staff team when their relative was first admitted. The ward had flexible visiting arrangements and staff supported patients with their leave requests which included time with family.

## Meeting the needs of all people who use the service

The service could accommodate patients and visitors with mobility issues. The ward had one bedroom and one bathroom adapted for use by patients with physical disabilities. These rooms were on the ground floor and next door to a communal patient activity room. The bedroom contained a hospital type bed and did not have a nurse call system installed. The bedroom was occupied at the time of our inspection, however staff told us the patient was there because it was their preference rather than because of a specific disability. We saw that this patient was

independently mobile during our inspection. Staff said the patient would be relocated upstairs if the facilities were required for someone with mobility issues. There was a lift in the building to the upstairs bedrooms; however, staff locked the lift to prevent patients from using it routinely. All patients who had bedrooms upstairs were fully mobile and able to use the stairs and staff told us they escorted patients to use the lift if required.

The ward had a number of well-organised and up to date notice boards that displayed a range of information about treatments, local services, the Mental Health Act, and how to complain. Information leaflets were available in different languages on request

Staff referred patients with specific communication needs to support their understanding of their care and treatment. We saw evidence that access to an interpreter was quick and easy and supported one patient twice weekly.

Patients had a choice of food available to meet their specific dietary requirements such as vegetarian and halal food. We saw evidence that staff supported one patient with specific religious dietary and spiritual requirements with an individualised care plan.

The ward had a faith room that included washing facilities and a comfort box to help soothe patients. Staff were respectful of people's cultural and spiritual needs. They supported external visits to places of worship and arranged for the chaplain or different faith representatives to visit if leave was not possible.

### Listening to and learning from concerns and complaints

This core service received no complaints between 1 June 2016 and 31 May 2017.The service received two compliments during the last 12 months between 1 June 2016 and 31 May 2017. The ward displayed information on how to complain on notice boards and in the patient welcome pack. Patients felt confident to complain either directly to staff, at the daily morning meeting or the monthly involvement group. Staff knew how to support patients to make a complaint and two patients told us about a complaint they raised informally with staff but felt it had not been resolved. The manager told us about the ongoing action they were taking in response to their complaints.

## Is the service well-led?

### Leadership

The ward had a number of staff changes that included the ward manager post and senior nurse band six posts. These were all acting posts until senior managers appointed staff to permanent positions. The ward manager was in an acting role for the four weeks before our inspection. The manager was fully committed to providing a good quality rehabilitation service. They had experience of working on the ward and previous leadership training. The manager was familiar with the learning and development needs of the staff and encouraged them to take lead roles on the ward according to their skills and areas of interest. The manager was based on the ward and highly visible on both days of our inspection. All staff felt the ward manager provided leadership to the ward and was visible and approachable.

The manager had a good understanding of the systems and processes that gave oversight to ward performance and the quality of the service. The manager planned staffing rotas at least four weeks in advance. This made sure that the manager could plan for identified gaps in staffing. The

manager was aware of the importance of using resources effectively and had oversight of the ward budget. The manager regularly discussed issues about staffing levels with senior managers and the trust financial department.

The ward manager and senior managers of the service had a good understanding of challenges of delivering the rehabilitation model in the current environment. Senior managers had engaged with staff and completed a proposal for how the service could improve. This options appraisal of the service was waiting approval from the care group directors.

Senior managers and board members included the ward in their “walk rounds” and carried out unannounced visits to make sure they were visible and approachable to all staff and patients.

## Vision and strategy

The trust’s vision was ‘we aim to be a leading provider of integrated health services, recognised for the care, compassion, and commitment of our staff and known as a great employer and valued partner’. The trust’s values were ‘caring, learning and growing’:

Staff supported the ward vision and values with a culture that aimed to support people on their recovery with a mission statement that stated, “our service aims to provide support and encouragement to people to regain autonomy and control throughout their individual journey to recovery and social inclusion”.

The service informed patients about the vision and values by displaying information around the ward and including information in the patient information booklet. We observed how staff demonstrated their vision and values in their interactions with patients and their focus on recovery.

## Culture

Staff morale varied but overall staff reported working in a supportive team. Staff worked well together and took action to make sure they had enough support when they needed it. Staff shared a culture that focused on patients’ rehabilitation and recovery but felt de-valued when low staffing prevented them from delivering the quality of care they aspired to. The common themes about low staffing, mix of patient needs and a feeling of disengagement about the future of the service all affected staff morale.

Staff safeguarded patients from abuse and knew how to raise concerns. Staff felt confident to use the whistleblowing process and were aware of the role of the Freedom to Speak up Guardian.

The manager had good support from the trust to deal with any staff issues such as poor staff performance and long-term sickness. The manager and the trust human resources department worked jointly to support staff to address the issues. Staff told us of their positive experiences of support from the manager and the occupational health department. There was no suspension and supervised practice data provided by the trust for this service.

It was not possible to view individual staff personnel files for evidence of their appraisal conversation because the trust held these files centrally. Staff gave mixed feedback of their experiences of their appraisal about how supportive the process was. The ward supported non-qualified staff to complete the associate nurse trainee programme that gave staff an opportunity for career progression. Staff felt this was a good opportunity.

The ward relied on bank and agency staff to cover staff sickness and maintain safe staffing levels. The overall sickness rate for the ward fluctuated and overall was higher than the trust average.

## Governance

Managers had acted to make sure that staff made the required improvements identified at the previous inspection in April 2016. However, at this inspection we identified two further legal requirements to improve patient safety.

The ward had gaps in documentation for checks on emergency equipment. Mandatory training compliance for basic life support was below 75% and it was not clear if there was sufficient staff on duty to carry out life support in an emergency. The systems and processes that were in place for assessing and managing individual patient risks were not robust. The electronic information system did not fully support staff to deliver and manage safe care and treatment.

There were systems and procedures to make sure that the ward had adequate staff and that staff received training and supervision. However, when low staffing levels occurred, this affected the care that staff could deliver to patients and the morale of staff. The staff rota for one month and the information provided by the trust for a one-year period identified gaps in staffing. The ward had unfilled vacancies for qualified nurses and support staff and more staff had left the service than at our last inspection in April 2016. Lower staffing levels meant they sometimes cancelled patient activities and staff had reduced their opportunities for individual clinical supervision.

There were clear responsibilities and systems of accountability to support the governance and management of the service. The ward held information that included minutes of team, directorate, and trust meetings. This included trust wide health and safety meetings, reducing restrictive interventions meetings and ward business meetings. Senior staff attended trust wide meetings and shared relevant and important information with the ward team. Managers held regular and well-attended team meetings and staff told us about these meetings.

Staff had learned from and implemented changes to their practice based on recommendations from reviews of incidents that affected the ward.

There was no data in the trust board assurance framework relating to the long stay and rehabilitation service.

## Management of risk, issues and performance

The ward had access to the trust emergency planning and business continuity arrangements but did not have a local risk register. Senior managers were aware of this and said the trust were in the process of reviewing this to give local ownership of risk registers. Senior managers were aware of the staff concerns and had prepared a business plan following consultation with staff to address those concerns.

There was no data in the trust risk register relating to the long stay and rehabilitation service.

## Information management

The ward provided electronic data to the trust such as the minimum mental health data set information and payment by results, staff training, and appraisal completion. This data was available to view and staff submitted the information as part of their daily work. The ward received feedback about this information with the exception of data about clinical supervision.

Staff had access to the electronic equipment and paper documents they needed to do their work. The electronic system supported staff to report incidents and manage their own performance. The managers had oversight of the information they needed to support their roles. However, the electronic system did not fully support the staff to complete a recognised risk assessment tool or identify individual electronic signatures for agency staff. The ward was “paper light” and kept all documentation securely and easily accessible for all staff.

## Engagement

The trust electronic system provided information for staff, patients, and carers about the service and everyone had opportunities to give feedback about the service. Staff ensured that patients had opportunities to engage in discussions about how the ward ran and displayed their responses.#

However, not all information provided was up to date. The trust website description of the rehabilitation service description and operating procedures dated November 2011 and a review date in September 2013 and referred to the closed ward. The electronic ward welcome pack was up to date but included information that related to a ward round held every Monday. It did not refer to recovery meetings that staff and patients held on Tuesdays. The trust policy for rapid tranquillisation that staff referred was up to date but contained some omissions and errors that could cause confusion for staff. The paper referral and assessment forms that staff told us they used were pilot documentations dated 2014 and due to be reviewed in April 2014.

Ward staff felt that senior managers had not kept them sufficiently informed of the future of the service and had concerns about how the service would operate in the future.

## Learning, continuous improvement and innovation

The ward continued to provide a limited outreach service to discharged patients despite the staffing difficulties. Ward staff and senior managers hoped to develop this service further and some initial preparatory work had taken place. However, senior managers of the trust needed to approve the options appraisal before the service could progress with plans for improvement.
The ward had achieved the Royal College of Psychiatrists’ accreditation for inpatient mental health services programme with excellence in 2016. Accreditation for inpatient mental health services programme is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. The trust provided information about the accreditation achieved by Hawthorne Court in the table below.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **AIMS - Rehab (Rehabilitation wards)** | Hawthorne Court | January 2016 |

The ward was waiting for the trust to confirm the necessary funding for re-accreditation.

Staff did not take part in any other standardised work that supported improvement and innovation such as quality improvement workshops or time out to work together to resolve problems in a systematic way. As there was only one long-stay rehabilitation ward in the trust, staff on the ward could feel isolated from other colleagues. However, the ward manager met with peers on a regular

basis at directorate and trust wide meetings. This gave the ward manager opportunities to share information, and learning from across the trust with the ward team.

# Forensic inpatient/secure wards

## Facts and data about this service

| Location site name | Ward name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| Willerby Hill | Darley House Ward (Low Secure - Mental illness) | 9 beds | Male |
| Willerby Hill | Derwent Ward (Medium Secure - Mental illness) | 10 beds | Male |
| Willerby Hill | Ouse Ward (Medium Secure - Mental illness) | 14 beds | Male |
| Willerby Hill | Ullswater Ward (Medium Secure - Learning Disability) | 12 beds | Male |
| Willerby Hill | Swale Ward (Medium Secure - Personality Disorder Unit) | 15 beds | Male |
| Willerby Hill | Greentrees Ward (Medium Secure - long stay) | 16 beds | Male |
| Willerby Hill | South West Lodge (Low Secure - community preparation unit) | 4 beds | Male |

## Is the service safe?

### Safe and clean care environments

**Safety of the ward layout**

Five of the inpatient wards were located within The Humber Centre. Derwent ward, Ouse ward, and Darley House wards were in the older part of the building. Swale ward and Ullswater wards had been built in 2010. Greentrees ward and South West lodge were in separate buildings a short walk away on the same site.

The service had adequate arrangements in place in relation to fire safety. Premises were free from fire hazards and signage was in place to direct people in the event of an emergency. Staff undertook regular fire drills. We found maintenance arrangements and records were in order, including the gas safety certificate and passenger lift service certificate. Contingency plans, building control certificates and liability insurance were in place. However, the service did not have personal emergency evacuation plans in place for those patients who may be secluded at the time of an emergency and we raised this at the time of the inspection.

Staff followed trust procedures in the safe management of keys and security on the wards and received a five-day security induction. Each ward had its own security profile and staff undertook daily checks of the environment to ensure the safety of staff and patients.

Most of the ward layouts allowed staff to observe all parts of the ward. Some of the wards were ‘L’ shaped and staff could not easily observe patients at all times. Staff positioned themselves outside the staff office to enable sight lines of both corridors.

Staff had mitigated the risk of ligature adequately. The trust completed ligature risk assessments on all wards every six months and these were up to date at the time of our inspection. Staff could identify where the ligature risks were and used the supportive engagement policy to closely observe and engage with patients whose risk to themselves or others was heightened. The ward security profiles identified ligature risks and assigned each one a severity rating and a plan of

action to mitigate the risk. Six of the wards presented a high level of ligature risk due to doors and soap dispensers that were red rated and there had been the removal of wardrobe doors on Ouse ward. South West Lodge presented a lower amber risk due to the unit's function.

Staff had easy access to personal alarms that they could use to summon assistance if required. There was a patient call system installed on all the wards. Patients were offered a mobile call system that they could keep either in their room or on their person. This meant that they could activate the alarm wherever they were on the ward. The alarm would trigger an alert on an alarm panel to support staff to get to the patient quickly and offer assistance and support.
The ward complied with guidance on eliminating mixed-sex accommodation, as all wards were male only.

## Maintenance, cleanliness and infection control

All areas were clean and tidy and this was reflected in the cleaning records. Domestic staff cleaned the wards daily and night time staff also maintained the cleanliness of the ward.

The Patient Led Assessment of the Care Environment scores for these wards showed that Humber Centre and Greentrees ward scored better than similar trusts for cleanliness at 100%. Greentrees ward also scored marginally better for disability at 86% compared to an England average of 85%, whereas the Humber Centre scored 82% for this aspect of the care environment.

Both locations scored worse than similar trusts for condition, appearance and maintenance. The Humber Centre scored comparatively lower at 88% compared to an England average of 95% and a trust average of 90%. The trust had made improvements to the environments on some wards by replacing flooring and painting the walls. Furnishings, curtains and windows had also been replaced on some wards. Remedial work had been undertaken on some bathrooms and ventilation had been improved.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Humber Centre** | MH - Forensic inpatient | 99.75% | 87.54% | - | 82.13% |
| **Greentrees** | MH - Forensic inpatient / Other | 100% | 89.20% | - | 85.76% |
| **Trust overall** | | **99.16%** | **90.34%** | **81.49%** | **82.92%** |
| **England average (Mental health and learning disabilities)** | | **97.8%** | **94.5%** | **82.9%** | **84.5%** |

Staff adhered to infection control principles, including handwashing. Handwashing notices were evident throughout the wards and hand gel dispensers were present and in working order. Each ward had completed an infection prevention and control report in September 2017. These reports were used to develop environmental audit action plans and progress against them was monitored regularly by the modern matron.

### Seclusion room

The trust had four seclusion rooms which allowed clear observation of the patient, had two way communication, toilet facilities and a clock. The trust had undertaken a risk assessment prior to

closing the seclusion room on Greentrees ward and developed procedures for staff to follow in the event of an incident requiring seclusion on Greentrees ward.

### Clinic room and equipment

There were adequate supplies of oxygen and defibrillators with two sets of pads on each ward. All wards had adequate supplies of medicines for use in a medical emergency. Staff carried out daily checks of medicines in accordance with trust policy.

The health hub was a shared resource off the main wards that was equipped to meet the physical health monitoring needs of patients. The necessary checks on equipment were generally in order, with the exception of the emergency grab bag. This was not checked on a weekend as health hub staff only worked during the week. We raised this at the time of inspection and the trust identified that weekend staff would be allocated to complete these checks in future.

Swale ward, Greentrees ward, and Ullswater ward had their own clinic rooms, which contained the required equipment. The clinic areas on these wards were clean and tidy. In the last three months, the grab bag had not been checked on Ullswater ward on three occasions. However, all other checks and monitoring of equipment in the clinic rooms across these three wards was in order.

Emergency equipment and medication was not stored in South West Lodge due to a lack of secure space. Patients at South West completed a first aid course prior to admission and would access support from staff on Greentrees ward in an emergency.

Staff checked and recorded medicines fridge temperatures daily in accordance with national guidance, they also checked the fridge temperatures in the occupational therapy kitchens. However, staff did not document whether they took action taken in response to fridge temperatures being outside of the required range.

Items of electrical equipment across most wards did not have up to date stickers in place. This had also been a concern at the previous inspection. We discussed this with senior management. All electrical equipment was subject to an annual sweep by an external contractor and the trust estates department completed the testing of any new equipment purchased throughout the year. The annual sweep had not taken place as required in March 2017 due to an error in communication. The trust provided evidence to show that an external company had undertaken these tests in the two weeks following our inspection. The trust put plans in place to ensure that the external contractor communicated directly with the estates department to ensure future tests happened in line with their policy.

## Safe staffing

### Nursing staff

The trust provided sufficient numbers of staff to meet their staffing establishment levels. Safer staffing reports from February 2017 to July 2017 showed that wards were usually at their required staffing levels or above. Managers reviewed staffing levels daily at a morning meeting and moved staff around the wards as required. There were sufficient numbers of staff to carry out physical interventions when required. Increased levels of engagement and patients in seclusion were factored into staffing levels with additional resource allocated as required.

Staff reported that staffing levels were improving. Seven patients felt there were sufficient staff and that they were visible and available to them when needed. Staff also said that they usually achieved their staffing establishment levels each day, although some staff and patients still felt the staffing levels were not sufficient to meet the needs of the patients.

The information in the table below is accurate as of 31 May 2017. Substantive refers to how many staff are in post currently and establishment means substantive plus vacancies, for example how many the trust want or think they need in post.

| **Substantive staff figures** | **Date** | **Core service** | **Trust target** |
|---|---|---|---|
| Total number of substantive staff (WTE) | At 31 May 2017 | 184 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 22 | N/A |
| Average WTE* leavers over 12 months (%) | 1 December 2016 – 31 May 2017 | 11% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall WTE (excluding seconded staff) (WTE*) | At 31 May 2017 | 2.99 over-established | N/A |
| Total vacancies overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 2% over-established<br>Range 7% over-established to 5% vacancy | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 8%<br>Range 7% to 10% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels registered nurses (Whole Time Equivalent*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 64.4<br>Range 57 to 64 | N/A |
| Establishment levels healthcare assistants (Whole Time Equivalent*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 67.2<br>Range 53 to 67 | N/A |
| Number of vacancies, registered nurses (Whole Time Equivalent*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 8<br>Range 0 to 9 vacancies | N/A |
| Number of vacancies, healthcare assistants (Whole Time Equivalent*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 2.3<br>Range 1 to 14 vacancies | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 12%<br>Range 1% to 14% vacancies | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 3%<br>Range 2% to 22% vacancies | Not provided |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (registered nurses) | 1 June 2016 – 31 May 2017 | 628 (38%) | N/A |

| | | | |
|---|---|---|---|
| Shifts filled by agency staff to cover sickness, absence or vacancies (registered nurses) | 1 June 2016 – 31 May 2017 | 131 (8%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (registered nurses) | 1 June 2016 – 31 May 2017 | 100 (6%) | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (healthcare assistants) | 1 June 2016 – 31 May 2017 | 1536 (33%) | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (healthcare assistants) | 1 June 2016 – 31 May 2017 | 20 (0%) | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (healthcare assistants) | 1 June 2016 – 31 May 2017 | 244 (5%) | N/A |

Managers reported that recruitment and retention of staff had been a challenge but this had improved in recent months. This core service had 22 (11%) staff leavers between 1 June 2016 and 31 May 2017. The service was over-established for medical staff. The trust had a rolling advert for nurses and ten had recently been appointed to work across the forensic and secure wards. At the time of inspection, the service had vacancies for three nurses and three healthcare assistants. To account for the national pressures on recruitment of nursing staff, the senior managers had undertaken a review of the skill mix of their staff and the needs of their patient group. As a result, they had developed a number of associate practitioner posts to work in designated roles alongside nursing, psychology and occupational therapy staff.

Staff reported shifts normally met the required staffing establishment levels. Between 1 June 2016 and 31 May 2017, bank staff filled 38% of shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 8% of shifts and 6% of shifts were unable to be filled by either bank or agency staff. Between 1 June 2016 and 31 May 2017, 33% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants. In the same time period, agency staff covered less than 1% of shifts and 5% of shifts were unable to be filled by either bank or agency staff.

The service managed the use of bank and agency staff safely. The majority of permanent staff provided bank shifts and knew the patient group, which provided consistency. The forensic and secure inpatient services had used three agency staff since December 2016. Each agency nurse had been employed for a three month period and had undertaken a full induction to ensure the safety of staff and patients. At the time of inspection, one registered agency nurse was currently working on the wards with no plans to recruit anymore as staffing levels were improving.

The trust average sickness rate was target 5%,this core service was higher at 8%,.
Managers reported sickness levels were improving in recent months, with a reduction in the number of staff on longer term sick.

The service had reviewed the staffing establishment levels using a combination of the Safer Care Nursing Tool and consultation with staff. Senior managers reviewed the activity levels on each of the wards and identified predictable periods of higher and lower activity. They developed an ideal establishment that provided a range of shorter shift patterns, to ensure more staff were on the ward during periods of high activity, such as lunch time.

In addition to the qualified nursing staff and healthcare assistants were the medical staff, managers, associate practitioners, occupational therapy staff, psychology staff, speech and language staff and social work staff.

Staff and patients reported that access to section 17 leave and medical appointments was now a priority and was rarely cancelled. The recruitment of associate practitioners and additional therapy staff meant the wards had seen an increase in activities and we saw activities taking place across the wards during our inspection.

**Medical staff**

Staff did not report any concerns about access to medical cover and patients reported they could see the doctor when requested. A team of five consultants provided medical input to each ward, along with junior doctors. Out of hours medical cover was provided by junior doctors with consultants as second on call. Consultants worked on a rota system covering one weekend in every five.

Junior doctors were not resident on site but were able to attend within 30 minutes. Medical staff acknowledged that getting a junior doctor to complete a medical review within the first hour of seclusion out of hours could be a challenge and staff would call the consultant to ensure the review occurred.

**Mandatory Training**

Staff were not sufficiently trained to ensure they met the needs of the patient group. Compliance with mandatory training had improved since the previous inspection. In March 2017 the service was meeting the trust target of 75% overall for compliance with mandatory training; however, we found this was not consistently maintained.

As of August 2017, the overall training compliance across the core service for mandatory training was 74%. Eight courses were above 75% compliance and nine courses were below 75%. Compliance with safeguarding children level 3 training was lowest at 41%, although the service had recently added this to their mandatory training list. Compliance with basic life support training was also low at 44% and the service reported there had been difficulty accessing this training with courses booked for November 2017. The compliance level for management of actual and potential aggression was below target at 72%, although the trust had recently recruited an internal trainer in order to improve this.

Compliance with immediate life support training overall was 83% as of August 2017, which ensured that there would always be staff that were trained in immediate life support on the site. All wards were over 75% with the exception of Ullswater ward, which had 50% compliance as a result of five staff, two who were not currently at work.

Overall as of 31 March 2017, staff in this service had undertaken 86% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% target in fire safety training.

Safeguarding adults and information governance training had the highest training compliance with 100%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 75% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate of 74%. The staff in this service had not

achieved the CQC 75% training target in seven courses. These courses are indicated in the table below.

Conflict resolution training had the highest training compliance with 100%. Basic life support scored the lowest out of all the training courses with 36% however staff had not been required to complete these courses in previous years.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| **Information Governance** | 100% | *70%* |
| **Safeguarding Adults** | 100% | *70%* |
| **Mental Capacity Act** | 98% | 81% |
| **COSHH** | 95% | 84% |
| **Display Screen Equipment** | 91% | 83% |
| **Health and Safety** | 89% | 86% |
| **Infection Prevention and Control** | 84% | *73%* |
| **Conflict Resolution** | 82% | 100% |
| **Equality and Diversity** | 82% | 81% |
| **Prevent** | 76% | 78% |
| **Safeguarding Children** | 76% | *62%* |
| **Moving and Handling** | 75% | *71%* |
| **Fire Safety** | *70%* | 80% |
| **Mental Health Act** | Not stated | 90% |
| **Basic Life Support** | Not stated | *36%* |
| **Immediate Life Support** | Not stated | 90% |
| **MAPA** | Not stated | *68%* |
| **Core Service Total %** | 86% | 75% |

The service was improving staff access to mandatory training and monitoring of compliance levels. An administrator focused on training and sent managers monthly updates on staff compliance. The service had organised for some courses to be delivered in the Humber Centre to ensure easy access for staff and improve attendance levels. In response to staff feedback, the administrator was organising supported group learning sessions to complete e-learning.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Staff had completed a current risk assessment and safety plan in all of the 31 records we reviewed. Staff used recognised risk assessment tools to identify and manage patients' risks. These were the Short-Term Assessment of Risk and Treatability tool and the Historical Clinical Risk management-20 tool.

Following the risk assessment, staff completed a safety plan, which identified how they would support the patient to manage their identified risks. Staff were aware of patients' risks and there was evidence of continual assessment of this in the morning meeting. Across the wards, the safety plan was reviewed each month in the multi-disciplinary team meeting. However, the way in which

staff documented this review varied which made it difficult to clearly see when the safety plan had been reviewed.

**Management of patient risk**

Staff understood the supportive engagement policy and used it to manage patients' individual risk. They focused on engaging with patients rather than observing them and the policy had been developed with input from staff. Patient records and observation of the staff morning meeting evidenced staff increasing or decreasing observation levels as risk levels changed.

There had been positive changes in restrictive practice since our previous inspection. Any restrictions were based on an individual assessment of risk and need and the service held monthly reducing restrictions meetings. The service had reviewed the ward security profiles and individual risk assessments were in place to justify any restrictions placed on patients. The service had developed policies and procedures to enable patients to have keys to their bedrooms and access to mobile phones where appropriate. Patients also had access to boiling water to make hot drinks and unsupervised access to outside space.

The trust had reviewed their search policy with the aim of least restrictive practice. Staff undertook bedroom searches randomly on a two weekly basis across all medium secure wards. Patients would only be subject to room and / or personal searches in response to specific intelligence or information.

Patients were now able to send and receive mail without restriction, unless there was the need for mail monitoring due to an identified risk. Where staff had concerns, they completed a restrictive intervention plan. At the time of inspection, 11 patients were subject to mail monitoring. We reviewed the restrictive intervention plans of six of these patients. Staff had indicated clear reasons for this to be in place and identified how often the plan would be reviewed.

The trust had adhered to best practice in becoming a smoke free site in September 2016. Support was accessed from local health trainers about nicotine replacement therapy. Patients had individual needs assessments and the service used a number of distraction activities during the early weeks, including the painting of a large mural in the 'street' area of the Humber Centre. Nursing staff monitored patients' body mass index following commencement of the nicotine replacement therapy to support those patients who may gain weight as a side effect of stopping smoking. Staff ensured these patients had access to additional physical exercise. The service was continuing to review the arrangements for patients who chose to smoke on leave in terms of where they could store their cigarettes, tobacco and lighters. This was being discussed with the patients' council and in the reducing restrictions group.

**Use of restrictive interventions**

Staff reported that they used de-escalation prior to restraint, although this was not always clearly evidenced in the restraint records. We reviewed the records of 11 restraints. Staff documented the necessity, proportionality and effectiveness of each incident and the record indicated the level of de-brief and physical health monitoring that had occurred following the restraint. The level of detail varied across the records and all except one were completed in full. Patients on Ullswater ward had positive behavioural support plans in place to support the management of behaviour that could challenge, in line with the positive behavioural support competency framework.

The forensic inpatient services reported 34 incidents of restraint, on 25 different patients between 1 June 2016 and 31 May 2017. The table highlights data from 1 June 2016 to 31 May 2017:

| Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|
| 72 | 34 | 25 | 8 (24%) | 0 (0%) |

The number of seclusion episodes was over double the number of restraint incidents. The service reported that patients in long term segregation would move between this and seclusion at times when their behaviour heightened. The long term segregation area contained the seclusion suite and patients would walk into the seclusion suite without the need for restraint. The de-escalation area was also contained in the seclusion suite. Patients would often move to the de-escalation area in response to verbal prompts and staff would record this as an episode of seclusion due to its location, in line with the Mental Health Act Code of Practice.

There were eight incidents of prone restraint, which accounted for 24% of the restraint incidents. Staff reported that one patient tended to put himself into the prone position at the start of a restraint incident and was quickly moved out of this position with the support of staff. There were no clear trends over time; however, there were peaks in October 2016 (three incidents) and May 2017 (two incidents).

Staff reported rapid tranquilisation was rarely used across the wards. There had been no instances of mechanical restraint or rapid tranquilisation over the reporting period.

Staff now used seclusion in line with the Mental Health Act Code of Practice and trust policy. Staff reported there had been a culture shift in the use of seclusion and that it was only used as a last resort. The service had undertaken work on the use and recording of seclusion over the previous 12 months. They had delivered numerous training sessions to staff to increase their understanding of the use of seclusion.

Over the 12 months between 1 June 2016 and 31 May 2017, the use of seclusion fluctuated with a total of 72 episodes. The number of seclusion episodes reported during this inspection was higher than the 29 reported at the time of the last inspection. Staff reported this was due to an increased understanding of seclusion and accurate recording of when seclusion had occurred.

We reviewed the records of five episodes of seclusion. We found good documentation of the reason for seclusion, evidence of observations at 15 minute intervals and a clear seclusion care plan with aims and objectives identified. Nursing reviews were documented two hourly in line with the trust policy. Seclusion records evidenced that staff had attempted de-escalation prior to seclusion. Where the patient had contact with their family, staff documented they had informed them of the episode of seclusion. Medical reviews took place as required in most cases, however this was not always clear to see from the records. On-call doctors did not always have access to the electronic system and would note their reviews on paper for this to be scanned into the computer. The trust was looking at ways to manage this to ensure medical reviews could be typed straight into the patient record.

Staff were adhering to the trust policy in their use and recording of seclusion. The modern matron completed a seclusion inspection report each month, taking a sample of seclusion records across each ward.

Staff adhered to the Mental Health Act Code of Practice and trust policy in their use of long term segregation. There had been six instances of long term segregation over the 12 month reporting period. The Mental Health Act Code of Practice defines long term segregation as 'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, it is determined that the patient is not allowed to mix freely with other patients'. The number of segregation incidents reported during this inspection was higher than the one reported at the time of the last inspection. This was partly attributable to the admission of a small number of patients with complex needs.

## Safeguarding

Staff knew how to identify adults and children at risk, although compliance with mandatory safeguarding training was below the trust target. Staff were able to identify signs of abuse and understood when and how to make a referral. Managers reported good relationships with the internal trust safeguarding team and understood when they may need to send a referral to the local authority.

The service kept a log on each ward of safeguarding concerns, which identified the issues, action taken and whether they were dealt with internally or referred to the local authority. The service had made 17 safeguarding referrals between October 2016 and July 2017.

Staff could give examples of safeguarding cases on their wards and knew which patients had current safeguarding concerns. Staff followed safe procedures for children visiting the service.

### Staff access to essential information

Staff had moved to an electronic case record system over the last 12 months. Staff reported the system was difficult to navigate and the majority of staff we spoke to identified problems with using the electronic system, such as it was slow and hard to use. Staff reported the system was implemented before everyone was trained and was rolled out very quickly. They also felt that learning from the roll out in forensic services had not been acted upon before the system was rolled out across other services.

The trust had used an administrator post to support staff in accessing training and using the system. The service identified 'champions' who offered staff one to one coaching sessions. Some issues remained, such as gaining access for the on call doctors so they could type medical reviews straight into the system. All paper documentation was scanned into the electronic system. The recruitment of ward clerks across the forensic services had helped reduce the burden of this on front line staff with the aim of ensuring more time to focus on patient care.

### Medicines management

We found medicines were prescribed in accordance with the provisions of the Mental Health Act. Medicines were stored securely in the clinic rooms with access restricted to authorised staff, in line with trust policy. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored and recorded appropriately. However, we found balance checks of controlled drugs were not always carried out weekly in accordance with trust policy on Ullswater, Swale and Greentrees wards.

Staff encouraged some patients to self-administer their medicines and carried out appropriate risk assessments to support this. Staff reviewed patients regularly to ensure self-administration

remained safe and appropriate for each individual. Staff had access to regular input from a pharmacist who visited the wards weekly and felt supported by this.

Staff did not always ensure relevant tests and investigations were carried out for patients who were taking antipsychotic medicines, in line with National Institute for Health and Care Excellence guidance CG178 (psychosis and schizophrenia in adults: prevention and management). We found two patients had not had an electrocardiogram and a third patient had not had the required blood tests. In addition, staff did not always complete the antipsychotic monitoring record form in the patient's notes to record when tests had been carried out.

## Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified. Between 1 June 2016 and 31 May 2017, there were no serious incidents reported by this forensic and secure inpatient wards and no incidents that met the trust threshold for serious incident reporting.

## Reporting incidents and learning from when things go wrong

Staff understood what required reporting as an incident and were aware of how to do so. The service used an electronic incident form to report all incidents. Staff discussed incidents from the previous day in the morning meeting and shift handovers. Staff also received 'blue light alerts' to highlight security issues and a regular global newsletter containing lessons learned.

The service monitored incidents to identify learning and ensure this was shared with staff. The senior management team had developed an incident tracking tool that enabled them to have more oversight of the types of incidents. A quarterly patient safety report was used to identify themes and trends. Incidents were also reviewed at the monthly clinical network meetings, which included representatives from all wards and disciplines across the service, alongside the trust research team and safeguarding team.

Staff reported they had access to de-brief following incidents and this was also documented on the restraint monitoring form.

The trust had a policy on duty of candour and staff understood their responsibilities in terms of duty of candour. The forensic services reported they had identified nine incidents at moderate level of harm since March 2017. Of these, six had a moderate level of harm relating to the patient and three were relating to staff. Duty of candour was undertaken by the trust in relation to the six incidents that involved patients and the incident was discussed with the patient and/or their next of kin. In addition to these, there were a further four incidents rated lower then moderate, where duty of candour was still undertaken by the trust. These related to incorrect information being entered onto patient records.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made by local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last two years, there had been no 'prevention of future death' reports sent to the trust that related to the forensic and secure inpatient services.

## Is the service effective?

### Assessment of needs and planning of care

Staff had completed a comprehensive assessment of each patient in all 31 records we reviewed, which included a review of their physical health needs. Patient records contained evidence of regular assessments of patients' physical health.

Staff developed a care plan in conjunction with the patient, which remained static unless the patient's needs changed. The care plans reflected the patient's needs identified in the comprehensive assessment.

Each patient record contained an up to date recovery star, which staff reviewed regularly with patients. The recovery star is a tool that measures change and supports recovery by providing a map of a patient's journey to recovery and a way of plotting their progress and planning actions.

Recovery stars were personalised to each patient's individual needs and identified where support was required from other services and the patient's family. In June 2017, therapy staff undertook a qualitative review of the recovery care plan, recovery star and associated action plan. They found that all 19 patients sampled had the necessary documentation in place but that they lacked focus or were unspecific in many areas and were mainly completed by nursing staff. An action plan was developed to implement the use of a multi-disciplinary approach to the recovery care plans and additional training for staff on goal setting. This work was ongoing at the time of inspection.

### Best practice in treatment and care

Staff provided a range of care and treatment interventions that were suitable for the patient group. Patients on Ullswater ward had positive behavioural support plans in place. These were based on the results of a functional assessment and used positive behaviour support approaches, which are recommended by the National Institute for Health and Care Excellence for use with patients who have a diagnosed learning disability.

In the records reviewed, medical staff had adhered to National Institute for Health and Care Excellence guidance when prescribing and administering medication. Staff received information about updates on policies and National Institute for Health and Care Excellence guidance through a generic email. Managers reported they had incorporated National Institute for Health and Care Excellence guidance into the service pathways.

Patients had good access to psychological therapies in a group setting and on a one to one basis. These included work on problem solving, anger management, skilful minds, anxiety management and sleep hygiene. Psycho-education groups around psychosis and personality disorder were also made available. The psychology staff completed a collaborative formulation with the patient within three months of admission. They also contributed to patient risk assessments and review meetings.

Patients had good access to activities intended to help them acquire living skills. Occupational therapists carried out an assessment of motor and process skills, which provided a measure of the quality of patient assisted daily living functioning. The development of the associate practitioner role had resulted in an increase in activities available to patients. Staff and patients felt positive about this and activities were occurring across the wards during our inspection. We reviewed the activities timetable for each ward that included sessions at the allotment, shop and cook, a walking

group and craft sessions. Patients were also supported by an art therapist and speech and language therapists.

Patients had good access to physical healthcare. Patient records showed that staff ensured they had access to medical treatment when required, such as dentists, opticians and specialists within the acute hospital.

The trust had made improvements in the physical health monitoring of patients. The Humber Centre had a GP who visited the service twice weekly. A health hub was staffed by two nurses and an associate practitioner, who was also a health trainer. Nursing staff undertook clozaril monitoring and held a smoking cessation clinic for patients. In addition, a long term conditions clinic had been established by the health hub team to improve the care of patients with diabetes. Staff at the health hub ensured Health Improvement Profiles were completed and reviewed at least annually.

Care records contained evidence of regular physical health monitoring, including patient's weight, waist circumference, body mass index, temperature and pulse. Staff monitored physical health and the side effects of medication using validated tools such as the Malnutrition Universal Screening Tool, the Liverpool University Neuroleptic Side Effect Rating Scale and the National Early Warning Score tool.

The service supported patients to live healthier lives. Nursing staff in the health hub had undertaken an audit of patients' body mass index in June 2017. As a result of this, staff were including health and well-being in recovery plans for all patients to include diet, exercise and preventative interventions.

However, staff did not always develop physical health care plans with patients who had long term physical health conditions. In four records, care plans were either absent or lacked sufficient detail. In one record of a patient with diabetes, the frequency of blood sugar monitoring was not stated. In another record of a patient with epilepsy, there was no care plan in place to guide staff on how their condition should be managed, in particular in the event of a prolonged seizure.

Staff used recognised rating scales to assess patients and monitor their outcomes. Psychology staff monitored patient outcomes with the use of the Clinical Outcomes in Routine Evaluation - Outcome Measure. This was a patient self-report questionnaire designed to be administered before and after therapy. Occupational therapists used the Model of Human Occupation Screening Tool to gain a base line assessment of patients' needs and highlight specific interventions that patients may require.

Staff also used the Health of the Nation Outcome Scales to monitor the health and social functioning of patients. The use of this tool was recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illnesses.

Staff used the 'my shared pathway' recovery based approach to ensure outcome based collaborative care planning. The 'my shared pathway' work stream is part of the national secure quality, innovation, productivity and prevention programme. It aimed to ensure services focused on moving patients along a pathway to less expensive community services and ensure the length of stay for patients in secure services was kept to a minimum.

Staff on Ullswater ward used the Life Star, which was an outcome tool developed for people with learning disabilities. The aim was to enhance a patient's capacity to input to their care and ensure improved communication and understanding of their progress.

Staff now participated in more clinical audits on the wards. The service had begun to use the Perfect Ward application to undertake and record audits. This was a tool that allowed staff to complete audits and record them in real time on an electronic device.

The forensic inpatient services participated in four clinical audits as part of their clinical audit programme in the 12 months prior to 31 May 2017. Three audits related specifically to forensic inpatient services, whereas the MH7 Re-audit of Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines audit was completed trust wide.

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| **SI-2015-29198 Audit of HCR-20 completed prior to leave and with leave and AWOL scenario** | Local clinical audit as a result of a serious incident | 29/07/2016 | Leave decisions are monitored. HCR20 training has been maintained and the START tool has been additionally implemented to support risk assessment in this service area. Re-audit planned October 2017 Monitored by Care Group and Clinical Network. |
| **MH5 Section 132 Patients' Rights under Mental Health Act 1983** | Local audit for the Mental Health Act | 27/02/2017 | Action planned developed and supported by the Mental Health Legislation Team which supports training and the introduction of forms and advice & support following the introduction of the electronic system (Lorenzo) within Forensic Services. Modern Matron monitor electronic records including application of Act and recording of rights |
| **Audit of Immediate Discharge Letters in Humber Centre** | Local clinical audit | 01/03/2017 | Action plan in progress () and re-audit being planned. |
| **MH7 Re-audit of Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines** | Local clinical audit | 10/03/2017 | Action on plan completed - new audit tool being developed for Re-audit March 2018.<br>ECT Policy revision. |

Since June 2017, the clinical nurse specialist had undertaken an audit on the use and management of Section 17 leave forms and the clinical care director had completed an audit of the standard of the records from multi-disciplinary team review meetings. The charge nurses, deputy charge nurses and modern matrons were involved in monthly audits of the environment, infection prevention and control and patient care records. All audits identified key recommendations and the frequency at which they should be repeated.

## Skilled staff to deliver care

All wards had input from a range of professionals to meet the needs of the patients, including psychologists, occupational therapists, general and mental health nurses, activity workers and social workers. The social work team had expanded from one staff member to three social workers and two associate practitioners. Each ward had a designated qualified psychologist and two assistant psychologists were shared across the wards. Trainee psychologists on placement undertook assessments and pieces of therapeutic work under supervision. The occupational therapy department had two vacancies at the time of this inspection but was supported by associate practitioners.

Staff had the right skills to meet the needs of the patient group. All staff had to undertake a five-day induction within eight weeks of commencing employment and were subject to a probationary period. The induction included the Quality Network of Forensic Mental Health Services standards for medium secure services.

The trust's target rate for appraisal compliance was 85%. As at 31 May 2017, the overall appraisal rates for non-medical staff was 94%. The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 88% reported in the previous year.

As at 31 May 2017, the overall appraisal rates for medical staff within this core service was 96%.

Between 1 June 2016 and 31 May 2017 the average clinical supervision rate across forensic inpatient wards was 49.8% against a trust target of 100%, excluding medical staff. The trust policy stated that supervision was to occur every four to six weeks and could be delivered on a one to one basis or in a professional group or forum. However, the trust monitored compliance with supervision on a one to one basis, it did not take into account staff attendance at professional groups and forums.

We reviewed a clinical supervision performance report, which identified one to one supervision rates had increased to 71% in August 2017. Staff had access to daily reflective practice sessions on their wards and a weekly reflective practice session with members of the psychology team. The majority of nursing staff we spoke with reported monthly access to supervision and that it would be facilitated by managers when requested. Therapy staff reported good access to regular clinical supervision and professional development. Medical staff had weekly peer supervision sessions and attended a practice development group with colleagues from other areas every three months.

Since May 2017, each ward had commenced regular team meetings. We reviewed the minutes of these meetings and found agenda items covered training, supervision and staffing amongst others. The service also organised regular team away days to ensure staff were involved in service development.

Some staff felt supported to access additional training, for example a nurse was studying forensics at master's level and social care staff were undertaking additional training in family therapy. Medical staff also reported access to specialist training for continuous professional development. Nursing staff on Ullswater specialised in learning disabilities and all staff on the ward had attended a one-day training course on autistic spectrum disorder. Other staff commented they were not supported to access training other than that deemed mandatory by the trust. Staff working on the personality disorder unit had not received any additional training, however the ward manager was a trainer in the Knowledge and Understanding Framework for personality disordered patients. Plans were in place to roll this training out with staff over the following 12 months.

A review of four staff supervision files showed that where performance was a concern, staff had a supportive development plan in place with increased supervision sessions and review meetings.

## Multi-disciplinary and inter-agency team work

Staff held regular and effective multi-disciplinary meetings. The multi-disciplinary team met each week and reviewed each patient at least monthly. In the meetings we observed, staff knew the patient well and the patient felt able to raise concerns and ask questions. Staff ensured the patient understood what had been discussed and involved the patient in reviewing their risk assessment

and recovery star. Staff spoke positively about the way in which the multi-disciplinary team worked together and all patients reported being invited to their reviews.

Staff shared information about patients at twice-daily handovers. Representatives from all wards attended a multi-disciplinary clinical handover each morning where they reviewed staffing levels and provided an update on patient activity and engagement levels on each ward. Any episodes of seclusion and security issues were also discussed.

Staff worked with other services and agencies to support patients' care and treatment. Patient records indicated staff liaised with the patient's community mental health team and local GP. Social work staff in the service undertook liaison work with the patient's local authority and made assessments about children visiting patients. The social worker also linked with the local multi-agency public protection arrangements team and employment agencies when planning for a patient's discharge.

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

Staff had a good working knowledge of the Act and its principles. As of 21 June 2017, 90% of the workforce had received training in the Mental Health Act. This was a year to date figure spanning training compliance from 31 March 2017 to 21 June 2017 and so this figure should not be directly compared to the training compliance outlined elsewhere in this report. The trust stated that this training was mandatory for all inpatient and community staff and renewed every three years. Data was not provided to enable us to compare compliance to previous years.

The trust had a Mental Health Act policy which was updated in August 2017 and had been revised in line with the Mental Health Act Code of Practice. Staff were able to access the policy on the trust intranet and we observed copies of the Code of Practice available on the wards. Easy read leaflets were also available explaining the Act to patients and a jargon buster leaflet available for families explained terms used within the Act. We saw information available across all wards informing patients of the independent mental health advocate and all those we spoke with knew how to access this service. If patients were deemed not to have capacity on admission, staff made an automatic referral to the independent mental health advocate.

Healthcare assistants told us that they would ask for support from nursing staff or from the trust Mental Health Act lead. We spoke with the Mental Health Act manager during our inspection. They explained that standard procedures had been developed to inform staff of their requirements around explaining patients' rights to them and ensuring they had access to independent advocacy. A pilot was occurring on Swale ward to use an electronic signature pad for patients to sign to say they understood their rights, which could then be uploaded onto the electronic system.

The trust had a Mental Health Act office that organised and scrutinised paperwork and we saw that regular audits of paperwork were undertaken. These included audits of Section 17 leave paperwork and staff undertaking discussion with patients about their rights in accordance with Section 132 of the Act.

We reviewed Mental Health Act documentation in 12 patient records. All records showed staff had discussed patients' rights with them as agreed in their care plan and patients had signed to confirm this. Staff ensured patients had access to Section 17 leave and in all records old Section

17 leave forms had been removed or crossed out. Detention paperwork was available to staff with reports from approved mental health professionals in place.

### Good practice in applying the Mental Capacity Act

As of 31 March 2017, 98% of the workforce had received training in the Mental Capacity Act. The trust stated that this training was mandatory for all inpatient and all community staff and renewed every three years. The training compliance reported during this inspection is higher than the 42% reported in the previous year.

Staff were able to demonstrate a good knowledge of the Mental Capacity Act and gave examples of assessing patient capacity in relation to finances, medication and diet. Staff stated they provided information to patients to support them to make their own decisions and understood the reasons why a capacity assessment may be required. Staff assumed capacity unless they had information to suggest otherwise, in line with the Act. They understood the importance of best interest decisions and least restrictive options. Staff were aware of which patients on their wards had capacity assessments in place and the reasons for these.

The trust told us that there had been no Deprivation of Liberty Safeguard applications made to the Local Authority between 1 June 2016 and 31 May 2017 for these wards.

The trust had a policy on the Mental Capacity Act. Staff had access to the policy on the trust intranet and the Mental Capacity Act Code of Practice was available on site.

Staff made assessments of patients' capacity where this was relevant. In one record, the responsible clinician had undertaken a two stage assessment of capacity with a patient who was being recommended for electro-convulsive therapy. A best interest meeting was planned involving the nearest relative, the safeguarding team, the independent mental health advocate and members of the multi-disciplinary team. In another record we saw an assessment of capacity by a speech and language therapist. The assessment gave a full description of the patient's inability to understand, retain, use and communicate information. The best interest meeting was attended by a range of professionals and staff had consulted with the patient's nearest relative. There was evidence of staff balancing the risks to the patient in favour of least restrictive practice and in the best interests of the patient.

## Is the service caring?

### Kindness, privacy, dignity, respect, compassion and support

During the inspection, we spoke with 15 patients and six carers whose relatives or friends were using the service. We also received feedback from five carers and seven patients in focus groups prior to the inspection.

Patients reported staff helped them, were supportive, reassuring, kind, caring and polite. Some patients felt involved in their care plan and reported they attended their monthly review meetings. Patients reported staff explained their care and treatment to them, including their medication, detention under the Mental Health Act and Section 17 leave plan.

Two patients felt that staff had not taken the necessary action when they raised concerns about abuse from another patient. We discussed this with staff and could see that the appropriate referrals had been made and they were taking action to manage the situation on the ward. All

patients felt able to raise concerns with staff and the advocate and would use the complaints procedure if needed.

We observed staff supporting patients in a way that was caring and sympathetic to their needs. Staff were warm and encouraging during activity sessions. To help build positive relationships between staff and patients, staff had developed 'getting to know me' books where staff listed their interests, likes and dislikes.

Staff across all wards had a good understanding of patients' needs. During patient review meetings, staff welcomed the patients and spoke to them in a clear manner, avoiding the use of jargon. Staff fully involved the patient, gave them time to input to discussion and checked their understanding. Staff recognised the significance of the patient's family and showed an understanding of their social situation.

The 2016 Patient Led Assessment of the Care Environment score for privacy, dignity and wellbeing was worse than similar organisations. Humber Centre scored 82% compared to a trust average of 85% and an England average of 90%. This includes aspects such as the provision of outdoor and recreational areas and access to television, radio, internet and telephones. The service had made changes since 2016 in terms of access to outdoor space, telephones, internet and television in line with their reducing restrictions group. This was now assessed on an individual risk and need basis and therefore may account for the low scores in 2016.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Humber Centre** | MH - Forensic inpatient | 81.96% |
| **Greentrees** | MH - Forensic inpatient / Other | 86.43% |
| **Trust overall** | | **85.31%** |
| **England average (mental health and learning disabilities)** | | **89.7%** |

Staff were aware of the need to maintain confidentiality of information about patients. Patient information was stored securely on the computer systems or in filing cabinets in the staff office. Exit doors had lists of patient names to be used in case of evacuation of the ward and staff had amended them to only contain patient's first names to protect confidentiality. Patients reported staff usually knocked before they entered their bedrooms and treated them with respect.

## The involvement of people in the care they receive

### Involvement of patients

Staff used the admission process to ensure patients were well informed and oriented to the ward. Prior to admission, staff would receive a report indicating the patient's level of risk and need. A care co-ordinator would be allocated and would try to undertake a visit to the patient in their current setting. Patients we spoke with reported they had visited the ward prior to their admission and had been made to feel welcome. They felt fully involved in the admission process.

Care plans were tailored to the individual needs of the patient and evidenced their involvement in regular reviews. Staff recorded the patient's thoughts and feelings on their planned care. The document contained a section entitled 'difference of opinion' and there was evidence of changes being made to take into account the patient's views. Staff offered the patients a copy and in all

records, patients had either signed to show they agreed with their care plan or staff had documented the reason they had not signed it.

Staff ensured patients were involved in reviews of their care and treatment. Staff met with patients prior to review meetings to ensure their views could be recorded and offered them the chance to discuss actions, outcomes and answer any further questions after the meeting. Staff gave patients a copy of their care programme approach report before their review meeting.

Staff ensured they communicated effectively with patients with communication difficulties. Positive behavioural support plans on Ullswater ward identified the patient's wishes in how they would like to be treated and their communication needs. On Ullswater ward, patients had visual diagrams of their own recovery star and pathways to aid understanding. Staff used an interpreting service to help patients who spoke other languages to understand their care.

The trust offered patients the opportunity to provide feedback on their care and treatment through the Secure Services Patient Reported Outcome Measure. The responses varied across the scale and the questions with the majority responding positively. The service repeated this survey at agreed intervals and tracked trends in the patient experience over time. In response to this survey, the forensic service had an action plan in place and produced a quarterly report to monitor service improvements.

Staff enabled patients to give feedback on the service. The psychology department held a focus group with patients in December 2016 and used the results to develop a needs analysis report. In response to these findings the psychology team began facilitating and developing a range of groups. A booklet containing information about the work that the psychology team offered was created and distributed to all of the patients to develop a better understanding about what psychology do. A follow up focus group in July 2017 showed that patients had responded positively to the changes made and plans were in place for further developments suggested by patients, such as a substance misuse group.

Each ward held patient meetings and minutes reflected that patients were able to raise concerns, with outcomes identified as actions for staff and patients. The service had developed a patient council, which they had named 'Our Voice'. Representatives from each ward were asked to attend the monthly meeting along with staff from the wards and senior management team. We reviewed the minutes of the last five meetings and found they clearly documented matters arising and had an action plan. An example of action being taken from the most recent meeting was a review of the dining experience for patients. The service had developed a dining experience group and a questionnaire to ensure patients' views shaped any changes in improving meal times for patients.

We saw evidence of 'you said we did' on the screen in the reception area at the Humber Centre. In response to feedback from patients and their families, the service had developed a jargon busting leaflet and provided more games and activities for older children on visits.

Staff ensured that all patients had access to an advocacy service and we saw information displayed about advocacy services on the wards. The advocate service attended the ward weekly and staff encouraged patients to attend the advocacy drop in sessions. All patients were familiar with the service and felt able to access it if needed.

### Involvement of families and carers

Staff informed and involved families and carers and provided them with support. All of the 31 records we reviewed contained information about the patient's family and carer involvement. Patients reported that staff kept their family informed, invited them to reviews and had met with them when requested. The social work associate practitioners assessed carers needs and referred carers to the local authority for carer's assessments.

The service enabled families and carers to give feedback and inform service development through a carer's group meeting every other month. Staff acknowledged the group was not always well attended and would benefit from a more pro-active approach. The trust had appointed a new lead for carers and it was hoped a strategic approach would give new direction to the carers meetings.

Feedback from carers about the service was mixed. Some reported communication with staff was good, that the patient's admission process was a positive one and they were involved in review meetings. Others had a less positive experience and felt communication with staff was poor and that they were not always involved in decisions about their relative's care and treatment. The majority of carers spoke positively about the behaviour of staff, finding them to be kind and polite. Carers felt able to input to the service development and reported that staff responded to their suggestions about their relative's care during review meetings.

## Is the service responsive?

## Access and discharge

### Bed management

At the time of the inspection, there were beds available on most of the wards. The trust provided information regarding average bed occupancies for all seven wards between 1 June 2016 and 31 May 2017. They reported average bed occupancies ranging from 50% to 100%. Ouse ward and Darley House ward recorded the highest bed occupancies of 95% to 100% and 93% to 100% respectively across the 12 month period. The forensic and secure wards reported no out area placements between 1 June 2016 and 31 May 2017.

| Ward name | Average bed occupancy range (1 June 2016 – 31 May 2017) (current inspection) |
|---|---|
| Darley House | 93% - 100% |
| Derwent | 80% - 100% |
| Greentrees | 81% - 88% |
| Ouse | 95% - 100% |
| South West Lodge | 50% - 100% |
| Swale | 84% - 100% |
| Ullswater | 58% - 73% |

We saw evidence in records of patients moving from medium secure to low secure wards within the trust. Each ward had a statement of purpose and the trust had pathways identified between the wards, although these could be flexible depending on the needs of the patient.

### Discharge and transfers of care

All patients were detained under the Mental Health Act (1983). For those referred to hospital for treatment under section 37 / 41, length of stay was dependent on the type of offence and the ability of the patient to recover and reduce risk to themselves and others. Discharges from this

section could only be agreed in conjunction with the Ministry of Justice secretary and had no time limit.

Derwent ward and Ouse ward were known as 'The Bridges'. Derwent ward operated as an assessment and admissions ward and Ouse ward had both an assessment side and a treatment side. Greentrees ward was termed as slow stream rehabilitation and therefore they did not expect high or rapid levels of discharge. South West Lodge was a community preparation unit for patients who were moving towards discharge. When patients moved to South West Lodge, the staff team from the transferring ward continue to provide care and treatment for the patient to ensure continuity of care.

The trust provided information for average length of stay for the period 1 June 2016 and 31 May 2017. Given the low discharge rate, the range of length of stay varied greatly. The greatest length of stay was recorded at Darley House ward in May 2017 at 299 days, followed by the Ouse ward with 101 days during the same month.

| Ward name | Average length of stay (1 June 2016 – 31 May 2017) (current inspection) |
|---|---|
| Darley House | 299 |
| Derwent | 1-42 |
| Greentrees | - |
| Ouse | 101 |
| South West Lodge | - |
| Swale | - |
| Ullswater | 14 |

The trust reported no readmissions within 28 days between 1 May 2016 and 30 April 2017 across the forensic wards.

Staff planned for patients' discharge in conjunction with community teams. Staff completed a 'my future plan' document with patients and the social worker was involved in liaising with community services to prepare for a patient's discharge. We saw evidence in care records of discharge planning, for example one patient's care programme approach review noted that NHS England were to be invited to the next review to discuss their discharge pathway. We also saw that where a provisional discharge date had been set for one patient, contingency plans were identified in case their mental health deteriorated before that time. In another record where progress towards discharge was being made, we saw the service had involved the patient's GP and community mental health team, with support being offered to open a bank account and details about compliance with their Section 41 conditions. We also saw evidence of Section 117 meetings which contained discussions about the patient's readiness for discharge.

Within the last twelve months, there had been two delayed discharges for the forensic inpatient wards, both of which were outside of the control of the service. One was a delay of 12 weeks as a result of the patient awaiting the availability of suitable accommodation. The other patient was awaiting Ministry of Justice agreement of a proposed placement due to a lack of bed availability and was delayed by 10 weeks at the time of inspection.

The forensic inpatient wards did not have any identified targets from assessments to admission.

## Facilities that promote comfort, dignity and privacy

Patients had access to a full range of rooms and equipment to support their care and treatment. The Humber Centre had a number of shared facilities, such as a patient shop, pool room and visitor's room. Patients had access to the health hub, an art therapy room, a wood workshop, a library, a sports hall, a laundry room and a social room. Each ward had a patient kitchen, communal areas with televisions and outside courtyards. Swale ward had a relaxation room and Greentrees ward and Ullswater ward had their own activity rooms.

Patients had their own bedrooms and were able to personalise them. All rooms had access to secure storage for patients' possessions. All bedroom doors had the facility to open outwards in the event of a patient barricading themselves in their room. On most of the wards, the telephone was in a shared patient area although staff advised they would support patients to have private calls with ward mobiles or in private rooms away from the ward. Patients were individually risk assessed to determine whether they could have access to a mobile phone on the ward.

There were no visiting rooms on any of the wards. All visitors met with patients in the main area of the Humber Centre. The visitor's room had a two-way mirror to allow staff to observe for safety reasons whilst enabling some degree of privacy for patients and their visitors.

Patients reported that the food had improved. A review of the previous four weeks menu plan showed that patients were given a varied choice of meals with the focus being on healthy eating. The Humber Centre had a food hygiene rating of five, which was the highest level awarded.

The 2016 Patient Led Assessment of the Care Environment score for ward food at the locations within this core service scored better than similar trusts. There were two locations including the Humber Centre and Greentrees ward, which scored 100% compared to a trust average of 95% and an England average of 92%.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Humber Centre** | MH - Forensic inpatient | 100% |
| **Greentrees** | MH - Forensic inpatient / Other | 100% |
| **Trust overall** | | **94.75%** |
| **England average (mental health and learning disabilities)** | | **91.9%** |

## Patients' engagement with the wider community

Staff supported patients to remain in contact with their family and carers through visits, leave and Skype.

Staff encouraged patients to engage with the wider community. The Humber Centre produced a magazine every quarter that highlighted their links with the local community and allowed patients to share pieces of art, poetry and creative writing. The art group had produced a piece of work to celebrate Hull being the City of Culture 2017. Patients had undertaken visits to various exhibitions across the city and their photography work was displayed in the reception area of the Humber Centre. Patients had also been involved in designing a leaflet about the area and the Humber Bridge, which was available for visitors in the reception area.

The service had developed an inclusion football league six years earlier that now included several teams made up of trust staff and service users. Patients reported enjoying the football and staff felt it had helped to break down barriers across different services. They had recently won the league and one of the patients designed the Humber Centre FC shield.

## Meeting the needs of all people who use the service

The service made adjustments for disabled patients. A building accessibility audit indicated that the building and wards were accessible by patients with a disability and that a disabled access bathroom was available. There were no specifically designed accessible bedrooms although all bedrooms were deemed accessible to those with a disability. We saw that one patient had an electric wheelchair and recliner chair sourced by the trust.

The service met the specific communication needs of patients. Ullswater ward was a learning disability specific ward and it catered for the needs of the patient group. We saw easy read information throughout the ward providing information for patients on topics such as 'why am I in hospital', 'prison transfers' and 'know your medication'. The notice board displayed information about health promotion in easy read format and had a picture tree containing positive patient comments about the ward.

Psychology staff had produced an easy read leaflet explaining the treatment they offered and introducing the staff. The activity room had a large visual representation of 'my shared pathway' and patients were involved in making displays across the ward. Patients and staff also used a velcro signing in board, which was easily readable and accessible to patients.

The service employed speech and language therapists who spent the majority of their time working with patients on Ullswater ward regarding communication, capacity, consent and patient pathways. Staff felt that this therapy was very positive for the patient group and fed into the patient's treatment plan in review meetings.

Staff had access to interpreters to support patients who spoke other languages. The trust had developed an interpretation and translation policy in February 2016 and staff could access leaflets in other languages.

Staff ensured patients had access to spiritual support and a choice of food to meet their needs. The Humber Centre had a multi-faith room containing religious texts and items. A vicar was available to meet with patients each week on a one to one or group basis. Staff told us that if this arrangement was not sufficient, patients could ask for support to meet their cultural or religious needs and patients were aware of the support offered by the vicar and how to access this. The kitchen could cater to meet the dietary requirements of religious and ethnic groups.

The wards displayed information on patients' rights and local services.

## Listening to and learning from concerns and complaints

Patients reported they knew how to complain and would feel comfortable doing so. The wards displayed information on how to complain to the patient advice and liaison service, the CQC and the commissioners and patients could provide feedback through comment cards.

Staff knew how to manage complaints in line with the trust policy and provided feedback to patients on the outcome of their complaints. Managers shared any learning from complaints with staff in team meetings and supervision.

Forensic and secure inpatient services received eight complaints between 1 June 2016 and 31 May 2017, five of which involved a patient. Five complaints regarded Swale ward, two Darley House ward and one related to Ouse Ward. Three complaints related to patient care, two of which questioned the role of the patient's care coordinator and the level of activity and occupation within the ward. Two complaints made reference to patients placed in seclusion and raised issues about communication with relatives and access to medical treatment.

This service received one compliment during the last 12 months from 1 June 2016 and 31 May 2017, which accounted for less than one percent of all compliments received by the trust as a whole.

## Is the service well led?

### Leadership

The senior management team consisted of a care director, clinical care director and assistant director. A service manager and two modern matrons, who in turn were supported by charge nurses and deputy charge nurses, supported them. We spoke to all levels of staff during this inspection, including staff that had been encouraged to develop their leadership skills and had been promoted to management roles within the service.

Managers had a good understanding of the service and could identify strengths and areas for development. They had improved systems and processes to ensure close monitoring of the service and used audit tools and action plans to evidence service development.

Staff views on whether senior managers were visible and approachable varied. Some staff reported they had little contact with senior managers. They did not always feel able to input to the development of the service and reported they sometimes felt they were not heard by senior managers and that senior managers were detached from the wards. Other staff reported that the modern matron and service manager were visible on the wards and that the modern matron sometimes worked a shift on the wards, which they felt was good practice. The charge nurses generally felt supported and connected to senior management. They described them as approachable and felt informed and involved in decision making. Staff reported the chief executive had visited the service on two occasions.

### Vision and strategy

The trust's vision was 'we aim to be a leading provider of integrated health services, recognised for the care, compassion, and commitment of our staff and known as a great employer and valued partner'. Senior leaders at the service were clear about the trust vision and values and integrated them into their work. Managers were required to communicate the trust's vision, values and six key objectives to staff. The vision and values had been incorporated into all strategies and plans agreed by the Board and we saw posters had been placed around the wards.

The majority of staff we spoke with were able to tell us about the trust values. The trust had identified that previously the values were too long to remember and that staff were not fully

engaged with them. They reviewed their values and identified three words that they felt reflected what they do and what they want to be known for: Caring, learning and growing.

- caring - caring for people while ensuring they are always at the heart of everything we do
- learning - learning and using proven research as a basis for delivering safe, effective, integrated care
- growing - growing our reputation for being a provider of high-quality services and a great place to work.

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Staff were invited to attend engagement sessions with management to discuss changes in service development. For example, managers had held consultations with staff about the proposed changes to shift patterns.

Staff had used budgets creatively to ensure high quality care. They had reviewed the recruitment budget and worked closely with finance to develop the associate practitioner role, with the aim of ensuring more staff on the wards to engage in patient activities and support their care and treatment goals.

## Culture

Staff told us they felt valued and spoke of being supported by immediate managers. They spoke positively about the working of the multi-disciplinary team and felt their views were respected. The majority of staff we spoke with reported they enjoyed their job and were happy in their work, although staffing levels were a pressure that was mentioned by most staff. Some managers felt the staff team were unsettled given the number of changes in staff and practice over the last 12 months.

Staff were aware of the whistleblowing process and the majority felt able to raise concerns if needed. Staff were familiar with the Freedom to Speak Up Guardian role. Freedom to Speak Up Guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers. We saw the appointment of the new trust guardian was shared with staff in a weekly newsletter and posters were displayed around the wards with their contact details.

Humber NHS Foundation Trust was a 'mindful employer', which meant the trust was signed up to ensure they were committed to positive mental health for staff. Staff were supported to attend occupational health where required and had access to group supervision sessions and de-briefs supported by the psychologist to discuss incidents and concerns at work.

Staff supervision files detailed examples of managers raising concerns with staff about poor performance and action plans being put in place to address this. Staff views on access to career development opportunities were mixed, with some saying the trust supported them to access additional training and others saying the appraisal process was based on the trust objectives as opposed to staff objectives.

The trust held staff awards that recognised the contributions of staff. The art therapist at the Humber Centre had been given an award for innovation based on the artwork undertaken in the shared patient resource, 'The Street'.

## Governance

Senior managers had made improvements to ensure they had more effective monitoring and oversight of the service. The appointment of ward clerks meant that staff had improved access to administrative support. The administrator role supported managers in monitoring the training and appraisals of their team. There was evidence of regular audits and action plans being developed with clear routes of where they fed into meetings and how information from these was shared with staff. Rates of compliance with mandatory training had improved and although they were still not hitting the required targets, we could see plans in place to address this.

Managers were well informed about what was happening on the wards and were taking a pro-active approach to monitoring performance. An example of this was a spreadsheet designed by the clinical care director to ensure compliance with the timing of care programme approach reviews. This was an issue we raised at the inspection in April 2016 and the majority of reviews now happened as required. Managers were aware of the compliance levels of supervision and training and were taking a pro-active approach to improving these.

Managers had focussed on increasing the number of staff appraisals completed annually. As this had improved, they now intended to focus on the quality of appraisals to extend this piece of work and maximise value for staff. The clinical care director had also developed an audit to review the quality of the minutes taken in multi-disciplinary meetings. They reviewed the last two meetings on each ward and shared the result with all staff, with each ward given each a red, amber, green rating in terms of quality. This was repeated over a six week period and there were improvements made across all wards.

Staff received daily and weekly emails that included learning from complaints and incidents, death reviews, safeguarding alerts and lessons learned were discussed in staff meetings. The reducing restrictions group also reviewed data on incidents and identified themes, which were shared with staff in team meetings.

The service held a number of regular meetings to ensure that staff of all grades were involved in service development and delivery and the sharing of information. The service had a risk and referral meeting, which discussed new referrals, patients awaiting a bed and any transfers and discharges, including those that may be delayed. A pathway meeting reviewed patients' movement towards identified goals, taking into account their current presentation with actions assigned to staff to support patients' progress. The ward business meetings enabled managers to share information on contracts and performance, safeguarding, training and operational updates.

## Management of risk, issues and performance

Staff had access to a risk register for the forensic and secure inpatient services. If ward managers wished to submit an item to the risk register, they would raise their concerns with the modern matron. The modern matron would then raise this at the forensic service business meeting.

Staff concerns matched those on the risk register. At the time of inspection, 22 items on the risk register related to the forensic and secure inpatient services, six of which were rated red, one of which was green and the remainder were amber. Examples of items were staffing, the use of

seclusion, staff supervision and risk of violence and aggression from patients. The risk register reflected concerns that were raised following specific incidents, such as a seclusion room door locking mechanism failed without warning.

The service had business contingency plans in place for emergencies that had been developed with other key agencies, such as the police.

## Information management

Managers had access to reports that monitored their key performance indicators on a monthly basis. The trust used key performance indicators to measure their performance in areas such as clinical supervision for staff, care programme approach reviews, risk assessment reviews, safeguarding training compliance, outcome plans for patients and delayed discharges. Managers shared any unmet targets or areas of concern with staff in meetings. The ward managers received a quarterly performance report and met with the performance lead to review the data. The performance lead also attended the ward business meeting once a month.

Staff had access to the equipment and information required to do their job. However, staff told us of their frustration with the electronic case record system. The service was able to develop additional forms and processes to be built into the system to ensure it was used to meet the needs of their service. Staff accessed the electronic system with a smart card and password to ensure confidentiality. All paper information was locked in staff offices.

The service made notifications to external bodies as required.

## Engagement

The trust provided patients, carers and staff with access to up to date information about the service through the intranet, bulletins and leaflets. A newsletter called 'Spotlight' was sent to staff every week and picked up three key areas for development across the service, along with three pieces of good news or good practice. The newsletter included themes from CQC visits and identified what needed to improve, why and who was responsible for it. The trust also sent a midday mail to staff that again highlighted three key topics and staff received a weekly global update across the trust.

The trust undertook staff, patient and carer surveys and encouraged feedback in various meetings and through the use of comment cards. We saw evidence that changes had been made in response to this feedback. Healthwatch had also been invited as a guest to one of the carers meetings to encourage engagement with external stakeholders.

Staff were able to meet with members of the senior leadership team. The senior managers were beginning to hold a series of focused reviews with staff. These included every ward and discipline of staff on a rolling programme. The care director, clinical care director and assistant director planned to meet with staff to review what was going well and identify any challenges. The terms of reference had been developed and information would be collated from the reviews to cascade good practice and share learning.

## Learning, continuous improvement and innovation

This service was not currently involved in any accreditation schemes. NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to a team the service with an accreditation.

The Humber Centre had taken part in the self-review and peer review in October 2016 of the Quality Network for Forensic Mental Health Services. This adopted a multi-disciplinary approach to quality improvement by sharing best practice and enabling services to benchmark against similar services and develop an action plan. The action plan for the Humber Centre indicated that all required actions either were on track or completed. one of these actions was that the service had reviewed the welcome pack to ensure that confidentiality details were included.

The forensic services had developed a reducing restrictions group in July 2016. The group was established to support the implementation of Positive and Proactive Care: reducing the need for restrictive practices and the requirements of the Mental Health Act Code of Practice regarding restrictive practices and the minimisation of blanket restrictions. Both of these were included in the commissioning for quality and innovation target - Reducing Restrictive Practices within Adult Low and Medium Secure Services. The group included staff, patients and carers and met monthly. The group had made a positive impact throughout the wards and all staff and patients could identify changes in practice, with the focus on least restrictive options and individual risk assessment. The service had developed a 'Positive Engagement Pledge' as part of their strategic commitments for 2017/18 and had reviewed their supportive engagement policy as part of this reducing restrictions work.

The forensic and secure services had developed a 'Road to Recovery Academy' that linked with the community recovery college. The aim was one of co-production between patients and staff to deliver courses and allow patients to undertake self-directed learning, developing skills for recovery and community living. The academy had completed one semester and held a graduation ceremony, with patients completing courses such as mindfulness, do it yourself skills and cooking. Courses planned for the second semester included understanding and applying for benefits, learning to give a presentation, creative writing and an introduction to politics.

At the time of inspection, the service was reviewing the dining experience of patients and had developed a task and finish group in response to patient feedback. The development of a mural in the dining areas was underway, with one dining area having an Italian theme painted on the walls and one an American diner theme. Staff and patients were invited to work together to paint the mural. The service also planned to improve the relationships between patients and the catering staff and further promote healthy meals as part of this development.

The service had supported five patients to complete their food hygiene certificate. These patients now worked with hotel services to cater for events held at the trust headquarters.

# Wards for older people with mental health problems

## Facts and data about this service

| Location site name | Ward name | Number of beds |
|---|---|---|
| Maister Lodge | Inpatient Service - Maister Lodge | 14 |
| Millview | Inpatient Unit - Millview Lodge | 9 |

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

## Is the service safe?

### Safe and clean care environments

#### Safety of the ward layout

Both wards had mitigated risks with in date comprehensive environmental ligature risk assessment. This identifies places to which patients intent on self-harm might tie something to strangle themselves. The layout of both wards meant that there were blind spots where staff could not observe patients and there were ligature risks throughout both wards. Some ligature anchor points were clearly necessary for the patient with mobility difficulties to get around, such as handrails and grab rails in assisted bathrooms. Staff were aware of the ligature risks across the older people's wards. They managed risk with the use of staffing levels, supportive engagement, zonal observation levels, and ongoing risk assessments depending on the patients' risks.

Each zonal area for observation at Maister Lodge had a folder containing patients' positive behaviour support plans, risk assessments, planned activity levels, and zonal chart for completion of observation levels.

Staff held handover meetings three times per day, where they reviewed and discussed patient risks and their required engagement levels. Nurses increased the level of engagement quickly if patients were at increased risk. For example, Maister Lodge used a higher-level ligature risk management tool when temporarily caring for patients with functional mental health needs who may present with higher levels of self-harm. Staff understood that engagement meant having a conversation with a patient rather than just observing a patient's whereabouts. This meant staff had a good awareness of risk to each individual patient and could manage ligature risks effectively.

During this inspection, we found both wards complied with Department of Health guidance on same sex accommodation. Over the 12-month period from 1 June 2016 to 31 May 2017, the trust reported no same sex breaches for the older people's service. At Maister Lodge, there were clearly designated male and female bedroom corridors either side of a large communal atrium area. There were doors on the corridor to separate the bedroom area from the communal area. At Millview Lodge, there were four bedrooms for men and four bedrooms for women at opposite ends of the communal area. The ninth bedroom was on the corridor near the nursing office. Staff could

allocate this room to patients of either gender, particularly where a patient required nursing that was more intensive.

All bedrooms were ensuite with shower, washbasin, and toilet. Bathrooms were available for members of each sex to use without passing the bedroom of a member of the opposite sex. Both bathrooms at Millview Lodge had appropriate privacy curtains in place to ensure patients' privacy and dignity. The wards followed good practice and provided dedicated female only lounges as well as communal areas where all patients could be together. However, the female only lounge at Millview Lodge had no sign on the door indicating its purpose. We discussed this with staff and found that the laminated sign had fallen off the door. Staff immediately re-fitted the sign.
There was a nurse call system in patient bedrooms. Staff attended quickly when we tested these on an unannounced basis. All staff carried personal alarms that linked with control panels throughout the wards. This meant that when they triggered their alarm, staff identified the area easily and responded quickly.

Staff carried out appropriate health and safety checks on equipment, such as checks on the fire extinguishers throughout the wards and appropriate electrical testing.

**Maintenance, cleanliness and infection control**

The service was clean throughout with good standards of hygiene and infection control. There were effective systems in place to reduce the risk and spread of infection, with hand gel dispensers placed around the ward. There were dedicated domestic support staff, who were present and cleaning on the wards during our inspection. The cleaner on Millview Lodge felt part of the team and took pride in the ward environment. Patients commented favourably on the cleanliness of the wards.

The trust originally scheduled Maister Lodge for major refurbishment in 2016, as the environment did not meet with current good practice around providing dementia friendly environments. The ward had a dark central courtyard, poor utilisation of space and limited use of colour or other markers to help patients orientate themselves around the ward. The trust postponed the decision whilst exploring the possibility of relocating the ward.

During this period, the trust redecorated and refurbished the ward, affixed clearer signage to doors indicating the use of the room, and fenced the garden area to make it more suitable for their patients. The trust reverted to their original plan in July 2017 and expected to relocate the ward in October 2017 so refurbishment could commence. Refurbishment plans included improved natural light, landscaped outdoor areas, improved zoning, the use of colour to differentiate different spaces and corridors and the installation of memory boards on doors.

Patient-led assessments of the care environment are self-assessments undertaken by teams of NHS and independent healthcare providers. The teams include at least 50% members of the public (known as patient assessors). The 2017 patient-led assessment of the care environment survey results were as follows:

The locations scored slightly higher than similar trusts for the cleanliness aspect. Maister Lodge received a score worse than other similar trusts for dementia friendly environment scoring 62.29% compared to 82.9% nationally, in disability (71.72% compared to 84.5% nationally) and also in condition maintenance and appearance (79.35% compared to 94.5% nationally).

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **Maister Lodge** | Wards for older people | 98.54% | 79.35% | 62.29% | 71.72% |
| **Millview** | Wards for older people | 99.02% | 93.63% | 84.66% | 82.27% |
| **Trust overall** | | 99.16% | 90.34% | 81.49% | 82.92% |
| **England average (Mental health and learning disabilities)** | | **97.8%** | **94.5%** | **82.9%** | **84.5%** |

**Seclusion room**
Neither ward had a seclusion room. The trust closed the seclusion room at Millview following the last CQC inspection, as it did not meet the Mental Health Act Code of Practice requirements.

**Clinic room and equipment**
Each ward had a well-equipped clinic room, which was clean, tidy and well organised. Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were contained in electronically monitored medication fridges that ensured temperature ranges remained within an acceptable range. Staff undertook regular comprehensive checks of equipment, resuscitation equipment, controlled drugs and stock medication to ensure everything was in working order and in date.

## Safe staffing

**Nursing staff**
The trust struggled to recruit staff to this core service.
This core service reported an overall vacancy rate of 12% for registered nurses and an overall vacancy rate of 44% for nursing assistants as at 31 May 2017.
This core service had six (12%) staff leavers between 1 June 2016 and 31 May 2017.

At the time of the inspection, Millview Lodge had no vacancies. Maister Lodge had vacancies for two qualified nurses and two healthcare assistants.

In March 2016, we gave the trust a requirement notice in respect of staffing levels and use of agency staff at Maister Lodge. Since the last inspection, Maister Lodge had increased the establishment level for deputy charge nurses. This ensured there was always a deputy charge nurse on duty during the day including weekends. They also provided the flexible workforce with a list of skills and experience required for an agency nurse to work on their ward. The ward had

recently increased staffing levels following a review of patients' needs. They had recruited three activity workers to post at the time of this inspection, who were due to start in October 2017.

Nurses and healthcare assistants worked across three daily shifts. The establishment level for the early and late shifts at Millview Lodge was two qualified nurses and two healthcare assistants. The night shift was one qualified nurse and two healthcare assistants. At Maister Lodge, the establishment level for the early and late shifts was two qualified nurses and four healthcare assistants. The night shift was one qualified nurse and four healthcare assistants. The wards relied on bank and agency staff and regular staff working additional hours and overtime to maintain safe staffing levels.

Between 1 June 2016 and 31 May 2017, bank staff filled 481 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 109 shifts. The wards were unable to fill 59 shifts by either bank or agency staff.

Between 1 June 2016 and 31 May 2017, 1970 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff covered 290 shifts. The wards were unable to fill 256 shifts by either bank or agency staff.

The rotas for the month preceding the inspection showed that both wards continued to have unfilled shifts. At Millview Lodge, the staffing level did not match the establishment levels during the inspection. On the first day of the inspection, the early shift comprised one qualified nurse and three healthcare assistants for the early shift and used a deputy charge nurse to fill the late shift to the required level. Millview Lodge used regular bank staff to fill shifts. They rarely used agency staff. The older people's crisis team offered the ward extra support as they were based in the same building. At Maister Lodge, the staffing level was lower than the establishment for one late shift. Staff told us they felt agency use had declined in recent months and there were now more familiar faces in the shift handover when they came on duty. New bank and agency staff received an induction to the ward.

Shifts not meeting the fill rate were usually due to unplanned events, such as staff illness or admission of a new patient needing high levels of observation. We asked the trust about the impact of staffing shortages on the wards. The trust told us that they had been three incident were staff shortages resulted in either the cancellation of section 17 leave or completing the required ongoing paperwork in a timely manner in the five months preceding the inspection.

Patients told us that there was enough staff around and available when they needed them. We observed staff available for patients to support their leave arrangements, planned activities, and supportive engagement. At Millview Lodge, staff and patients planned daily leaves and activities together every morning. There was a protected time each day for therapeutic engagement. Staff on both wards used the three-hour handover period to facilitate patients' planned leave. Staff and patients said that staff shortages occasionally resulted in leave being rearranged.

The staff rotas did not identify those staff trained in life support on each shift. However, all qualified nurses actively on duty at Maister Lodge and Millview Lodge were up to date with their life support

training. This was also a requirement for bank and agency nurses working on the ward. This meant the wards always had adequately trained staff on duty at all times.

The sickness rate for this core service was 11% between 1 June 2016 and 31 May 2017.
This core service has reported an over-established rate of 4% as of 31 May 2017.
Please refer to the table below for details about staffing on the ward.

## Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| Substantive staff figures | Date | Core service | Trust target |
|---|---|---|---|
| Total number of substantive staff | At 31 May 2017 | 54 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 6 | N/A |
| Average WTE* leavers over 12 months (%) | 1 December 2016 – 31 May 2017 | 12% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) (WTE*) | At 31 May 2017 | 2.2 over-established | N/A |
| Total vacancies overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 4% over-established<br>Range 23% over established to 1% vacancy | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 10.5%<br>Range 5% to 12% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 25<br>Range 24 to 26 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 32<br>Range 24 to 32 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 3<br>Range 0 to 4 vacancies | N/A |
| Number of WTE vacancies nursing assistants | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 14<br>Range 1 to 14 vacancies | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 12%<br>Range 0% to 16% vacancies | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May | 44%<br>Range 4% to 44% | Not provided |

| | | | |
|---|---|---|---|
| | 2017 | vacancies | |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 481 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 109 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 59 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 1970 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 290 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 256 | N/A |

*WholeTime Equivalent

The compliance for training courses as of 31 March 2017 was 78%. Of the training courses listed six courses had fewer than 75% staff trained. Staff compliance with equality and diversity training was the lowest out of all the training courses with 38%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 64% of the various elements of training that the trust had set as mandatory. This was lower than the overall trust average mandatory training rate of 74%. The staff in this service had not achieved the CQC 75% training target in 13 courses. These courses are indicated in the table below.

Mental Health Act had the highest training compliance within the core service with 82%. Equality and diversity training continued to have the lowest compliance of all applicable mandatory training courses with 38%.

Training in equality and diversity remained below the compliance rate at the time of the inspection. Staff we spoke with were able to discuss the protected characteristics under the Equalities Act and the vulnerability of the patient group they cared for.

Healthcare assistants were required to complete mandatory training in basic life support. At the time of the inspection, 45% of healthcare assistants were compliant with this training on Maister Lodge. At Millview Lodge, 60% of healthcare assistants were compliant with the training. Qualified nurses completed mandatory life support training at a higher level and all substantive nurses actively working on the wards were compliant. This meant the wards always had staff on duty who could provide life support if needed.

The trust confirmed that both wards complied with the trust target for management of actual or potential aggression training at the time of the inspection. All staff had oversight of their mandatory training performance and booked onto the courses they needed to complete. Please refer to the table below for the details of all the mandatory training.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Health and Safety | 85% | 75% |
| Information Governance | 100% | *54%* |
| Mental Capacity Act | 96% | *73%* |
| Mental Health Act | Not provided | 82% |
| Basic Life Support | Not provided | *48%* |
| Conflict Resolution | 98% | *50%* |
| COSHH | 83% | *63%* |
| Display Screen Equipment | 77% | *63%* |
| Equality and Diversity | *40%* | *38%* |
| Fire Safety | *55%* | *70%* |
| Immediate Life Support | Not provided | 77% |
| Infection Prevention and Control | *72%* | *59%* |
| MAPA | Not provided | 78% |
| Moving and Handling | *64%* | *64%* |
| Prevent | *74%* | *73%* |
| Safeguarding Adults | 100% | *59%* |
| Safeguarding Children | *72%* | *55%* |
| Core service total % | 78% | *64%* |

**Medical staff**

There was adequate medical cover for the service throughout the day. At Maister Lodge, there was a full time psychiatrist supported by two junior doctors covering the ward. At Millview Lodge, there was a psychiatrist and one junior doctor. The wards had access to out of hours medical arrangements and emergency services.

## Assessing and managing risk to patients and staff

**Assessment of patient risk**

We reviewed 11 patient records, which were all paper records. Overall, 10 of the 11 risk assessments we reviewed were completed and up to date. Initial risk assessments were completed and updated before admission to the ward by either the trust community mental health team or the trust crisis team for older people. This formed the basis for the initial safety plans nurses developed during the admission process as the wards no longer used the electronic risk and safety tool identified on the last inspection

Millview was preparing to use an alternative tool called the electronic functional analysis of care environments risk assessment tool when they moved to electronic record keeping later in the year.

At Maister Lodge, all patients had a bespoke risk assessment document based on their formulation meeting and a patient centred dementia care model.

Risk assessments included routine and ongoing monitoring of existing physical health problems and potential physical health risks that might develop. Staff assessed patients for the risk of falls and the risk of developing venous thromboembolism as part of their admission assessment process. Venous thromboembolism also known as deep vein thrombosis is a blood clot that forms in the veins of the leg. This can cause strokes or other health conditions. Staff used nationally recognised tools to assess various physical health conditions. For example, they used the Waterlow tool to assess and manage the risk of developing pressure ulcers.

**Management of patient risk**

The assessment process, observation levels, handover, and reviews meant staff were up to date with their knowledge of individual patient risks. We observed one handover on Millview Lodge, where staff discussed individual patient risks and required observation levels. Staff used supportive engagement as a means of positive risk taking, allowing patients unrestricted access to garden areas at both wards. If staff increased levels of engagement, they made team decisions to review and reduce the level as soon as possible.

The wards followed the trust policy for searching of patients. The trust had recently introduced a revised policy and staff were awaiting the equipment needed to assist with searches. Staff checked patients' belongings on admission to the ward. They carried out random searches on patients returning from leave to check for restricted items. Staff gave patients and carers information about restricted items and searches in patients' welcome packs on admission.

Both ward displayed a clear notice at the entrance that informed all patients how they could leave the ward. Patients knew how they could leave, and we observed how staff supported patients to leave the ward according to their status under the Mental Health Act and leave arrangements.

**Use of restrictive interventions**

Staff understood the definition of seclusion and only used restraint as a last resort. Staff described and we observed how they used de-escalation to manage incidents. Staff used an electronic incident reporting system to report their use of all restraint. This allowed senior managers to identify any themes emerging from the use of restraint.

When we inspected Maister Lodge previously, we identified that staff were not always recording all restraint episodes. A restraint happens when staff place hands on patients to prevent them from harming themselves or others, or when staff hold a patient for a sustained period to provide basic care in their best interests. During this inspection, we saw that staff were now reporting incidents of restraint appropriately.

This core service had 101 incidents of restraint (on 49 different service users) and 11 incidents of seclusion between 1 June 2016 and 31 May 2017. Over the 12 months, there was an increase in the use of restraint in May 2017, where there were 22 incidents. There were no reported incidents of prone restraint or mechanical restraint over the reporting period.

Incidents resulting in rapid tranquilisation for this core services have been mostly static across the previous 12 months, however there was a slight peak in November 2016 with three.

Staff managed and recorded seclusions episodes appropriately. The modern matron gave assurances staff met safeguards for seclusion when they prevented patients from leaving any area to manage their behaviour. The wards did not keep a separate record of seclusion episodes; instead, they formed part of the patient notes. Most of the seclusion episodes were brief lasting a few hours only. The modern matron audited all seclusion documentation ensuring that the rationale for seclusion, observations, initial and ongoing medical reviews and ongoing nursing reviews all complied with trust policy.

Over the 12 months, there was an increase in the use of seclusion in May 2017, where there were four instances.

There have been no instances of long term segregation over the 12 month reporting period.

There were seven reported incidents of the use of rapid tranquillisation. This happens when staff administer an injection to patients who are very agitated and disturbed. We saw staff correctly reported such incidents using the electronic reporting system. Records showed that staff completed physical health observations according to the trust policy.

The wards participated in the trust restrictive intervention reduction programme. They displayed information about their pledge to reduce restrictive interventions for patients and visitors to see. Senior staff representatives attended the trust reducing restrictive practice group and fed back information to ward staff at regular team business meetings.

Please refer to the table below for information about the use of seclusion, long-term segregation, restraint and rapid tranquillisation in this service between 1 June 2016 and 31 May 2017

The below table focuses on the last 12 months' worth of data: 1 June 2016 to 31 May 2017.

| Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|
| 11 | 101 | 49 | 0 | 7 |

**Safeguarding**

Staff we spoke with had a good understanding of the trust safeguarding procedure and knew what to do when faced with a safeguarding concern. The ward had an identified safeguarding link at the trust. We saw evidence that staff raised safeguarding incidents through the electronic system making appropriate referrals. We observed staff discuss safeguarding issues at their multi-disciplinary meetings.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted

to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust was unable to break down the data by ward/team to assign safeguarding referrals to core services for the period between 1 June 2016 and 31 May 2017

There were rooms off the wards that children who were visiting patients could use. This meant that patients could see their young family members in private and in a suitable environment.

The trust told us they had not been involved in any external case reviews in the last 12 months that relate to this core service.

**Staff access to essential information**

Patient information was stored securely in locked facilities and accessible to all staff. All information needed to provide patient care was paper based and available to all relevant staff. In addition, Maister Lodge had a well-ordered and organised selection of files clearly marked with essential information available to all staff working on the ward. This included a 'how to do this' file, containing worked examples of records and forms, which staff could refer to for guidance. For example, a fictional record illustrating what a seclusion episode that followed the trust's seclusion policy should look like.

**Medicines management**

The ward had safe systems and processes for the management of the medicines on the ward. Staff ensured they kept the medicines and medicine keys securely. The ward pharmacist or pharmacy technician visited daily to attend the ward and patient meetings. They reviewed and audited the medication charts and all medicines on the wards. At the last inspection, we identified that Maister Lodge did not have a proper system in place to monitor or assess whether staff completed these records correctly. The ward now complied with safe medicines management.

During our inspection, we reviewed all the medication charts. We found systems in place and an improvement in the quality of medicine administration records. The wards had appropriate arrangements for the management of controlled drugs. These medicines require extra checks and special storage arrangements because of their potential for misuse. We saw one examples of medicines given covertly (this is where medicines are disguised in food or drinks when patients lack capacity). The decisions to give medication covertly was in accordance with the Mental Capacity Act as we saw corresponding records of best interests decisions in the patient's notes.

Staff ensured they monitored the effects of medication on those patients prescribed medication for physical co-morbidities. No patients received high doses of anti-psychotic medication at the time of our inspection. These medicines require additional physical health checks. At Millview, staff supported one patient to gain independence to take their own medications safely. Patients understood about their medications and had opportunity to discuss their choices with staff.

**Track record on safety**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 June 2016 and 31 May 2017 there was one Strategic Information Executive System incident reported by this core service. This is categorised as pending review.

This was an external investigation commissioned by the trust in response to whistleblowing concerns raised by staff working on Maister Lodge in April and May 2016. The completed report

detailed the investigation and recommended actions. The trust responded with an action plan, which led to changes on the ward to improve staff morale and safety. The incident was due for review and closure at the next trust meeting with the clinical commissioning group.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with Strategic Information Executive System.

**Reporting incidents and learning from when things go wrong**

Staff had a clear understanding of what constituted an incident and how to report it using the trust's electronic risk management system. We reviewed a range of incidents reported by staff during the three months preceding the inspection. This included verbal and physical aggression, damage to property and low staffing. The system escalated notifications of incidents to ward managers, and if appropriate to senior managers, dependent upon the severity. This ensured appropriate investigation.

Staff on both wards confirmed they received debriefing after serious incidents. Staff discussed incidents and lessons learned during handover and team meetings. This meant that staff learnt from incidents in order to improve their practice. The clinical psychologist at Maister Lodge held weekly reflective practice sessions that staff used for support. In addition, debriefs took place at the end of each shift, which helped staff to reflect on their practice.

Staff knew about the requirements placed on them to meet the duty of candour. Duty of candour regulations ensure that providers are open and transparent with patients and people acting on their behalf in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Duty of candour was included in the incident reporting system as a prompt and actioned where necessary. Staff were aware of the need for openness and transparency if there was an incident. They encouraged patients and their carers to complain if they were concerned about any aspect of care. Records showed that managers apologised to relatives for shortfalls in patient care and sent formal letters of apology.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. They are made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Humber NHS Foundation Trust.

## Is the service effective?

### Assessment of needs and planning of care

We looked at 11 patients' care and treatment records across Maister Lodge and Millview Lodge. At Maister Lodge, patients had well-organised and documented assessments and care plans that were clear, up to date and available to all staff providing care.

At Millview Lodge, staff kept components of patients' assessments and care plans in different places. This could potentially lead to confusion for anyone not working regularly on the ward. The ward was expecting to transition to electronic records in October 2017, which would bring the records together in one place. Four out of five care plans were of poor quality. Aspects of the recovery star tool used were either not fully personalised or holistic or not completed.

Medical and nursing staff carried out their initial assessment over a three-day period. This included both mental and physical health assessments with junior doctors taking the lead for physical health. There were appropriate investigations to rule out a physical health cause for people admitted with confusion or suspected early stages of dementia.

Following the initial assessment period, one of the nursing team at Maister Lodge held a meeting with the patient and their family. This helped staff gather information about the patient's physical and mental health, preferences, and wishes. The ward psychologist then held a multidisciplinary formulation meeting to consider all aspects of the patient's care and treatment. In the meeting, staff created a care plan individualised to the needs of the patient.

#### Best practice in treatment and care

We looked at 11 patient care records and 24 prescription records.

The multidisciplinary team provided a range of care and treatment interventions suitable for the patient group. Staff used and followed guidance recommended by the National Institute for Health and Care Excellence. For example, 'Violence and aggression: short-term management in mental health, health and community settings' (NG10) and 'Falls in older people: assessing risk and prevention' (CG161).

The service offered medication and psychological therapies. We found evidence of good practice in recording and reviewing all prescription records. We found medical staff followed National Institute for Health and Care Excellence best practice guidance and prescribed medication within British National Formulary limits in the 24 records we reviewed. No patients were prescribed high dose antipsychotics. There was a low use of psychiatric medications although many patients had physical co-morbidities. Medical staff did not prescribe hypnotics for more than seven days. The pharmacist regularly checked that prescribing and relevant physical checks were in keeping with best practice.

Both wards had psychological provision. The psychologist provided cognitive testing and facilitated reflective practice and formulation sessions with staff, which supported them with the work they did with patients. At Millview Lodge, there were two weekly group therapies available to patients: coping with emotions and long-term conditions.

Staff on Maister Lodge worked with patients, relatives, and carers to obtain accurate information about patients' life stories, which they summarised in an 'all about me' document. This ensured staff provided care and treatment to patients with dementia, which was individualised and respected patients' individuality in line with recognised research into providing quality dementia care.

Physical health needs were an essential feature of patient care on the wards. Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Medical and nursing staff considered, addressed and monitored patients' physical health needs and ensured patients accessed specialist advice if needed.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. They completed the malnutrition universal screening tool for relevant patients with corresponding care plans. Staff used the modified early warning system tool to help monitor patients' physical health. National early warning scores monitor heart and breathing rate, blood pressure, level of consciousness, oxygen saturation, and temperature. At Maister Lodge, patients had physical observations taken daily if staff had concerns.

We pathway tracked the care records for one patient on each ward. We found well-documented care plans for diabetes and epilepsy. Patients received electrocardiogram testing to check the heart's rhythm and electrical activity and had blood tests where appropriate. Falls and osteoporosis screening tools were completed and staff referred patients to physiotherapy if required. Staff arranged and supported patients to attend hospital appointments with specialists. For example, a special x-ray test such as computerised tomography scans.

Staff supported patients to live healthier lives. For example, they offered patients advice and support with healthier eating and dealt with issues relating to substance misuse such as alcohol detoxification.

Staff used a variety of evidence-based tools to assess and record severity and outcomes such as the clustering tool, the brief psychiatric rating scale, the geriatric depression scale, and Addenbrooks cognitive examination test, for the assessment of dementia and other neurological disorders.

Staff participated in clinical audits specific to the service. These included audits such as compliance with the Mental Health Act and Mental Capacity Act, and defensible documentation. Staff also carried out regular checks of equipment and medicines to make sure they were safe to use.

Please refer to the table below for information about three clinical audits the core service participated in as part of their clinical audit programme 2016 – 2017.

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| **NICE QS15 Statement 12** | Local clinical audit | 15/11/2016 | Monitoring via the IG Committee need for regular audits to support services achieving increased compliance. Numerous services using SystmOne have transferred to another provider so requirement to reassess compliance planned for Q3 2017/18. Care Groups to develop action plans for improvement |
| **MH7 Re-audit of Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines** | Local clinical audit | 10/03/2017 | Action on plan completed - new audit tool being developed for re-audit March 2018.<br><br>ECT Policy revision |
| **Audit of clinical equipment on inpatient units** | Local clinical audit | 25/05/2017 | Action plan being developed. Presentation of audit due through medical devices meeting. |

**Skilled staff to deliver care.**

A range of suitably skilled healthcare professionals provided input to the service and supported the needs of patients on the ward. We spoke with a number of staff including, the modern matron, charge nurses, registered nursing and non-registered nursing staff, junior doctors, the clinical psychologist, occupational therapists and pharmacy technician. Staff we spoke with were positive and motivated to provide high quality care. Millview Lodge used volunteers to assist with activities. They received a trust induction and supervision from the occupational therapist.

The trust's target rate for appraisal compliance was 85%. As at 31 March 2017, the overall appraisal rate for non-medical staff within this core service was 80%.

The teams failing to achieve the trust's appraisal target were Millview lodge with an appraisal rate of 56% for healthcare assistants. However, these figures included three new starters who were not due an appraisal at that point in time.

Healthcare assistants we spoke with on the ward confirmed they had received their yearly appraisal. Please refer to the table below for information about appraisal rates for permanent non-medical staff as at 31 March 2017.

| | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 30 | 24 | 80% |
| **Trust wide** | 1399 | **1063** | 76% |

The trust's target rate for appraisal compliance was 85%. As at 31 March 2017, the overall appraisal rates for medical staff within this core service was 79%.

The performance report for August 2017 showed all staff at Maister Lodge had received an appraisal during the last 12 months.

| | Total number of permanent medical staff requiring an appraisal | Total number of permanent medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 24 | 19 | 79% |
| **Trust wide** | 1440 | **1063** | 74% |

During the inspection, we found not all staff received clinical supervision in compliance with the four weekly trust targets. Staff placed the needs of the patients on the ward over individual supervision, particularly when staffing levels were below the required fill rate. However, all staff had a range of opportunities to receive peer supervision that supported them in their work. At Maister Lodge, there was a built in 15 minute debrief time at the end of every shift. The weekly reflective practice and formulation meetings also ensured staff received peer support. At Millview Lodge, staff we spoke with all felt supported in their role. The clinical psychologist offered impromptu supervision once a week during clinical review although they did not document this. Monitoring of individual supervision relied on staff remembering to complete the team supervision chart after the event.

Between 1 June 2016 and 31 May 2017 the average rate across one team in this core service was 100%, achieving the trust target of 100%.

The rate of clinical supervision reported during this inspection is higher than the average of 55% reported at the last inspection.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Core service total** | 100% | 12 | 100% |
| **Trust Total** | 100% | 3244 | 69% |

Staff on both wards had access to specialist training that enhanced skills within the team and professional development. For example, staff had undertaken training in phlebotomy, end of life care, bowel and bladder training and best interest assessor training amongst others. Two members of staff at Maister Lodge were booked on to 'best practice in dementia training', which had recently become available. All unregistered staff had access to the National Vocational Qualification level 3 in health and social care and the nursing associate training scheme, which one healthcare assistant was currently undertaking. All staff new to the wards had a local induction to the ward.

Both ward held monthly business meetings for staff to attend. No staff were currently being performance managed.

**Multi-disciplinary and inter-agency team work**

Patients received multi-disciplinary input from medical staff, registered nursing and non-registered nursing staff and other professionals including psychologists, physiotherapists and occupational therapists. Patients had access to other professionals via referral, for example dietician or speech and language therapy.

At Millview Lodge, the multi-disciplinary team met daily for a clinical review of patients. At Maister Lodge, there was a weekly multi-disciplinary team meeting to review all patients, which we observed. A wide range of healthcare professionals, including nurses from the older people's crisis team, attended. A healthcare assistant from the ward gave an update of each patient's current presentation. The multi-disciplinary team had in depth knowledge of each patient leading to comprehensive discussion. This ensured that all members of the multidisciplinary team were up to date on current issues with patients and decisions about future care and treatment. The team updated care plans and discussed any safeguarding concerns, incidents, section 17 leave, or discharge plans for their patients. Care co-ordinators from the older people's community mental health teams were invited to attended these meetings when appropriate.

Ward staff had a range of opportunities to share information about patients including three handovers every day. We observed one handover at Millview Lodge, where staff discussed patients' current physical health care needs, risks, and observation levels. They discussed discharge plans and support from other services such as district nursing teams and social services. This ensured that staff coming on duty were up to date with all aspects of patient care and treatment. However, staff did not keep a permanent record of the handover discussion and did not use a standardised format. This meant the ward manager did not have assurance of the quality and consistency of information that staff handed over.

**Adherence to the Mental Health Act and the Mental Health Act Code of practice**

The trust was unable to provide annual Mental Health Act training figures as of as of 31 March 2017. For the financial year to date (between 1 April 2017 and 21 June 2017) 82% of the workforce had received training in the Mental Health Act. The trust stated that this training was mandatory for all core services for inpatient and all community staff and renewed every three years.

We carried out routine Mental Health Act monitoring visits in May 2015 to Maister Lodge and in January 2016 to Mill View Lodge. We found a number of areas for improvement, such as the recording of patient rights and section 17 leave. At Maister Lodge areas for improvement related to environmental issues and variable quality of care plans amongst other things. On this inspection, we reviewed care and treatment of patients detained under the Mental Health Act and found both wards had improved their adherence to the Mental Health Act and the Code of Practice. There were systems in place to support the operation of the Mental Health Act. Staff had a good understanding of the guiding principles of the Mental Health Act and its application.
Staff had easy access to the trust's Mental Health Act policies, procedures and to the Code of Practice. They knew whom their Mental Health Act administrators were and how to access support

and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff understood the limitations of the Mental Health Act. For example, they were aware that they could not use the Mental Health Act for decisions around treatment for physical health issues for detained patients.

Patients had easy access to independent mental health advocacy. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. Patients confirmed that they knew how to contact the independent mental health advocate and met with their advocate regularly. Staff explained to patients their rights under section 132 of the Mental Health Act regularly and recorded their understanding. We saw notice boards on both wards clearly displayed information about the role of advocacy and patients' legal status and rights under the Mental Health Act. Millview Lodge had seven patients detained under the Mental Health Act at the time of the inspection. All patients at Maister Lodge were detained patients.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. The wards had taken action following the Mental Health Act Reviewer visits to ensure the system for recording and auditing section 17 leave was thorough.

The ward made requests for an opinion from a second opinion appointment doctor when necessary. Copies of the patients' detention papers and associated records were available on the wards to all staff that need access to them. Detention papers showed staff had undertaken the appropriate medical and administrative scrutiny for patients detained under the Mental Health Act. Detention paperwork was well completed, and up to date.
The pharmacist regularly checked treatment cards to make sure that all treatment was authorised correctly. Several patients had the new assessment of capacity to consent to treatment forms introduced to the service in September 2017. These forms were fully complete and included a summary of the discussion between the patient and responsible clinician about treatment.

Both wards displayed a notice on their doors that told informal patients they could leave the ward. Informal patients told us they knew how they could leave the ward and how staff supported their requests.

Staff participated in audits to ensure they applied the Mental Health Act correctly. Ward managers received quarterly feedback from the trust and discussed the findings at team meetings.

**Good practice in applying the Mental Capacity Act**

As of 31 March 2017, 96% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff we spoke with understood the basic principles of the Mental Capacity Act and its application. They knew how to access information about the Mental Capacity Act and trust policy online and where they could seek further advice from within the trust. The service took part in a trust audit to monitor its adherence to the Mental Capacity Act.

Staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis about significant decisions. Staff gave patients assistance to make a specific

decision for themselves where possible. When staff deemed patients lacked capacity, they made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture, and history. We saw completed best interest decisions, including comprehensive best interest decision records around do not attempt resuscitation orders and covert medication.

Humber NHS Foundation Trust told us that 37 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between 1 June 2016 and 31 May 2017. Ten of which were pertinent to this core service. The greatest number of DoLS applications were made in October 2016 and February 2017 with two.

CQC received five direct notifications from the trust between 1 June 2016 and 31 May 2017. The numbers do not match what the trust has submitted in the provider information request.

This discrepancy was due to delays with the local authority (the supervisory body) processing applications. The trust notified us of Deprivation of Liberty Safeguards applications when they knew the outcome of the application.

The number of DoLS applications made during this inspection is lower than the 14 reported at the last inspection.
Please refer to the table below for details of Deprivation of Liberty Safeguard applications.

**Number of DoLS applications made by month**

| | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Applications made** | 0 | 0 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 0 | 0 | 0 | 10 |
| **Applications approved** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **1** |

## Is the service caring?

### Kindness, privacy, dignity, respect, compassion and support

We observed positive interactions between staff, patients and their carers. There was a strong, visible person centred culture, which stemmed from staff knowledge and skill in managing their patients' preferences. Staff offered care that was calm, kind, and promoted people's dignity. We observed the multi-disciplinary team's consideration and regard for patient privacy and dignity and how this translated into practice. Staff actively protected distressed patients and patients whose circumstances made them vulnerable, while providing emotional and practical support to the patients' carers and relatives. They participated in individual patient activities and provided patients and carers with help, support and advice as it was required.

Staff on Maister Lodge were often unable to involve patients in their care in a meaningful way due to their cognitive impairment. However, they engaged with relatives to help them understand how to manage their loved ones' care, treatment, and condition. At Millview Lodge, staff helped patients understand and manage their care and treatment during one to one time, reception meetings and care plan discussions. Staff on both wards understood their patients' individual physical, emotional, and social needs and reflected this in the care and treatment they provided.

At Maister Lodge, one patient commented that staff were incredibly caring, they were sensitive to his needs and always acted appropriately. Two other patients we spoke with and four carers shared this view. Everyone we spoke with reported that staff respected patient privacy and were kind, helpful and supportive. Patients' comments reflected their appreciation of the food served on the ward. At Millview Lodge, patients spoke highly about staff, complimenting their friendliness, helpfulness, and professionalism. They said staff respected their privacy and always had time to talk to them.

Staff maintained confidentiality of information about patients. The location and design of the staff office on both wards meant that it was not possible for others to see confidential information contained on visual display boards.

The 2016 patient led assessment of care environment score for privacy, dignity and wellbeing at Millview Lodge scored comparable to similar organisations. Maister Lodge scored worse when compared to other similar trusts for privacy, dignity and wellbeing (70.83% compared to 89.7% nationally).

Please refer to the table below for details of the patient led assessment of care environment score.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **Maister Lodge** | Wards for older people | 70.83% |
| **Millview Lodge** | Wards for older people | 84.04% |
| **Trust overall** | | **85.31%** |
| **England average (mental health and learning disabilities)** | | **89.7%** |

## The involvement of people in the care they receive

### Involvement of patients

Staff at both wards helped orient patients to the ward with a tour of the ward and a comprehensive information pack welcoming them to the ward. The pack discussed practical matters about being a patient and explained the care and treatment provided.

Staff involved patients and their carers in their care planning and risk assessments. Not all patients could remember if staff offered them copies of their care plan. The care plans we reviewed showed staff offered patients or their carers a copy of their care plan.
Staff clearly documented patient involvement in their care plan records, where this was possible.

Staff encouraged patients to give feedback on the service in a variety of ways. At Mill View Lodge, patients had an opportunity to comment on the running of the ward at the morning community meeting. This included discussion about the environment, cleanliness, activities and catering amongst other things. Due to patients' cognitive impairment, staff on Maister Lodge consulted with patients' carers and relatives where this was appropriate.

Staff ensured that all patients had access to an advocacy service, including specialist advocacy for patients detained under the Mental Health Act known as independent mental health advocates. We saw information displayed on the wards about advocacy services. Staff told us that there were good links with the advocacy service. Staff informed patients about the availability of the independent mental health advocates and enabled them to understand what assistance the independent mental health advocate could provide. Patients we spoke with were aware of the independent mental health advocacy service.

**Involvement of families and carers**

At Maister Lodge, staff involved carers and relatives as early as possible in the care planning and risk assessment process, where this was appropriate. Staff gave them a flow chart explaining the order in which things usually happened once a patient came on the ward. This informed carers and relatives about attending the patient's reception meeting, carer's support session, and when the formulation meeting took place. The flow chart included a glossary of terms to help carers and patients understand the terminology used by clinical staff.

The service sought feedback from families and carers using the friends and family survey. Millview Lodge displayed these results on notice boards. They also displayed 'You said, we did' feedback and information from the ward's performance report for July 2017.

Maister Lodge had its own survey for relatives as families and carers did not always respond to the official feedback channel. This telephone survey recorded ratings based on a score ranging from one to ten, with ten being excellent. The latest results from the survey in August 2017 showed that families rated:

- 'care' as nine
- 'inclusion and updates about relative's care' as eight
- 'environment and facilities' as seven

Carers we spoke with valued their relationships with the staff team and felt that staff were committed to working in partnership with them to understand patients' individual preferences and needs. Staff referred carers to the local authority for carer's assessments where appropriate. We saw information boards and information leaflets available for carers on the wards.

# Is the service responsive?

## Access and discharge

### Bed management

The trust provided information regarding average bed occupancies for two wards in this core service between 1 June 2016 and 31 May 2017.

| Ward name | Average bed occupancy range (01 June 2016 and 31 May 2017) (current inspection) |
|---|---|
| **Maister Lodge** | 65% - 100% |
| **Mill View Lodge** | 99% - 119% |

The trust provided information for average length of stay for the period 1 June 2016 to 31 May 2017.

| | Average length of stay range (previous inspection) | Average length of stay range (1 June 2016 – 31 May 2017) (current inspection) |
|---|---|---|
| **Core service total** | 41- 112 | 0 – 99.4 |
| **Trust total** | 8 - 3845 | 0 - 386.5 |

Occasionally, Maister Lodge admitted patients with functional mental health needs due to bed availability issues on Millview Lodge. This meant that patients received treatment as an in-patient in a suitable bed close to their home rather than an out of area placement. Staff transferred these patients to Millview Lodge as soon as a suitable bed became available.

This core service reported zero out area placements between 1 June 2016 and 31 May 2017.

This core service reported two readmissions within 28 days between 1 June 2016 and 31 May 2017. One readmission was a readmission to the same ward that the patient had been discharged from. The average of days between discharge and readmission was 10 days. There were zero instances whereby patients were readmitted on the same day as being discharged.

Please refer to the table below for information about readmissions.

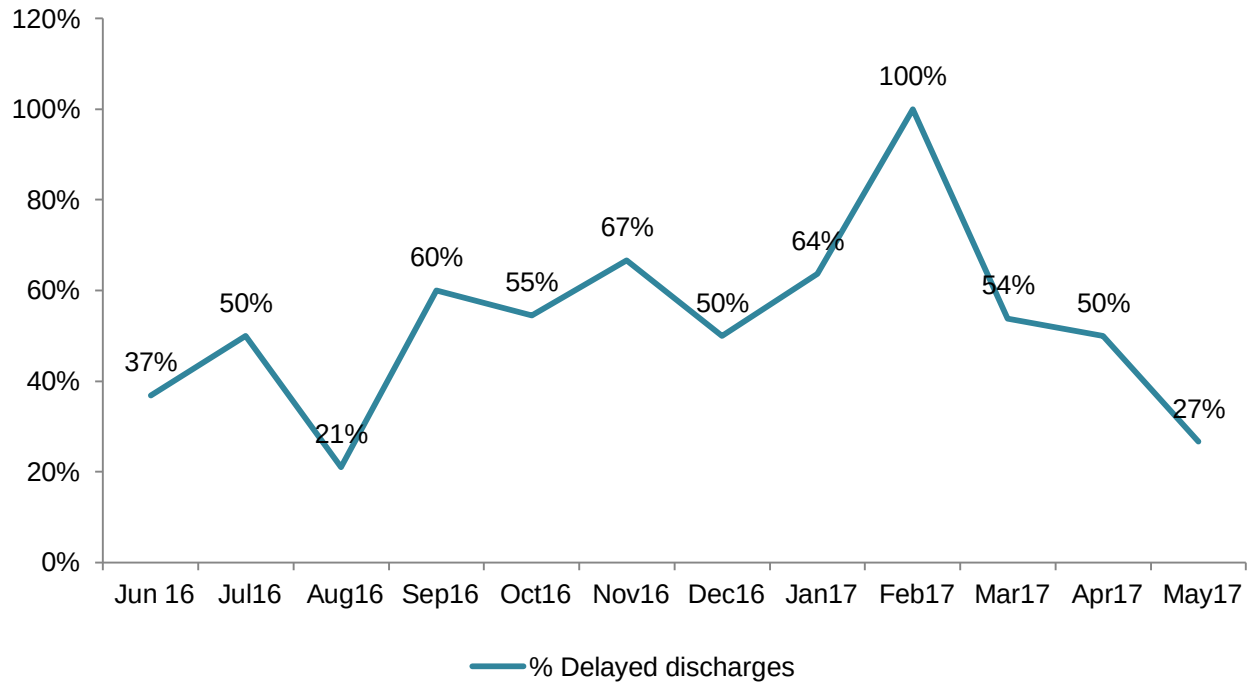
| Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|
| **2** | 2 | 50% | 1 - 18 | 10 |

### Discharge and transfers of care

At the time of the inspection, there were three delayed discharges on the wards. The primary cause of these delays was the lack of available, suitable residential care home and nursing care home beds in the community, followed by delays in agreeing funding packages.

Between 1 June 2016 and 31 May 2017, there were 143 discharges within this core service. This amounts to 8% of the total discharges from the trust overall (1799).

The graph below shows the trend of delayed discharges across the 12 month period. The graph suggests a spike in February 2017.




**Facilities that promote comfort, dignity and privacy**

Staff and patients had access to a range of rooms and equipment on both wards to support patients' treatment. Each ward had communal areas and other quiet rooms, which could be utilised as private interview rooms. There were interview rooms and family visiting areas off the wards.

At Millview Lodge, patients used an individualised electronic key fob to access their own bedrooms. Patients could personalise their bedrooms if they chose to. They had secure storage to lock valuable possessions and a removable lockable medicine cabinet for those patients who were self-medicating. The ward environment at Millview Lodge was clean and comfortable. There was a meeting room with a digital reminiscence therapy machine for patients to use and a patients' phone. There was a large lounge with a TV and a smaller female lounge. Patients on Millview Lodge had open access to a small secure outdoor space, which included a smoking shelter.

The ward environment of Maister Lodge had improved since the last inspection. The redecoration had created a more cheerful and calming environment and the ward had replaced the large television set, which dominated the main communal atrium, with a wall size map of the world. Patients on Maister Lodge had open access to a large outdoor space, which had been fenced to ensure it was suitable for those with impaired mobility.

Both wards provided some activities for their patients. At Millview Lodge, the occupational therapist covered both the ward and the crisis team who were located in the same building. Patients discussed the group activities planned for the day during the morning meeting. The patient, carers, and staff we spoke with said activities did not always happen due to patients' lack of interest and staffing priorities. The attendance register for previous activity sessions showed some activities were well attended. There was a breakfast club twice weekly and we observed a patient having a hand massage. At Maister Lodge, activities occurred either on an individual or group ad hoc basis, for example making a fruit salad. The ward was in the process of recruiting five health care assistants and at the time of the inspection, three healthcare assistants were in post. The healthcare assistant role incorporated an activity assistant role on a rotational basis. This was to ensure patients had access to activities seven days a week.

Several patients at Millview Lodge had their own mobile phones. Staff individually risk assessed patients before allowing them to keep their mobile phone chargers, as they could pose a ligature risk. Patients also had access to the ward phone.

Patients on both wards told us that the food was of good quality and snacks and hot drinks were readily available. Each ward had a suitably equipped kitchen so that patients could prepare meals under the supervision of an occupational therapist. The kitchen at Millview Lodge was due a refurbishment to improve the layout and accessibility for patients.

The 2016 Patient led Assessment of Care Environment score for ward food at Maister Lodge scored better than similar trusts. The score for Millview Lodge was comparable to similar trusts.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **Maister Lodge** | Wards for older people | 99.55% |
| **Millview** | Wards for older people | 89.54% |
| **Trust overall** | | **94.75%** |
| **England average (mental health and learning disabilities)** | | **91.9%** |

**Meeting the needs of all people who use the service**

Each ward was equipped to care and treat people with significant mobility issues. Both wards were on the ground floor with easy access throughout the ward areas and to outside garden space. There was at least one assisted bathroom with appropriate equipment on each ward as well as disabled toilets and showers adapted for people with limited mobility.

The doors across Maister Lodge had picture symbols as well as writing to help patients with dementia understand the function of each room and help them find their way around the ward. The refurbishment plans for Maister Lodge sought to improve the environment and use of space so that it was dementia friendly and suited to the needs of this patient group.

On admission to the wards, staff gave patients or their carers an information welcome pack. This included information about how the ward ran, visiting times, support sessions, patients' rights, and

how to complain. Each ward had a number of well-organised and up to date notice boards that displayed a range of information about treatments, local services, the Mental Health Act, and how to complain. These were appropriate to the patients at Millview Lodge and the relatives and carers at both wards.

Staff could access signers, interpreters, and information in other languages via the trust head office to support patients with specific communication needs. Staff told us that the catchment area for the trust did not currently include significant numbers of older non-white or non-English speaking communities.

Patients had a choice of food available to meet their specific dietary requirements such as vegetarian options. Patients could request halal food or kosher food if required. At Maister Lodge, the ward was able to cook food on site. The chef met patients' individual needs. For example, offering patients with dementia finger food, and patients at risk of malnutrition high protein enriched food.

Patients could access spiritual support. At Millview Lodge, patients could access a multi-faith prayer room in the main hospital on the Castle Hill Hospital site. Patients at Maister Lodge could access spiritual support through utilising escorted leave or requesting a specific faith leader to attend the ward.

**Listening to and learning from concerns and complaints**

This core service received four complaints between 1 June 2016 and 31 May 2017.

Following investigation, the trust upheld two of the complaints. There were no referrals to the Ombudsman. Staff received feedback on the outcome of investigation of complaints.

The wards informed patients, families, and carers about the complaints process and the support available to raise and progress complaints. They displayed information on how to complain on noticeboards and provided information in the patient welcome pack. At Millview Lodge, patients felt confident to either complain directly to staff or raise concerns during the daily morning meeting. At Maister Lodge, patients who were able to express an opinion told us they knew how to complain if they wanted to.

This core service received four compliments during the last 12 months from 1 June 2016 to 31 May 2017, which accounted for 1% of all compliments received by the trust as a whole.

## Is the service well led?

### Leadership

The senior management team had a good understanding of the service they managed, and the systems and processes that gave oversight to ward performance. The team comprised a care group director, a service manager/ modern matron and charge nurses (ward managers) for each ward. Deputy charge nurses supported the charge nurses. Since the last inspection, the trust combined the modern matron and service manager role and recruited an extra senior nurse to help support Maister Lodge at weekends. This was essential due to the geographically isolated location of the ward.

The ward managers were familiar with the learning and development needs of their staff and encouraged them to take lead roles on the ward. For example, at Millview Lodge there was a carer support lead and an infection control lead. At Maister Lodge, the ward manager supported the deputy charge nurses to access leadership courses and developmental opportunities such as rotation within the service. Staff felt the ward managers provided leadership and were visible and approachable.
All staff we spoke with felt well supported by their immediate managers and above. They reported senior managers were visible on the wards. All staff knew the service's care director and reported the chief executive had visited the service and met with staff.

## Vision and strategy

The trust had reviewed their vision and values since the last inspection. The new visions and values were based on quality and sustainability. The trust's vision was 'we aim to be a leading provider of integrated health services, recognised for the care, compassion, and commitment of our staff and known as a great employer and valued partner'. Some staff we spoke with confused the new values with the nursing professions commitment to the '6Cs'. All staff knew where to find the values as the trust had incorporated them into emails, strategies and plans. The revised values identified three words the trust felt reflected what they do and what they wanted associating with their name: caring, learning and growing.

We saw posters displaying the vision and values on both wards for staff, patients and carers to see. Our observations during inspection showed staff reflected these values in their interactions with patients and in their work ethos.

The trust issued all staff with a booklet entitled "Our Strategic Plan" in August 2017.

## Culture

Staff morale had improved significantly since the previous inspections in 2016. Staff we spoke with felt part of the multi-disciplinary team. They reported feeling valued, supported, and respected by their colleagues. Staff commented on the pressure caused when staffing levels were low.
We observed staff's commitment to a culture that focused on providing patients with high quality care. Staff respected senior nurses and felt well supported by them.

Staff knew how to use the whistle blowing process and felt able to raise concerns without fear of retribution. They had a varied understanding about the role of the 'freedom to speak up' guardian. 'Freedom to speak up' guardians work with the trust to create a culture where staff speak up in order to protect patient safety, and empower workers.

It was not possible to review individual staff appraisals as the trust held personnel files centrally. The service was committed to career progression. They supported non-qualified staff to complete the associate nurse trainee programme and qualified staff to complete leadership training.

The ward used bank and agency staff to cover staff sickness and maintain safe staffing levels. The overall sickness rate for this service was higher than the trust average. Staff had access to group supervision sessions and de-briefs supported by the psychologist to discuss incidents and concerns at work.

## Governance

During the previous inspection in 2016, we identified governance issues with medicines management. At this inspection, we found the service had implemented clinical audits that were sufficient to provide assurance with good medicines management.

Overall, the trust had an effective governance structure in place to oversee the running of the older adult wards. The trust had recently changed its quality assurance reporting and accountability processes to the new adult mental health and older people's mental health care group.
There were effective systems of accountability in place to support the governance and management of the service. This included safer staffing, training, incident recording, and complaints procedures. However, the systems and processes that were in place for assessing and managing supervision were not robust and were reliant on the accuracy of staff self-reporting.

The service manager and the care group director had good clinical oversight and awareness of the challenges facing the service, which they were working to address. For example, staffing rotas, staff, and patients confirmed that actual staffing on the wards was frequently lower than the planned establishment. The service was actively recruiting to vacancies and exploring ways to recruit and retain staff by looking at development, progression, and succession.
The service held monthly business meetings at team, directorate, and trust level. We reviewed the minutes of some of these meetings as part of our inspection. Minutes from these meetings showed there was a clear framework to share and discuss essential information in across the wards.
Senior nurses carried out local clinical audits such as daily clinic room and equipment checks.

## Management of risk, issues and performance

The service did not have a local risk register. Staff discussed service risks at team level and could escalate concerns through line management if needed. Senior managers discussed risks in business meetings and could escalate concerns for inclusion in the trust risk register. Service specific items on the trust risk register reflected staff concerns.

There were no risks in the board assurance framework specifically relating to this core service.

The trust has provided a document for older people's mental health detailing their highest risks; one risk has a score of 16 or higher.

**Risk ID COPMH29:** The risk is to the safety and wellbeing of patients and staff as a result of the continued delay in identifying a suitable, safe alternative to Maister Lodge for the care and treatment of patient with dementia. Current risk score 16. The risk remains unchanged from the previous update.

Please note that this is the most recent version of the risk register provided by the trust, actions and risks may have been worked upon since this last release.

The wards had access to the trust emergency planning and business continuity arrangements.

The care group director and modern matron gave assurances that cost improvements would not compromise patient care.

## Information management

The service used a number of tools and audits to collect data from each ward, which informed the monthly ward specific performance report. The trust used key performance indicators to measure their performance in areas such as mandatory training compliance, appraisal rates, occupied bed rates, and delayed discharges. This gave ward managers a breakdown of their current position in relation to key performance indicators and an overview of budget expenditure in areas such as staffing. Information about clinical supervision rates was not included in the monthly report. Ward managers discussed their team's performance at the monthly business meeting with the care group director and modern matron.

Staff had access to the electronic equipment and paper documents they needed to do their work. The electronic system supported staff to report incidents and manage their own performance. The wards had not yet made the transition to electronic records. The managers had oversight of the information they needed to support their roles. There was sufficient equipment and information technology for staff to do their work.

The service made notifications to external bodies as required.

## Engagement

The trust worked closely with external stakeholders such as commissioners and NHS Improvement. Commissioners had recently visited both services to see the standard of care and treatment provided.

Staff had access to the trust's intranet through which they received emails, updates, and newsletters about the trust. They also received updates at team meetings and through supervision.

Staff, patients, and carers could access information about the service through the trust website. Everyone had opportunities to give feedback about the service. This could be formal through staff, patient and carer surveys and comment cards or informal by attending various meetings. Patients told us that they were able to feedback at their morning meetings and directly to staff. However, we did not see evidence that patients were involved in decisions about changes to the service.

## Learning, continuous improvement and innovation

Both wards participated in team away days, which supported improvement and innovation, enabling colleagues to work together to resolve problems in a systematic way. The ward manager at Maister Lodge met with peers on a regular basis at directorate and trust wide meetings. This gave them opportunities to share information and learning from across the trust with the ward team.

The modern matron was involved with the reducing restrictive practice group, which looks at reducing the need for restrictive practices and use of blanket restrictions in accordance with the requirements of the Mental Health Act Code of Practice. They shared learning from this with staff via team meetings. Both wards displayed their positive engagement pledge on notice boards.

- NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a

certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

- The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

| Accreditation scheme | Service accredited | Comments and date of accreditation / review |
|---|---|---|
| **Accreditation for Inpatient Mental Health Services (AIMS)** | AIMS - OP (Wards for older people) | Not provided |

Millview Lodge had accreditation with the Royal College of Psychiatrists' accreditation scheme for wards for older people. Accreditation for Millview Lodge was from 14 April 2017 until 13 December 2018.

# Wards for people with a learning disability or autism

## Facts and data about this service

| Location site name | Team name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| **Townend Court** | Willow Ward | 6 | Mixed |
| **Townend Court** | Lilac Ward | 8 | Mixed |
| **Townend Court** | Beech Ward | 6 | Mixed |

Humber NHS Foundation Trust provides three mental health wards for people with learning disabilities or autism. All three wards are located in one unit called Townend Court.

Townend Court has 20 beds for patients, to provide accommodation for male and female patients over the age 18 who are being treated informally or under the Mental Health Act who also have a diagnosis of learning disability or autistic spectrum disorder.

Willow ward is the assessment unit and has six beds. Lilac ward is the treatment unit and has eight beds, and Beech ward is the enablement unit and has six beds. At the time of our inspection, 13 patients were admitted to the unit with one patient on overnight leave.

We last inspected this service in April 2015 and rated the service as 'requires improvement overall', with ratings of 'good' in the caring and responsive key questions.

## Is the service safe?

### Safe and clean care environments

The service consisted of three units; Willow (six beds), Lilac (eight beds) and Beech (six beds). All of the units were in use by patients at the time of the inspection. We checked the whole of the environment to consider whether it was safe and clean.

**Safety of the ward layout**

Staff completed regular risk assessments of the care environment. We reviewed the assessments completed in relation to security, fire and the environment. All assessments were thorough and a senior staff member had completed them within the last twelve months.
The fire risk assessment and accompanying documentation evidenced staff completing fire evacuations and weekly fire alarm tests. A trust wide team were responsible for checking and maintaining alarm systems, and for monitoring electrical appliance testing. The fire safety team were on site completing tests during our inspection.

The environmental audits highlighted any risks to patients' staff or visitors when using the building.

The modern matron had completed a ward security profile for each unit which cross referenced to environmental audits and gave a risk rating to all areas of the service. The trust had also completed an external security risk profile which offered recommendations such as the removal of some lightweight fencing which was a risk to patients and plans for its removal were underway.

Willow and Lilac wards allowed clear lines of sight for staff to observe patients at all times as the nursing offices were in a central position on the ward. In line with the Trust's Supported Engagement Policy, staff assessed patient risk levels as: general, intermittent or constant. This ensured that those patients with an increased risk of aggression or self-harm were monitored closely by staff.

Beech Ward had an L shaped layout. This meant that staff could not easily observe patients at all times. However, the patients on this ward are preparing for discharge back to their home which may include supported living or residential care, therefore not deemed to require the levels of constant observations provided on the Willow and Lilac Wards. In line with the Trust's Supported Engagement Policy, levels of observations required are regularly reviewed to balance safety and increased supported independence.

All areas of the service contained ligature points (a ligature point is something which a patient intent on self-harm could use to tie something to in order to strangle themselves). We were concerned about these risks during our inspection of the service in April 2015. However at this inspection, there had been some improvements in safety. The modern matron had undertaken a ligature risk assessment in May 2017 which indicated ligature risks and clearly identified those which were higher risk. High risks included fixed items such as grab rails, window and door closers and were located in areas patients may access without staff support. The trust had made improvements to mitigate these identified risks such as boxing in pipework and changing some fixtures and fittings to reduce risk, such as collapsible shower and curtain rails and anti-ligature door handles in patient bedrooms. The trust had also installed vision panels (privacy glass which can be changed between a clear or obscured view) in patient bedrooms windows to allow privacy for patients but enhanced observations for staff. However, the unlocked communal dining areas in the service were not included in the service's ligature risk assessment. We saw that patients used these dining areas without supervision during our inspection.

Staff also mitigated risk through the use of patient observations. Staff would monitor a patient who had an increased risk of self-harm more closely. The multi-disciplinary team reviewed patient observation levels on a weekly basis and staff discussed them daily in handover meetings.

The wards were able to admit both male and female patients to all wards. During our inspection Willow and Beech wards had only male patients admitted and Lilac only female.

During times when units provided mixed gender accommodation, they remained compliant with Department of Health same sex accommodation guidance and the Mental Health Act Code of Practice because the service had separated male and female corridors and bathrooms and all wards had a space which patients may use as a female only lounge if required.

Staff carried personal alarms which they could use to summon support in the event of an emergency. During the inspection, we saw the alarms sound, they worked well and staff responded quickly. Not all patient bedrooms contained nurse alarm call systems. The service manager told us that this risk was managed by staff ensuring patients who were not able to summon help verbally, or may need emergency support were placed in bedrooms with access to alarm call systems. They also said that staff could give patients a personal alarm if required and that they had offered this to patients previously.

**Maintenance, cleanliness and infection control**

The wards were clean and the service employed permanent domestic staff. Cleaning schedules were detailed and in order. However, we also saw that one patient had stains on their bathroom ceiling which staff had not removed.

Some areas of Townend Court required re-decoration to improve the environment for patients, staff and visitors. One carer commented that the building would benefit from re-decoration. Also, the furniture in the female only lounge on Lilac ward was torn which may present an infection control risk. The service manager explained that the Trust were aware of the request for redecoration and that replacement furniture had been placed on order.

Staff had recognised that some areas of the ward and communal areas were not entirely private for patients because some doors had clear rather than obscured glass. This was because the privacy glass was not yet in place. Therefore staff had used sheets of paper to obscure the view. This looked unsightly and also meant that cleaning could not be thorough.

Patient led assessments of the care environment are undertaken by local people visiting services and assessing the care environment. Townend unit scored better than the England average for all four aspects of care whilst also achieving the same or higher than the trust average.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **TOWNEND LD UNIT** | Both mental health and learning disabilities provided from the same site by the same provider | 100% | 96% | 84% | 83% |
| **Trust overall** | | **99%** | **90%** | **81%** | **83%** |
| **England average (Mental health and learning disabilities)** | | **98%** | **93%** | **75%** | **78%** |

Staff had completed infection control audits in March 2017 in all areas of the building. In this most recent infection control audits, the wards had scored as follows; Beech 95%, Willow 97% and Lilac 97%. Each ward had an action plan for any issues which required attention from the service, and staff had taken action to respond to actions. Staff adhered to hand washing and infection control principles however the results of the most recent hand hygiene audit in August 2017 was 85%. We observed that staff wore personal protective equipment when undertaking meal preparation and while serving food to patients.

**Seclusion room**

The unit had one seclusion room on Willow ward. The trust had made improvements to this facility since our last inspection.

During the last inspection, the seclusion room was not included on the ligature audit and some ligature risks were present, the viewing panel was scratched and there was no clock on display for

patients. At this inspection, the service had rectified all of these concerns and the seclusion facility met with guidance contained in the Mental Health Code of Practice.

At the time of the inspection, the seclusion suite was out of use to patients due to re-organisation of the unit layout. The modern matron told us that should another patient require seclusion the team would discuss this on a case by case basis and take a decision on how to keep all patients safe.

**Clinic room and equipment**

Each ward had its own clinic room. All rooms were clean and well ordered, with examination couches and privacy screens. Clinic rooms contained equipment such as blood glucose machines, examination couches and blood pressure monitors. Nursing staff had checked that all equipment in the clinic rooms was calibrated and fit for purpose.

Each clinic room contained an emergency grab bag and all the emergency medication stored in these bags was in order. Staff reviewed these bags daily. However, whilst most of the equipment in these bags was in order, during the inspection we found that some items such as plasters and bandages were out of date in the emergency bags. The nurse in charge explained that the trust was developing a new process to streamline all emergency grab bags. This meant that in the interim staff were unable to order new stock which had left some current stock out of date. However, we saw evidence that qualified nurses had raised this concern with senior managers. Staff confirmed that the trust would dispatch new bags later the same week.

During the inspection we observed staff using the clinic room on Lilac ward with an outpatient. Staff explained that they sometimes did this with patients known to the service to complete de-sensitisation work with specialist learning disability nurses. Whilst we appreciate that this is good practice in supporting outpatients, we raised concerns with the service about how staff managed this risk and also how this impacted on the privacy and dignity of patients on the unit. The senior leadership team told us that they understood there was a need to review this and provide a more appropriate and discreet stand-alone clinical area to undertake the interventions provided.

## Safe staffing

The table below details staffing levels across the service. Substantive staff refers to how many staff are currently working in the service. The establishment level refers to how many staff the service needs in post i.e. substantive staff plus any vacancies.

| Substantive staff figures | Date | Core service | Trust target |
|---|---|---|---|
| Total number of substantive staff | At 31 May 2017 | 78 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 16 | N/A |
| Average WTE* leavers over 12 months (%) | 1 December 2016 – 31 May 2017 | 21% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) (WTE*) | At 31 May 2017 | 3.2 over-established | N/A |

| | | | |
|---|---|---|---|
| Total vacancies overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 5% over-established<br>Range 5% vacancy to 12% more than budget | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 4%<br>Range 3% to 8% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 23<br>Consistent at 23 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 32<br>Consistent at 32 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 5<br>Range 3 to 7 vacancies | N/A |
| Number of WTE vacancies nursing assistants | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 14<br>Range 7 to 18 vacancies | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 22%<br>Range 14% to 31% vacancies | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May 2017 | 44%<br>Range 22% to 54% vacancies | Not provided |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 127 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 0 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 285 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 1449 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 0 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 198 | N/A |

*Whole Time Equivalent

The service manager used the 'Hurst' safer nursing care tool, which is a recognised tool to calculate the number of staff required to work across the units per shift. All wards had staff who worked 12 hour shifts from 8am to 8pm during the day and 8pm to 8am at night.

Willow and Lilac wards ran shifts with two qualified nurses and 3 healthcare support workers during the day and one qualified nurse and two healthcare support workers at night. Beech ward ran with one qualified nurse and two healthcare support workers during the day. At night staffing levels reduced to one qualified nurse and two healthcare support workers on Willow and Lilac wards and two healthcare support workers on Beech ward with no qualified nurse. Should staff need the input of a qualified staff member, they were easily accessible on the other two wards. Beech ward was also designed for patients working towards discharge and therefore the patients on this ward did not have complex needs. This was also reflected in the adjustment of reduced observations from constant to more intermittent and general observation of patients.

The service also had a senior leadership team who were supernumerary (not included in day to day unit staffing numbers). This meant that if patients required additional support the unit manager and band seven nurse could step into the unit and provide support. Staff planned for this at morning communication meetings.

The service manager explained that they had autonomy in arranging staffing for the unit and could bring in additional staff as required and according to the needs of the patients.

The service reported an overall vacancy rate of 22% for registered nurses and an overall vacancy rate of 44% for healthcare assistants between 1 June 2016 and 31 May 2017.

The sickness rate for this core service was 4% between 1 June 2016 and 31 May 2017.
This service reported that there were 16 (21%) staff leavers between 1 June 2016 and 31 May 2017. The trust recorded that the high level of staff leavers were due to retirement and staff progression.

The high vacancy rates for the service meant that the wards employed bank (temporary) staff to cover shifts with low staffing numbers to ensure the safety of patients. Between 1 June 2016 and 31 May 2017 bank staff covered 127 qualified nurse shifts and 1449 healthcare assistant shifts. In the same time period, temporary staff could not fill 198 shifts. The service did not use agency staff.

The trust provided data which showed that most healthcare support worker shifts reached optimum (or often higher than optimum) throughout the day and night between 1 April 2017 and 31 July 2017.

However, qualified nursing shifts during the day rarely met the optimum staffing level. In April 2017 the average nursing shift had a fill rate of 59%. This had improved to 68% by July 2017. We asked the trust to provide assurance that they had safely staffed the unit during these times. The trust stated that there were a number of factors which meant that despite low staffing numbers the wards remained safe. They said that patient numbers were lower with 13 patients admitted, to a staff ratio for 20 beds. The trust also explained that staffing reports we reviewed did not include shifts worked by staff that were not included in daily rotas such as the unit manager and clinical lead nurse.

Senior leaders were aware of the staffing concerns and they described this as their most significant concern about the service. They spoke of the difficulties in recruitment of qualified staff, and in the retention of staff. However, patients told us that staff were always available to have one to one time with their named nurse and carers told us that staff were contactable and responsive. We saw staff rarely cancelled activities and ensured that leave was never cancelled but on

occasions times were altered within the same day. The service had an induction programme for new staff. Staff (including temporary staff) were inducted to the ward by taking part in an 'induction shift' where they worked in addition to planned staffing numbers to allow them time to observe staff practices. Each ward also had an induction handbook for new staff to follow which the staff member's supervisor regularly reviewed.

In addition to nursing staff and healthcare assistants, the following whole time equivalent staff also supported the wards:

- consultant psychiatrist
- staff grade doctor
- service manager
- modern matron
- unit manager
- clinical lead nurse
- physical healthcare nurse
- psychologist
- occupational therapist (two days per week)
- speech and language therapist
- social worker
- activity workers
- patient involvement worker

**Medical staff**

There was adequate medical cover for the unit throughout the day and night. The service had the support of a consultant psychiatrist and staff grade doctor, and was recruiting for a further consultant. The medical team were based on site, so were able to chair and attend multi-disciplinary team meetings each week. Whenever the doctors were not on site there was a trust wide on call rota in place which staff could use in an emergency.

**Mandatory training**

The trust had mandatory training requirements for all staff to complete. Overall as of 31 March 2017, staff in this service had undertaken 83% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% training target in three courses.

Safeguarding adults training had the highest training compliance with 98%. Fire safety training scored the lowest out of all the training courses with 64%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 69% of the various elements of training that the trust had set as mandatory. This was lower than the overall trust average mandatory training rate of 74%. The staff in this service had not achieved the CQC 75% training target in eight courses. These courses are indicated in the table below.

Health and safety (87%) and Prevent (84%) had the highest training compliance within the core service. Basic life support (13%) and Fire safety (45%) achieved the lowest compliance of all applicable mandatory training courses. Equality and diversity and safeguarding adults training were also below 75% at our last inspection of this service.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Health and Safety | 87% | 87% |
| Information Governance | 94% | *57%* |
| Mental Capacity Act | 96% | 80% |
| Mental Health Act | Not provided | 83% |
| Basic Life Support | Not provided | *13%* |
| Conflict Resolution | 83% | *73%* |
| COSHH | 80% | 75% |
| Display Screen Equipment | 90% | 75% |
| Equality and Diversity | *69%* | *70%* |
| Fire Safety | *64%* | *45%* |
| Immediate Life Support | Not provided | *73%* |
| Infection Prevention and Control | *73%* | 75% |
| MAPA | Not provided | 75% |
| Moving and Handling | 78% | *47%* |
| Prevent | 83% | 84% |
| Safeguarding Adults | 98% | *69%* |
| Safeguarding Children | 82% | 77% |
| **Grand Total** | 83% | ***69%*** |

At the time of the inspection, the service provided us with data that showed an improving picture of mandatory training. By 31 August 2017, overall mandatory training had increased to 75%, and the service had achieved:

- Mental Capacity Act 100% qualified nurses, 91% healthcare assistants
- Mental Health Act 100% qualified nurses and 94% healthcare assistants
- Management of Actual or potential aggression 100% qualified nurses and 94% healthcare assistants.
- Immediate life support 100% qualified nurses
- Basic Life support 91% healthcare assistants.
- Adult safeguarding level 1 100%

Senior managers told us that they were aware of the low levels of mandatory training in some areas. They attributed this to difficulties in releasing staff from the ward to undertake training due to staff vacancies and the current complex patient group. However in order to manage this, they had brought trainers into the service to train groups of staff as had been arranged for information governance training. The senior management team discussed training needs at the safer services meeting on a monthly basis to highlight gaps in training compliance. In order to address the lower levels of training in basic life support, a member of staff had been trained to enable them to train staff on the ward.

When we spoke with staff about training, they agreed that it was difficult to complete due to the demands of the wards at the present time. Some staff also told us that they were concerned that the trust did not insist that they trained temporary staff working on the unit in the management of actual and potential aggression. The trust confirmed that they had only trained two bank staff, but stated that they ensured all shifts ran with at least five staff trained in the management of actual and potential aggression in the building at any one time. We reviewed planned staffing rotas and saw that this was the case.

Within two months of the inspection, the trust told us that training compliance for the service had reached 95%.

## Assessing and managing risk to patients and staff

During the inspection, we reviewed the care records of 11 of the 13 patients admitted to the service.

### Assessment of patient risk

All patients had a risk assessment in place. All patients had initial risk assessments completed within one month of admission.
We saw that staff updated risk assessments on a six monthly basis and also after any change in the patient's condition or when an incident had taken place. Staff used the clinical risk assessment and management tool as an initial assessment of patient risk. Staff then updated this with a risk assessment and management plan. All patients had a clinical risk assessment and management plan in place. The trust was preparing to move towards use of the functional assessment of care environments risk assessment tool and had trained several staff in preparation.

### Management of patient risk

Due to the complex care needs of the patient group staff had put measures in place to monitor and manage specific risk issues such as physical health and mobility needs. All patients had health action plans in place which identified additional care needs, and staff managed these appropriately.

Staff made good use of the trust supportive engagement policy to support patients who portrayed increased levels of risk. Staff could undertake observations at enhanced levels to ensure patient safety and staff discussed this in daily handover meetings, and weekly multi-disciplinary team meetings. After a specific incident or change in risk level, a review of the patient's care needs also took place and staff made changes to care plans, risk assessments and observations as a result of this. We saw good practice examples that the service did not restrict patients unnecessarily after an increase in risk.

The service had made improvements since our last inspection in the use of blanket restrictions on patients' freedom. The service had recognised that two blanket restrictions remained in place; the locking of kitchens and that staff held all cigarette lighters. These restrictions were justified to maintain the safety of the patient group. Other than this, patients moved freely around the wards, had their own bedroom keys, access to mobile phones, and an open visiting policy. Staff did not routinely undertake searches of patients; there was a procedure in place to follow should this be required.

Patients were able to smoke in the outside areas of the wards. The service had not yet implemented a smoke free policy but was offering smoking cessation to patients.

During our inspection there were no patients admitted to the wards informally. However we saw notices throughout the wards to explain to informal patients their rights to leave should they wish to.

**Use of restrictive interventions**

Between 1 June 2016 and 31 May 2017 the service had used some restrictive interventions with patients to manage risk. Staff always used these interventions to manage aggressive or high risk patient behaviour. When reviewing records of restraint and seclusion, we saw that staff had always used restrictive interventions in line with Mental Health Act Code of Practice guidance; using them as a last resort and for the shortest possible length of time. We viewed patient records which recorded clearly what de-escalation practice staff had used in attempts to calm patients prior to using restrictive interventions.

The table below shows the restrictive interventions use with patient on the wards between 1 June 2016 and 31 May 2017.

| Unit | Seclusion | Long term segregation | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|---|
| Willow | 16 | 2 | 85 | 24 | 0 | 0 |
| Lilac | 0 | 0 | 127 | 29 | 0 | 0 |
| Beech | 0 | 0 | 1 | 1 | 0 | 0 |

Between 1 June 2016 and 31 May 2017 staff had undertaken 213 episodes of restraint with 54 patients. Staff had undertaken the highest number of restraints on Lilac ward. There had been an increase in the use of restrictive intervention since our last inspection of this service from 75 restraints at the last inspection to 213 restraints. The service told us that the increase was because of the complexity and challenges of the current patient group. The service had not used rapid tranquilisation (the use of medication to rapidly calm patients) and had not used prone (chest down) restraint in the same time period.

Between 1 June 2016 and 31 May 2017 there had been 16 episodes of seclusion, all taking place on Willow ward where the seclusion suite was located. Staff told us that the last episode of seclusion had taken place in July 2017. Willow ward also had two patients in long term segregation.

Since the time of our last inspection there had been an improvement in the management of restrictive interventions.

We reviewed six records of seclusion which had taken place between 01 January and 1 July 2017. The records showed that staff had undertaken restrictive interventions in line with the Mental Health Act Code of Practice.

In all records, the reason for seclusion was recorded and justifiable and mainly undertaken due to aggressive behaviour from patients. Staff closely monitored patients in seclusion and recorded

observations every 15 minutes. All seclusion episodes ended after an appropriate period of time with justifiable reasons for the continuation of seclusion if necessary.

All patients who were cared for in seclusion had a seclusion care plan, with a clear exit plan which staff had explained to them. After each episode staff had noted a de-brief with the patient. Patients who had been secluded told us that it did not cause them distress.

However seclusion reviews did not always take place in a timely manner as per guidance in the Mental Health Act Code of Practice. We reviewed three seclusion records and on six occasions nurses did not conducted two hourly reviews within the specified time. Nurses noted that reviews were late due to other issues taking their time on the ward. This further indicated the staffing concerns the service had. Our Mental Health Act reviewer had also raised this at their visit in February 2017. In order to address the concern, the modern matron had reviewed all seclusion episodes and provided feedback at monthly safer services meetings, and to staff to improve practice.

The service was caring for two patients in long term segregation. The Mental Health Act Code of Practice defines long term segregation as ‘a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, it is determined that the patient is not allowed to mix freely with other patients’.

The two patients the service cared for in this manner had significant difficulties in sensory processing related to diagnosis of autistic spectrum disorder. The service had recognised that for these patients, providing care away from other patients reduced their distress and aggressive presentation because they were unable to tolerate sharing space with other patients. The service and the trust had recognised that the specific and complex nature of this method of ‘care away from others’ was a new process and the trust had designed an interim procedure until the trust wide policy could be updated.

Staff had temporarily redesigned Willow ward to ensure that these patients had their own bedroom, bathroom, living area and corridor space which were not accessible to other patients. The patients had continual observation from staff via both viewing panels and staff entered the segregation areas throughout the day and night to provide care and to interact with the patients and undertake activities as per their care plan. One of the patients had daily escorted leave into the community. Staff tried regularly to encourage the other patient to leave the ward, as part of their care plan, however they chose not to leave the ward. In order to ensure the patient had adequate amounts of activities and stimulation staff provided activities and equipment in the patient’s own outside space.

The service was aware of the need for the care of these two patients to be highly scrutinised and monitored. Senior managers internal and external to the service undertook reviews on a monthly and three monthly basis and provided reports based on their visits. In addition, the modern matron sent weekly updates to commissioners and the care group director. Staff reviewed the care of both patients in weekly multi-disciplinary team meetings.

In line with the Mental Health Act Code of Practice, the medical team reviewed both patients every 24 hours. This took place the majority of time; however the service recognised that there were sometimes gaps where medics did not record these reviews in the patient record. External review reports In March 2017 and July 2017 also recognised this as an area for improvement. The

service told us that this was something they hoped to resolve once a further doctor was in post as the current medical team had very stretched caseloads. The consultant provided assurance that if face to face visits could not conducted; they had always undertaken a telephone review, we saw that this had not always been recorded in the patient's care record.

Both patients in long term segregation had thorough and detailed care plans which staff regularly reviewed and updated. These included a detailed sensory integration profile, a functional behavioural assessment, and positive behaviour support plans. Staff had completed restraint care plans for both patients which explained how they liked to held in line with their sensory impairment to reduce distress if this was required. Communication care plans and proactive support strategies for both patients took into account their complex needs and staff had devised strategies such as the use of now and next boards to allow patients time to process information.

Carers provided feedback that they are happy with the service delivering care in this manner. They told us that they are able to visit regularly, staff kept them updated, and they were able to have conversations with their relative via 'Skype'.

During the inspection we spent time observing the care and treatment of both patients in long term segregation. Care was person centred. We saw that staff were consistent in their approach and that all levels of staff including domestic staff had learnt to communicate with both patients and we observed them doing so. Staff knew the patients well as to when to approach them and when to allow them time alone. We observed one member of staff in a patient's suite playing dominoes on the corridor floor because this is how the patient had requested the activity take place.

The service was creating individual care specifications for both patients and working with commissioners on discharge plans to emulate the current care plan in a community rather than hospital setting. This was in line with national guidance 'transforming care'.

## Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene and support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

Staff had received safeguarding training; however there were gaps in this training. Only 69% of staff had received training in safeguarding adults, and 77% in safeguarding children. However, despite the lower levels of mandatory training (which the service attributed to low staffing numbers), staff knew about safeguarding and knew when to make a referral.

During the inspection we conducted a review of all incidents taking place on the units between 01 June 2017 and 01 September 2017. When an incident indicated potential abuse staff made the appropriate safeguarding referral.

Staff had raised 20 safeguarding concerns between 1 June 2016 and 31 May 2017. This meant that they understood different types of abuse and the need to share and refer their concerns. Staff we spoke with had a good understanding of safeguarding policy and procedures and were able to give examples of times they have managed potentially abusive situations appropriately on the wards. We also observed members of the multi-disciplinary team discussing a disclosure of abuse made by a patient. Staff appropriately managed this and explained how they shared it with the relevant external professionals.

Staff were aware of the vulnerabilities of the patient group and their protected characteristics under the Equality Act. Staff were able to give examples of how they had protected patients from harassment and discrimination such as intimidating behaviour between patients admitted to the service.

However, during our review of incidents at the service, we saw that staff had recorded two incidents of unexplained bruising on a patient on Willow ward. The patient was unable to communicate where the bruising had developed from. Staff noted that they thought the patient was hitting themselves when they were distressed. However the record did not note whether staff had reported the incidents as a safeguarding concern or flagged this up for further investigation in order to protect the patient.

The service did not usually have children visiting the ward. Staff planned visits outside of the service where patients could meet with children in a more relaxing space. We saw evidence of one patient who was at risk of aggression towards others having a detailed care plan and risk assessment completed with staff to allow them to visit family with young children at Christmas.

Humber NHS Foundation Trust has had no external case reviews commenced or published in the last 12 months that related to this core service.

**Staff access to essential information**

The service used both electronic and paper recording systems. Information was readily available to staff working on the wards and to visiting professionals, for example by use of a specific file containing patient information for care and treatment reviews. However, some paper files were complex to follow and this made information difficult to locate. The service recognised this and was moving to a new electronic system which the trust was providing training for which would encompass all information about patients being held in one place.

**Medicines management**

The service followed good practice in relation to medications management and storage. All medications were clearly labelled and correctly stored. Medication storage areas were secure and accessible only by staff, they were temperature controlled and audited daily. The service did not store any controlled drugs. Despite this, the service had undertaken audits of the controlled drug storage and procedures in May 2017.

A pharmacy technician visited the ward on a weekly basis and reviewed all medications and prescription charts. Where they detected errors, the technician highlighted this to senior managers for improvement. A pharmacist also visited the ward on a weekly basis and attended multi-disciplinary team meetings to offer advice and support in the care and treatment of patients.

Patient files contained monitoring of medication side effects. Patients had regular electro-cardio graphs and blood tests scheduled and reviewed by the medical team. Staff told us that they used the Liverpool University Neuroleptic Side Effect Rating Scale and the 'Lester' tool to monitor and screen for medication side effects.

We reviewed the prescription charts of all 13 patients admitted to the service. All patients were receiving medication as prescribed and in accordance with the Mental Health Act. Consent to treatment information was stored with medication charts and we saw that the responsible clinician had applied for a second opinion doctor review for patients who lacked capacity to consent to their care and treatment.

All patients receiving treatment for physical health conditions outside of the scope of treatment under the Mental Health Act had undertaken capacity assessments with staff to ascertain their capacity to consent to treatment for physical health conditions such as diabetes and epilepsy.

Doctors had prescribed some patients 'as required' medications. On Lilac ward, only one of five patients had care plans in place for this medication. The service agreed to rectify this following our visit.

**Track record on safety**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

One serious incident had been identified by the service in June 2017 where the service admitted a young person to the adult Willow ward.

Although the incident concerned mainly the children's services and the processes prior to admission to Willow ward, the service demonstrated good practice and conducted a thorough review and analysis into the incident. We reviewed the report during the inspection and found that all relevant parties had been involved in the investigation including the patient's family. The report made eight recommendations with an action plan for various services to be completed by December 2017. The modern matron shared the report and its findings with all care groups to ensure learning was trust wide.

The Chief Coroner's Office publishes the local coroners' 'Reports to Prevent Future Deaths' which all contain a summary of Schedule 5 recommendations. These made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.
In the last two years, there have been no 'prevention of future death' reports sent to the trust related to this core service.

## Reporting incidents and learning from when things go wrong

We reviewed incidents taking place on each ward between 1 September 2016 and 31 August 2017. Fifty incidents had taken place on Beech, 139 on Willow and 222 on Lilac. Staff had reported all incidents via the trust's electronic system. We saw evidence that where an incident indicated a safeguarding concern, staff reported this appropriately. A centralised team also reviewed all incidents and sent monthly and quarterly incident reports to the service to identify themes and trends.

The service had a thorough system for reviewing incidents. The service manager and modern matron received all reports for review. The care group director and consultant psychiatrist also received all incidents. This meant that senior leaders could identify themes and trends and enabled them to share learning with staff.

Where incidents did not meet the trust's criteria for investigation as a 'serious untoward incident' but a review had highlighted a need for learning, the service investigated these as a 'significant event analyses.' This reduced the likelihood of repeat events and ensured staff learned and shared lessons. The modern matron had completed such an analysis for a patient who went absent without authorised leave from the unit.

In order to ensure safety remained a high priority, senior leaders at Townend Court conducted a monthly 'safer services meeting'. The meeting followed a set structure where they discussed incidents, lessons learned, seclusion and restraint episodes, training compliance, audits, the safety of the environment, staffing, and safeguarding. The topics were colour rated for completion and they noted further action required for the next meeting. This meant that senior leaders were aware of concerns within the service and reviewed these risks on an ongoing basis. Staff told us that feedback and actions from this meeting where disseminated to staff in staff meetings and supervision.

The Duty of Candour regulation is in place to ensure that providers are open and transparent with people who use services. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The service had not reported any incidents which had met the threshold for the use of this regulation. However all staff we spoke to where aware of the regulation, and could clearly explain its meaning. Staff were open and transparent with patients and their carers.

The service had embedded the process of de-briefing staff and patients following incidents. Staff always de-briefed patients after an incident, or a situation involving restraint or seclusion. The psychologist also offered staff reflective de-brief sessions.

## Is this service effective

### Assessment of needs and planning of care

We reviewed the care plans of 11 of 13 patients admitted to the service. All patients had a variety of holistic care plans depending on their needs to aid staff to provide care such as; 'independence' 'keeping well' 'mental health' 'eating and drinking' 'going out' risky behaviour' and 'rights'. Care plans were entirely personalised and all completed in an easy read format. All care plans clearly contained the patient's voice, their likes and dislikes, and goals for achievement. Staff had given all patients the opportunity to sign their care plan. Every patient had a discharge care plan which set out clear goals for discharge and staff had completed this within 48 hours of admission.

The service aimed to conduct a thorough assessment of patient needs and design a treatment plan within 28 days of admission to the units. Eight patients had initial care plans in place which staff had undertaken within one month of admission. The service said that all patients had assessments and that us being unable to review these three assessments was due to disorganised paperwork.

Despite being unable to see initial care plans for three patients, staff had updated all patient care plans on a regular basis. Staff aimed to update and review all care plans on a six monthly basis. However we saw that staff had updated most care plans before this following any changes in patient's needs, behaviour or if incidents had taken place.

The physical healthcare of patients was high quality and was a priority for the service. One of the band five nurses employed by the service was responsible in a permanent role for meeting the physical healthcare needs of patients. All patients had a health action plan in place and a health improvement profile. We saw that staff monitored patients with long term conditions such as diabetes and epilepsy. Staff also used national early warning scores, which recorded patient's respiratory rate, temperature, blood pressure and heart rate. This system highlighted early warning signs of ill health to staff so that they may seek appropriate support for the patient.

The service had learnt from incidents where patients with acute health conditions had been admitted to the units. For some patients with communication difficulties, presenting with complex behaviours can mask underlying physical health concerns or chronic pain and cause a misdiagnosis of mental health issues. In order to reduce this risk the service had developed a working relationship with a hospital liaison nurse in the local acute trust.

The physical healthcare nurse had received additional training which enabled them to perform blood tests and electro-cardio graphs on site. This reduced patient distress, as they did not need to leave the site for tests.

The physical health nurse also supported patients by liaising with other professionals such as dentistry, cardiology, GP services and by escorting patients to hospital outpatients' appointments.

## Best practice in treatment and care

National best practice guidance underpinned the operation of the service. We saw that staff used the following guidance:

- Transforming care service model (NHS England 2017). To ensure this guidance was embedded the service held a weekly transforming care meeting. The service worked with commissioners to ensure that they appropriately admitted, treated and discharged patients in a timely manner, and reduced the need for hospital inpatient treatment.
- The positive behavioural support competency framework. Each patient admitted to the unit had a positive behavioural support plan which staff had updated on at least a six monthly basis. Positive behaviour support plans aim to enhance the quality of life as both an intervention and an outcome for people who display behaviour that challenges and those who support them.
- Staff practices embedded National Institute for Health Care Excellence Guidance such as; mental health problems in people with learning disabilities (NG54 2016), autism spectrum disorder in adults (CG142 2016) and challenging behaviour in learning disabilities (NG11 2015).

In addition to the above guidance, staff used a range of interventions to support patients. This included access to onsite psychological therapies, occupational therapy and speech and language therapy. We saw in patient records that each discipline of the multi disciplinary team was working with patients on specific issues to aid their recovery. The service also had activity workers who supported patients to be active throughout weekdays and weekends.

We reviewed the plans of eleven patients and found that they were highly detailed. The plans detailed stages of patient's distress levels and described how at each stage staff could use strategies to de-escalate and modify behaviour. This increased the likelihood of staff being able to deescalate behaviour in the earliest stages and reduced the need for more restrictive interventions such as the use of restraint or seclusion. The multi-disciplinary team had developed the plans meaning that all professionals had provided input, for example by using psychological skills and communication skills from the speech and language therapist. Staff used innovative practice to support these care plans, such as using bubble machines with patients to reduce anxiety.

During the inspection, we did not see that any patients required specialist nutrition or hydration support. However the service would be able to provide this as needed and staff told us how they would address any additional hydration or nutritional needs within patients' individual health action plans.

Staff used a variety of tools to assess and record patient outcomes. These included the malnutrition universal screening tool, the health of the nation outcome scale and the psychiatric assessment schedule for adults with developmental disabilities checklist.

Staff participated in a range of audits to monitor the quality and safety of the service. These included infection control audits, ligature and environmental audits, Mental Health Act and Mental Capacity Act audits, privacy and dignity audits, fridge and water temperature checks and medication audits.

In order to improve the use and monitoring of audits, the service had recently begun to use the 'perfect ward app'. This was a tool which allowed staff to complete audits and record them in real time on an electronic device. This could provide running data to enable the monitoring of audits and staff found this a positive addition to the service. The senior leadership team discussed audit results and changes required at safer staffing meetings each month. They ensured that any concerns or good practice were recognised, and action plans were developed and they shared them with the staff team.

This core service participated in one clinical audit as part of their clinical audit programme within the last 12 months.

| Date completed | Core service | Audit type | Objective |
|---|---|---|---|
| **01/12/2016** | Learning Disability services | Local clinical audit | Documentation of capacity to consent to treatment (Townend Court). |

## Skilled staff to deliver care

Patients had access to a full range of specialists within the multi disciplinary team to support care and treatment while admitted to the wards. This included; a consultant psychiatrist, staff grade doctor, psychologist, occupational therapist, speech and language therapist and a social worker. The service had specifically funded a social work post to improve discharge for patients which was a positive addition to the staff team. The social worker was also able to support patients with their finances and housing concerns.

The service had experienced and qualified staff and managers ensured they supported professional development. In addition to mandatory training staff had undertaken training in a variety of additional skills. These included; phlebotomy, electro-cardio grams, epilepsy, autism, challenging behaviour, leadership and management, medication management, counselling, mentorship, outcome tools, diabetes, oxygen therapy, clinical skills, injection technician, mental health awareness, intensive interaction level four, prevent, learning disability awareness and dementia.

Healthcare assistants continued to take part in training to enhance their skills. Seven of the team had undertaken the care certificate, nine had undertaken their national vocational qualification and two had undertaken a care assessor training course.

The team met on a regular basis for team meetings. In addition to these, smaller staff groups had individual team meetings such as; mentorship meetings, nursing meetings and healthcare assistant meetings. Senior leaders reviewed meeting minutes and responded to questions raised by staff in these meetings.

Following our last inspection of this service, overall staff appraisal rates had improved from 50% to 88% between 1 April 2016 and 31 March 2017. This was higher than the trust target of 85%. However the appraisal rate for the units administrative staff and for staff on Willow ward was below the trust target at 78% and 70% respectively. Senior leaders monitored appraisal figures on a monthly basis to ensure compliance; we saw evidence of managers emailing staff to arrange appraisals when they required completion.

| Team | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| Hull LD - Admin (Team) (Support to doctors and nursing staff) | 9 | 7 | 78% |
| Hull LD - Modern Matron (Team) (Qualified nurses) | 2 | 2 | 100% |
| Townend - Beech Ward (Team) (Other qualified ST&T) | 0 | 0 | N/A |
| Townend - Beech Ward (Team) (Qualified nurses) | 3 | 3 | 100% |
| Townend - Beech Ward (Team) (Qualified nurses) | 1 | 1 | 100% |
| Townend - Beech Ward (Team) (Support to doctors and nursing staff) | 15 | 14 | 93% |
| Townend - Beech Ward (Team) (Support to ST&T staff) | 2 | 2 | 100% |
| Townend - Lilac Ward (Team) (Qualified nurses) | 9 | 8 | 89% |
| Townend - Lilac Ward (Team) (Support to doctors and nursing staff) | 8 | 7 | 88% |
| Townend - Willow Ward (Team) (Qualified nurses) | 8 | 8 | 100% |
| Townend - Willow Ward (Team) (Support to doctors and nursing staff) | 10 | 7 | 70% |
| Townend Court (Team) (Support to doctors and nursing staff) | 0 | 0 | N/A |
| **Trust wide** | **67** | **59** | **88%** |

The trust did not provide data for appraisal rates for medical staff.

Between 1 June 2016 and 31 May 2017 the average supervision rate across the service was 94% against the trust's target of 100%.

| | Clinical supervision target | Clinical supervision required | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|---|
| Core service total | 100% | 106 | 100 | 94% |
| **Trust Total** | **100%** | | | **69%** |

The trust had a supervision policy which stated that supervision should be delivered to qualified staff every four weeks and unqualified staff every six weeks. The trust did not routinely record figures for managerial supervision, as it was often carried out alongside clinical supervision.

During the inspection, staff told us that they felt supervision could improve and was not taking place as often as they would like. Due to this, we reviewed the most recent figures and found that between 1 May 2017 and 31 July 2017, supervision rates for staff had reduced to 50% for healthcare assistants whereas figures remained above 80% for qualified nurses.

The service had recognised this was a concern for staff who had raised concerns in team meetings. The service attributed the difficulties in recording one to one supervision to low staffing numbers which reduced the opportunity for staff to move away from the ward for supervision. In order to rectify this, the service was developing a new supervision structure for the service. However we saw that support was taking place on an unplanned basis. Senior managers were based in the building and we observed staff talking to them for advice and guidance. Staff were also supported by the psychologist in de-briefs following incidents.

Managers informed us that there was no poor staff performance which had been dealt with in the last twelve months.

Recruited external volunteers did not support the service; however some patients were undertaking voluntary work in the wards. This work included helping to make drinks for meetings and visitors, working in the reception area of the service and helping with some administration tasks. Patients enjoyed this work and it helped them to learn new skills and gain experience.

**Multi-disciplinary and inter-agency team work**

There was a range of professional disciplines available at the service which made up the multidisciplinary team. This included psychiatry, psychology, social work, nursing, speech and language therapy, occupational therapist and pharmacy support.

The team met weekly to discuss patient needs and were based on site. In addition to multi disciplinary team meetings, there was a daily handover meeting twice daily at the start of each shift. The nurse in charge of both shifts and healthcare support workers beginning a new shift attended these meetings. We observed two hand over meetings during the inspection and found them to be of good quality. The nurse in charge of the current shift discussed each patient in turn including their observation level, incidents and any change in risk. The team also made plans for the day for escorted leave and activities and discussed security arrangements. Handover sheets were in place for temporary staff or staff who had been away to review. In addition to this, a

representative from each ward then met together, alongside the clinical lead to discuss any staffing concerns or any additional support needed.

We observed a multi-disciplinary meeting during the inspection. All professionals involved in patient care attended the meeting. Staff also invited the patient, their carer or relative, and any professionals from outside of the service to the meeting. The consultant psychiatrist chaired the meeting. An administrative worker was present to update patient notes. Staff discussed a range of issues for each patient, including physical healthcare, best interest decisions and mental capacity, discharge and future placements, section 17 leave, detention under the Mental Health Act, and reductions in medication. We saw that the meeting gave all professionals the opportunity to give a view on the patient and their progress. Staff spoke about the patients respectfully at all times. The patient did not wish to attend the meeting so nursing staff agreed to give feedback to questions they had completed in preparation.

The service had effective working relationships with professionals outside of the service. We saw that staff had regular discussions with commissioners about the discharge and admission of patients. Staff worked closely with the community learning disability team to support future planning and relapse prevention plans for patients. The team also worked closely with a health liaison nurse in the acute trust and with the local GP. Staff had made referrals to other professionals to support patients with ongoing physical health problems which required specialist support.

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

As of 31 May 2017, 83% of the team had received training in the Mental Health Act. The trust stated that this training was mandatory for all staff. At the time of the inspection the service manager showed us data that this had improved further with all of qualified nursing staff and 84% of healthcare assistants trained. This was a significant improvement on the previous inspection where training was not mandatory and only 23 of 55 staff members had completed it.

The service had good support in the administration of Mental Health Act paperwork. The responsible clinician was the trust lead in the Act and there was also an office manager who scrutinised paperwork on site. The trust had a Mental Health Act Office who organised and scrutinised paperwork and we saw that regular audits were undertaken.

Staff had a good working knowledge of the Act and its principles. Less senior staff told us that they would ask for support from the responsible clinician or from the trust Mental Health Act lead. The service used the trust wide Mental Health Act policy which was updated in August 2017 and revised in line with the Mental Health Act Code of Practice. Staff had access to the policy on the trust intranet and we observed copies of the Code of Practice stored in the service for reference.

We reviewed the Mental Health paperwork of eleven patients during the inspection. We fed back to the provider at the time of the inspection that the storage of paperwork was disorganised and this meant that some documentation was difficult to find. All documentation was in place, but required scrutiny to ascertain where it was located.

Our Mental Health Act Reviewers had last visited the service in June 2016 (Beech ward), August 2016 (Willow ward) and February 2017 (Lilac ward). During each visit, the reviewer had raised a number of concerns on each ward. These included; lack of training for staff in the Mental Health

Act, seclusion reviews not always completed on time, a lack of community meetings for patients, patients section 17 forms not in appropriate order, staff not reading patient rights to them, a lack of female lounge on Lilac ward and lack of patient access to the internet.

During the inspection we saw that the service had rectified the majority of these concerns. For example Mental Health Act training was in place and staff had completed it, Lilac wards now had a female lounge, hot and cold drinks were openly accessible to patients, section 17 leave paperwork was in order and staff read all patients their rights on a regular basis.

However there were two outstanding issues. Patients continued to be unable to access the internet. Staff could not rectify this at service level, and staff had flagged the concern with the trust information technology department. Also staff did not always undertake seclusion reviews as per the Code of Practice. However the modern matron was carrying out detailed reviews of every seclusion episode to identify errors and feedback learning to staff.

All patients admitted to the service who lacked capacity to consent where referred to an independent mental health advocacy service. Staff offered all patients the support of the patient involvement worker, who was a qualified nurse.
All patients were informed of their rights under the Mental Health Act on a regular basis; how often this took place was dependent on the need of the patient, and was recorded in a 'rights' care plan. Staff displayed patients' rights information around the units, and informal patient notices were visible.

Patients were allocated section 17 leave by the responsible clinician in weekly multi-disciplinary team meetings. Staff documented leave appropriately and struck out old leave forms.
Where patients did not have capacity to consent to treatment, the responsible clinician requested a review from a second opinion appointed doctor. On two occasions a doctor was not available on time and the responsible clinician completed a section 62 emergency treatment in the interim until the Care Quality Commission confirmed an appointment.

Senior members of staff undertook audits of Mental Health Act paperwork on individual patient files. We reviewed the audits from 30 July 2017 of eight individual patients. After each audit the senior staff member gave feedback to the relevant staff member about any issues identified or changes required. We saw evidence of staff making changes in patient files as a result of these audits taking place.

## Good practice in applying the Mental Capacity Act

As of 31 May 2017, 80% of the team had received training in the Mental Capacity Act. The trust stated that this training was mandatory for all staff.

At the time of the inspection, the service manager showed us data which confirmed a further improving picture. As of 31 August 2017, 100% of qualified nurses and 91% of healthcare assistants had completed training. This was a significant improvement on our previous inspection where only 58% of staff had completed this training which was not mandatory.

Staff had a good working knowledge of the Act and its principles. Less senior staff told us that they would ask for support from the responsible clinician or from the trust lead.

Humber NHS Foundation Trust told us that the service made 23 Deprivation of Liberty Safeguard applications to the local authority between 1 June 2016 and 31 May 2017. This meant that the service were aware of the legislation and able to make appropriate referrals.

| | Number of DoLS applications made by month | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Total |
| **Applications made** | 2 | 4 | 2 | 2 | 5 | 2 | 2 | 1 | 1 | 1 | 1 | 0 | 23 |
| **Applications approved** | | **2** | | | **4** | | **1** | | | **1** | | | **8** |

At the time of the inspection, one patient of thirteen was subject to a Deprivation of Liberty Safeguard. The patient no longer met criteria for detention under the Mental Health Act but needed to remain at Townend Court until a placement was finalised. However they lacked capacity for an informal admission. Therefore the use of the Mental Capacity Act provided the safeguards the patient required and was appropriate for this patient.

The trust provided a Mental Capacity Act policy for staff. This was last reviewed in February 2016 and despite the policy being overdue a further review in March 2017, it detailed current and relevant guidance. The policy referenced the Mental Capacity Act Code of Practice with clear guidance regarding Deprivation of Liberty Safeguards. Staff had access to the policy on the trust intranet and the Mental Capacity Act Code of Practice was available on site.

We saw evidence in patient records that staff often discussed patients' capacity. Staff had undertaken capacity assessments with all patients regarding consent to treatment for physical healthcare issues. This was because due to the complexity of the patient group they met criteria for capacity assessment due to their impairment.

Staff were clear about the process of arranging capacity assessments and holding best interests meetings. We observed a multi disciplinary meeting where staff discussed a patient who lacked capacity to make decisions surrounding an operation and staff made a decision to hold a best interests meeting with the patient and their family. However, for one patient who lacked capacity to consent to a controlled diet for physical health concerns, staff had put a care plan into place but had not documented a capacity assessment and best interest discussion.

Throughout the inspection we observed staff supporting patients to make decisions. When patients did not communicate verbally, staff used a variety of techniques such as signs and picture cards to support patients to communicate and make decisions.

The trust had a mental health legislation lead that staff could refer to for advice and support. Senior members of staff undertook audits of Mental Capacity Act paperwork on individual patient files. We reviewed the audits from 30 July 2017 of eight individual patients. After each audit feedback or changes required were discussed with the relevant staff member. We saw evidence of staff making changes in patient files as a result of these audits taking place.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

We offered all patients who were able to speak with us, the opportunity to do so. Of the 13 patients currently admitted to the unit seven wished to speak with us. Five patients also completed comments cards about their experience of the service.

All patients who gave feedback to us described staff as kind, carrying and respectful. Patients described staff as ‘really nice’ ‘hard working’ ‘always there’ and ‘always listening’. Patients told us that staff always respected their privacy and we saw evidence of this while observing staff working on the wards.

We observed staff interactions with patients during mealtimes, activity sessions, and while they were undertaking day to day care on the wards. In all interactions staff had patience, actively listened and communicated with each patient according to their individual needs.
Staff were passionate about the service and the quality of care they delivered. Each staff member we spoke with knew patients well. They were able to describe their care needs, communication profiles and their wishes for the delivery of their care.

We saw staff making efforts to meet the individual care needs of each patient. Patients with autistic spectrum disorders had access to weighted blankets, tents for shelter, and ball pits and paddling pools to meet their sensory needs. Staff had offered other patients support with their religious needs, such as purchasing rosary beads with one patient. We observed staff taking time to sit with patients who were feeling distressed or anxious. Staff were aware of trigger points for patient’s anxieties and were able to use techniques to de-escalate situations and reduce anxiety.

Staff spoke passionately about the patients they cared for and told us that they would feel comfortable raising concerns about poor attitudes or abusive behaviour towards patients.
Where this was required, staff directed and referred patients to other services where specialist skills or knowledge were required to support them.

Staff maintained patient confidentiality in all areas of the service. Patient information boards were only visible to staff and all documentation was securely stored.

The service manager was the privacy and dignity lead and undertook regular audits to monitor quality. Patient led assessments of the care environment are undertaken by local people visiting services and assessing the care environment. Townend scored better than the England average for privacy, dignity and wellbeing whilst also achieving higher than the trust average.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **TOWNEND LD UNIT** | Both mental health and learning disabilities provided from the same site by the same provider | 91% |
| **Trust overall** | | **85%** |
| **England average (mental health and learning disabilities)** | | **84%** |

## The involvement of people in the care they receive

### Involvement of patients

Patients using the service and their families were active partners in their care. Staff at the service were fully committed to working in partnership with people.

When patients were first admitted to the unit staff gave them one to one care for at least 48 hours to support them to become orientated to the ward environment.

Patients told us that they had been involved in their care plans. Staff had embedded the needs, wishes and aspirations of patients throughout all care planning. Staff invited patients to multi-disciplinary meetings. Patients we spoke with told us that they knew why they were taking medication and how their treatment would progress, and what their plans for discharge were.

Staff delivered all of the information to patients on the unit in an easy read format, including individual care plans. Where patients were unable to communicate verbally, staff had developed communication profiles with the support of the speech and language staff. This allowed staff to use tools such as pictorial cards, and now and next boards, allowing and encouraging patients to make choices. Staff were committed to ensuring they were able to communicate clearly with all patients. All staff had access to computer software which converted words to symbols to allow communication and patient choice for those who cannot understand verbal information. Patients each had white boards in their bedrooms which staff completed to show their named nurse and planned activities for the day. We also observed that throughout the building were ‘sign of the week’ posters. These were to support patients and staff to learn signs to aid communication.

We saw highly individualised discharge planning. Staff had written individual service specifications for patients ready for discharge who had complex needs to ensure commissioner could identify the correct long term placement.

Patients were involved with decisions about the service. We saw that at patients’ request, staff had given patients jobs to complete on the ward such as helping staff on the reception task and photocopying information which was not confidential. Patients enjoyed their roles and it provided them with opportunities to build their skills and self-esteem.

The service was passionate about giving patients a voice and enabling them to give feedback about their care. They had employed a patient involvement worker who chaired weekly patient meetings and also offered advocacy support to patients. This was good practice because it allowed patients to give honest feedback about the service away from regular staff members and ensured the service heard patient voices. All patients knew this worker well, and spoke highly of their input into the service. Patients also told us that they had been involved in recruitment of staff.

### Involvement of families and carers

Staff were passionate about family involvement, and this was embedded throughout the service. The service saw patients’ families and friends as a strength and they supported patients to have choice about family contact. We saw examples of good practice where the service had supported patients and their carers to rebuild relationships which were important to them. Some patients had not had family contact for several years and the service had supported this contact. For the

patients the outcome was wholly positive and had reduced anxieties and mental health issues. The service also supported carers with visits with patients.

There was not a formal process in place for carers to offer feedback to the service. The service told us that they had attempted to embed carers groups and meetings but this had not worked well, due to the changing patient group. The service planned for the newly appointed involvement worker to support carers and encourage their feedback about the service. We did not see evidence that staff had provided carers with information about how to access a carers assessment, however support required on discharge was discussed at multi disciplinary team meetings and this would be the role of the community team who were fully involved with the discharge process.

We spoke with eight carers during the inspection, and seven of the eight carers gave feedback which was positive about the service. Carers told us that they felt supported, involved and always felt welcome in the service to visit their relative with open visiting hours. Carers described staff as caring, always available and easily contactable. Carers said that the service made sure their relative was safe and well cared for, and that they felt confident that staff were meeting all of their needs. One carer told us that the support offered by the service had 'meant to world' to their family. Carers said that staff were always available on the wards, and that there were always enough staff. They described a clean and relaxing environment for patients with access to outings and activities where this was appropriate. Carers said that they would feel confident in making complaints about the service and raising concerns. However, one carer did not agree that the service was always quick to respond to concerns.

# Is the service responsive?

## Access and discharge

### Bed management

The trust provided information regarding average bed occupancies for the three units between 1 June 2016 and 31 May 2017.
Each ward had reached optimum average bed occupancy during the period of between 80% and 85% which is similar to the previous inspection in December 2015.

| Ward name | Average bed occupancy range (01 June 16 - 31 May 17) (current inspection) | Average bed occupancy range (1 June 2015 and 30 November 2015) (previous inspection) |
|---|---|---|
| **Beech Unit** | 39% - 99% | Data not provided previously |
| **Lilac Unit** | 67% - 96% | 77% |
| **Willow Unit** | 67% - 100% | 85% |

At the time of the inspection, there were 13 patients admitted to the service.
Four patients were admitted to Willow ward, which had a maximum bed occupancy of six.
Four patients were admitted to Lilac ward, which had a maximum bed occupancy of eight.
Five patients were admitted to Beech ward (with one patient on overnight leave) which had a maximum bed occupancy of six.

The service managers explained that although there were currently empty beds within the wards, they did not feel pressure to fill these beds. Managers held a weekly referrals meeting, however

were careful to balance the need for treatment against the patient mix on the ward. The director of the care group agreed that the team had autonomy in decision making regarding admission and discharge and that they supported the decisions of the team.

The trust provided information for average length of stay for patients during the period 1 June 2016 to 31 May 2017.

The information for this core service suggests that three wards in the core service presented a shorter length of stay for this period to the trust average of 91 days. When compared to the information provided at the time of the previous inspection, it appears that the average length of stay has increased slightly since then.

| | **Average length of stay range (**1 January 2015 to 31 December 2015**) (previous inspection)** | **Average length of stay range (**1 June 16 - 31 May 17**)) (current inspection)** |
|---|---|---|
| **Core service total** | 60 days (range:8 – 121 days) | 72 day average (range: 6 – 222 days) |
| **Trust total** | | 91 days |

The service reported no out area placements between 1 June 2016 and 31 May 2017. This meant that the trust had not moved patients out of the area for care and treatment. The service was providing care to patients from outside the local area. However there were beds available for the local population as required.
We saw that patients often had periods of overnight leave as a transition to a new care setting. The service did not use these beds for newly admitted patients until staff had fully discharged that patient.

This service reported that no patients had been readmitted to the units within 28 days of discharge between 1 June 2016 and 31 May 2017.

The service consisted of three wards. Willow and Lilac wards focussed on admission and treatment, whilst Beech ward focussed on enablement and supporting patients to move on from a hospital setting. This gave the service the opportunity to support patients in different settings following a journey of care and treatment. This also allowed staff to support patients to move between units due to an enhanced need for care or due to changes in risks. When staff did this, they did so in discussion with the team and the patient and in a planned manner rather than as an emergency response.

**Discharge and transfers of care**

Between 1 June 2016 and 31 May 2017 there were 94 discharges from the service. This amounted to 3% of the total discharges from the trust overall.

In the same time period, the trust reported that two of these discharges were delayed. The service acknowledged that delays in discharge related to the complexities of the patient group and finding an appropriate service to meet their needs outside the hospital environment.

In order to reduce delayed discharges, the service firmly embedded discharge planning throughout the patients' admission. All patients had a discharge care plan, which staff completed within 48 hours of admission. This care plan included all actions which patients should achieve before discharge.

The service was using innovative practices to support discharge for patients to appropriate settings and reduce the risk of readmission to hospital. For example, staff had identified a group of patients who could be cared for together in a community setting. They had identified a suitable property for these patients and were working with commissioners to identify a suitably skilled care provider. Staff and the patients involved had chosen this community setting in close proximity to Townend Court to enable ongoing support and reduce anxieties for this patient group, who had repeated admissions to hospital due to anxieties about living in the local community. The patients involved in this project were very happy with the plans.

The service was providing a 24 hour service for the learning disabled community and had a variety of methods to work closely with community teams to prevent crises and hospital admissions, and involvement with other agencies such as the police. The service had devised that following the community learning disability teams ending their day at 5pm, Willow ward had a telephone number which community patients and their carers could use as a contact for emergencies. This helped to calm situations which otherwise may have ended in a crisis, and therefore prevented the use of other community services. If staffing would allow, staff from the wards may complete evening home visits to patients they knew well, to reduce anxiety and behaviours and further prevent crisis care and treatment.

## The facilities promote comfort, dignity and privacy

All patients had their own bedrooms with ensuite bathroom facilities. Patient bedrooms were personalised and contained lockable cabinets to enable patients to store their possessions securely. All patients we spoke with liked their bedrooms and told us that they were comfortable and clean. All patients had taken part in a risk assessment about their bedroom key and the majority of patients held their own bedroom key.

Patients had access to a wide range of spaces around the individual wards such as lounge, dining area and communal bathrooms and toilets. There were also shared communal spaces outside of the wards including an activity room with craft and sports equipment, an occupational therapy kitchen to practice cookery skills, and communal spaces to meet visitors away from the units. Staff had access to clinic rooms on each ward to enable examination of patients as required and the administration of medication. There were a variety of meeting rooms for patients to meet with staff, visitors and external professionals.

Patients were all able to have access to their own mobile telephone. Where patients did not have their own telephone they were able to use the unit office phone to make contact with their family and friends, which was cordless so that patients could use it in private.

All three wards had direct access to outside space into garden areas. Patients took full advantage of these spaces and some patients used them to grow their own plants and vegetables. The gardens had fencing which meant that doors remained open throughout the day and patients did not need staff supervision.

All patients we spoke with told us that the food was high quality. Catering staff cooked meals on site. Staff gave patients a daily menu from which they could choose their food. Patients were also able to have takeaway food ordered to the ward. Patients were able to make hot and cold drinks throughout the day and night from the unlocked dining areas. However we saw one blanket restrictions in relation to snacks between meals. Patients had restricted access to snacks because

staff locked them away. Patients told us that this was because staff were encouraging them to be healthy and that they could have a snack whenever they wished but they needed to ask staff to access them.

Patient led assessments of the care environment are undertaken by local people visiting services and assessing the care environment. The 2016 food score for Townend Court was 100% and higher than the trust average.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **TOWNEND LD UNIT** | Both mental health and learning disabilities provided from the same site by the same provider | 100% |
| **Trust overall** | | **95%** |
| **England average (mental health and learning disabilities)** | | **89%** |

## Patient's engagement with the wider community

Patients admitted to the service were encouraged to remain an active part of their local community. Staff offered all patients leave from the units and the amount of leave and staffing required was reviewed in weekly multi disciplinary meetings. Patients also went on regular outings as a group such as to the local fair or to a weekly tenpin bowling game.

Staff supported patients to maintain contact with their families and carers. Carers we spoke with described how they had open access to visit relatives on the ward. We saw that family contact often took place on the ward, rather than in visitor rooms. Carers and families told us that they always felt welcomed to visit. Staff invited families and carers to all patient meetings. Carers told us that they felt involved in the care of their relative and knew the next stages of their care and treatment. To aid communication, patients with families who lived outside the local area were encouraged and supported to have 'Skype' calls with their families.

Staff ensured that patients had daily opportunities to access the local community even if they may have highly complex support needs. When an incident had occurred on leave, staff reviewed this and updated risk assessments but this did not prevent the patient from having future leave opportunities.

Due to the complexity of the patient group, employment opportunities were limited. However, staff found tasks for patient to complete within the service such as photocopying, helping on reception and completing shredding of non-confidential waste. Patients really enjoyed this and their involvement in the service.

## Meeting the needs of all people who use the service

Staff were passionate about meeting the needs of patients and had made significant adjustments to ensure communication and support. In the entrance to the wards, we saw speakers placed on the reception desk and toilets. Patients who were unable to communicate verbally could activate these speakers and indicated (for example) needing to use the bathroom, or to request the attention of the receptionist.

The service was located on the ground floor entirely which meant that people using wheelchairs or with mobility difficulties were able to access the service. Each unit also had a bedroom with a higher specification including a hoist and tracking and profiling bed. This meant that the service was able to admit patients who needed this higher level of support.

Throughout the unit, we saw posters and leaflets to support patients. These explained patient rights, how to make complaints, how to contact advocacy and the Care Quality Commission and different types of treatment. Displays were bright and inviting and information always provided in easy read format to meet the needs of the patient group. This extended to individual patient care plans which staff provided in pictorial or easy read format dependent on the needs of the individual patient.

The service employed a speech and language therapist. This meant that each patient had their own communication assessment and profile. This was available to all staff and meant that each patient had ease of communication using a process individualised to them. Staff supported by the speech and language therapist where necessary, could arrange support for patients who used Makaton, sign language, required an interpreter or those who were non-verbal.

Patients were able to make choices about meals. Because the service provided food on site, catering staff were able to meet the needs of individual patients such as those with specific dietary needs.

Staff supported patients in their spiritual and cultural needs. Patients had access to a spiritual room. However, the service recognised that this was in the outpatients' area and would benefit from improvements such as the addition of appropriate religious texts and the provision of a less clinical environment. At the time of the inspection the service did not have a plan to improve the space.

## Listening to and learning from concerns and complaints

This service had received one complaint between 1 June 2016 and 31 May 2017. This related to a patient being unhappy with comments made by a senior staff member. We reviewed this complaint during the inspection which had been partially upheld. We saw that the service had supported and encouraged two patients to raise concerns about their care and treatment in a formal manner. The trust made an apology to these patients, and followed this up in writing in an easy read format. The staff member involved also made a direct apology to the patients.

The service encouraged patients to give feedback about their care and encompassed this in the weekly patient meetings. Patients also had access to comments and suggestions boxes should they wish to raise a concern anonymously.

Patients we spoke with told us that they would feel comfortable raising a complaint with staff.

Staff we spoke with where aware of the complaint patients made and how patients had been supported to voice their concerns. This meant that senior managers had shared the incident and learning with the staff team.

This service received five compliments during the last 12 months between 1 June 2016 and 31 May 2017.

## Is this service well-led

### Leadership

The senior leadership at service level consisted of a modern matron, consultant psychiatrist and service manager. The team were well established and had worked in the service for a number of years. The leaders were passionate about the service and worked towards making continuous improvement. The leadership team continued to contribute to good practice and the modern matron had recently received a leadership award in the 'talent for care awards'. The leadership team had a number of measures in place to audit and monitor the quality of the service which meant they were continually aware of risks and able to manage them and make changes.

Throughout the inspection we observed that leaders were visible to both patients and staff. They often conducted walk arounds on the units. They knew all staff members well and spoke to them and patients directly throughout the day. The care group director and chief executive had visited the service and the staff team knew who they were.

Several members of the team had been encouraged to develop and undertake training and this had resulted in the opening of leadership positions within the team.

### Vision and strategy

Humber NHS Foundation Trust stated that they had a mission to be a multi-specialty health and social care teaching provider committed to Caring, Learning and Growing. Their vision was that they aim to be a leading provider of integrated health services, recognised for the care compassion and commitment of our staff and known as a great employer and a valued partner.

The trust values were;

- **caring** - caring for people while ensuring they are always at the heart of everything we do
- **learning** - learning and using proven research as a basis for delivering safe, effective, integrated care
- **growing** - growing our reputation for being a provider of high-quality services and a great place to work. Senior leaders at the service were clear about the trust vision and values and integrated them into their work.

The provider worked to communicate the values to ward level staff by displaying values on the trust intranet system. The majority of staff we spoke with were able to tell us about the trust values.

The leadership team up to care group director had a clear future vision for the service and was planning to ensure this could be achieved. This was in the early stages with staff 'timeout' days arranged for September and October 2017 for consultation with staff around the staff charter, and team objectives and development.

Staff were able to provide high quality care within the trust budgets available to them. We saw evidence of this because the difficult staffing levels within the service had not impacted patient care. The service had reconfigured the management of the service within its current budget to ensure the delivery of high quality care with additional input from clinical lead staff.

### Culture

The culture of the service was one of person centred care delivery.

Staff told us that they felt respected and valued by the senior leadership team. Staff we spoke with spoke highly of the service, made comments that they 'loved' their jobs, and wouldn't wish to leave. Staff told us that their jobs were stressful, and that they would benefit from being able to access regular breaks during the working day and would like more supervision and training. However, they described the service level managers as supportive and said that they felt respected, valued and were thanked for their work. Staff also said that the consultant psychiatrist was highly respectful of staff ideas and innovation for patient care and welcomed feedback in multi disciplinary team meetings.

Staff knew how to use the whistle-blowing process and told us that they would have no worries about raising concerns about bullying and harassment in the workplace, because they felt that they worked within a supportive culture.

Teams worked well together, the multi-disciplinary professional approach was high quality with all areas of the team working closely together to produce care and support plans for patients. We saw that when staff raised concerns, for example about low rates of supervision, senior leaders recognised this and spoke to staff about how they would make improvements. Teams were encouraged to hold meetings without senior leaders to allow them to discuss issues freely, and obtain peer to peer support.

Staff worked in a culture of development and progression; significant numbers of staff at all levels had undertaken additional training to further progress their skills and opportunities.

The sickness and absence rates for the service were 4% which was below the trust average of 5%. Staff members spoke highly of the service supporting them to return to work after periods of sickness and changing work patterns to support good mental and physical health for staff members.

The Trust is a 'mindful employer' which means the trust was signed up to ensure they were committed to positive mental health for staff. The trust supported the health and wellbeing of staff by offering an occupational health service. At a service level, the team had group supervision sessions and de-briefs supported by the psychologist to discuss incidents and concerns at work.

The trust recognised contributions of staff by holding annual staff awards. At a service level, staff had received awards external to the trust in leadership, mentor of the year, and 'rising star learner'.

At the time of the inspection, the service did not have practice concerns, nor had they suspended any staff from the service.

## Governance

The governance systems within the service were effective and ensured patient safety. There was a clear framework in place which ensured managers could share essential information.

At service level, senior managers discussed individual patient risk at weekly multi disciplinary meetings. In addition to this, managers held monthly safer services meeting. At these meetings managers discussed risks for patients and the service. They rated all risks or concerns with actions for completion. Senior leaders attended quality forums and meetings with other parts of the trust to discuss concerns, themes from incidents and lessons learnt from complaints and incidents.

In order to ensure patient safety a number of quality checking processes such as audits and external reviews were in place which managers also fed back to staff in team meetings. Staff told us about learning from incidents and said that often this led to changes in practice such as different observation levels for patients.

In order to ensure quality and high standards of patient care, the team worked closely with other professionals such as commissioners, community teams, GP's and the acute hospitals.

## Management of risk, issues and performance

The management of risk was high on the agenda for the focus of the senior leadership team. The care group director was also aware of the risks for the service and their concerns matched the concerns at service level. Concerns relating to the service were on the corporate risk register which were; physiotherapy staff recruitment and staffing concerns at Townend Court. The service had also completed a local standard operational policy (June 2017) which contained a business continuity plan. This plan was thorough and covered threats to the running of the service such as adverse weather, information technology failures, loss of staff, and loss of premises and the impact of each threat. The plan noted key recovery activities for each threat so that the service was able to function and provide care to patients in extreme or emergency events.

## Information management

The service used a number of tools and audits to collect data from each ward and use this data to monitor quality and risks within the service. The service received monthly reports for example of incidents to identify themes and trends.

Audits were embedded in the service and the trust had introduced an app which allowed staff to collect information directly to reduce impact on staff time. The service displayed the most recent reports on training, supervision, appraisals, seclusion and restraint in patient and staff areas to ensure they shared information and priorities with staff, patients and carers and that this was done in an open and honest way.

Staff had access to the equipment and information required to do their job. The information technology infrastructure was available for staff use. However staff told us of their frustration in regular changes to systems and process which could make their role more complex. The service managed this with the use of paper files in the interim that the trust had trained all staff in the systems.

Patient records were stored safely and securely and staff were mindful of discussing confidential information in open ward or communal areas. Staff had hidden patient information boards from view.

The service made notifications to external bodies as required. However they did not notify the local safeguarding team of patients in long term segregation as per guidance contained within the Mental Health Act Code of Practice.

## Engagement

Patient engagement was high on the agenda for the service, and staff offered patients opportunities to feedback about the service in a variety of ways which included patient experience

worker, the use of advocacy and the use of comment boxes across the wards. We saw an example of staff supporting a patient to make a complaint about the service.

Information about the service was available to staff, patients and carers on the trust intranet. In addition to this, the service ensured that information bulletins, leaflets and data were available to patients and carers by displaying them on the wards and in visitor areas.
Staff and patients told us that senior leaders did visit the service and they felt able to give feedback and approach them.

The service worked closely with commissioners and held weekly transforming care meetings to discuss admissions and discharges to the service. The service had planned and undertaken meetings to engage with local Healthwatch.

## Learning, continuous improvement and innovation

Staff had the opportunity to be involved in research and members of the team had published research in a medical journal in 2017. This research discussed 'chromosome 4q deletion syndrome' and associated behavioural difficulties. Its publication evidences the in-depth knowledge of the service into the disorders experienced by the patient group and how they share their clinical learning with other professionals to improve care and treatment for patients.

The service had trialled new ways of working in an effort to improve patient care. For example the employment of an on-site social worker to support discharge, the employment of a patient involvement worker, and the permanent employment of a physical healthcare nurse. This allowed innovation within the service and meant that we observed an increase in the quality of patient care since the last inspection. Staff were involved in forums and sub-groups such as the reducing restrictive intervention forum to offer ideas and share learning across the trust.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to attain the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. There were no wards currently accredited in this core service.

# Community-based mental health services for adults of working age

## Facts and data about this service

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| Willerby Hill | Bridlington Adult CMHT | N/A | - |
| Willerby Hill | Holderness Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Beverley Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Pocklington Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Haltemprice Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Driffield Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Goole Adult CMHT | Appointments are made to suit individual needs | - |
| Willerby Hill | Community Mental Health Team Hull East | Appointments are made to suit individual needs | - |
| Willerby Hill | Community Mental Health Team Hull West | Appointments are made to suit individual needs | - |

Humber NHS Foundation Trust delivers community mental health service to adults of working age across Hull and the East Riding of Yorkshire. The community mental health service delivers an integrated community mental health service in Hull through a single contract for health and social care and in the East Riding of Yorkshire through a Section 75 partnership agreement with the Council.

The team comprised community mental health nurses and support workers employed by Humber NHS Foundation Trust and social workers and case workers (trainee social workers) employed by the Local Authority.

There were eight community mental health teams and these were based at nine sites. Hull (West) was based at the Waterloo Centre and Hull (East) was based at The Grange. In addition to these two teams, there were Goole and Pocklington, Bridlington and Driffield, Beverley, Haltemprice and Holderness.

The Goole and Pocklington and Driffield teams used health premises as their base. Bridlington teams used local authority premises as their base.

The eight teams provided a community mental health service to adults aged 18 and above, with a full range of mental health problems and needs ranging from moderate to severe, with a degree of complexity within clusters 5 to 17. Patients are allocated to clusters by the clustering tool in relation to the nature and extent of the staff interventions they are expected to need. The trust is paid by the CCG in relation to the number of patients in each cluster.

The service is a needs-led, recovery-focused, intervention and treatment community team. A full range of multidisciplinary professionals worked effectively together within the teams, with very quick and easy access to Consultant Psychiatrists and Psychologists.

We inspected three of these teams across five sites, namely, Community Mental Health Team (CMHT) Hull West, Pocklington Adult CMHT, Goole Adult CMHT, Bridlington Adult CMHT and Driffield Adult CMHT.

Pocklington Adult CMHT will cease to operate under Humber NHS Foundation Trust on 31 December 2017. The service based at the Pocklington location will be managed by Tees, Esk and Wear NHS Foundation Trust from 1 January 2018.

During our inspection, we:

- spoke with 16 patients by telephone and one patient in a clinic.
- visited four patients in their own homes.
- spoke with 42 members of staff, including consultant psychiatrists, psychologists, team leads, clinical leads, nurses, social workers, care officers, healthcare workers and support workers.
- reviewed 27 patients' care records.
- reviewed a range of documents relating to the running of the service.

# Is the service safe?

## Safe and clean care environments

Staff did regular risk assessments of the environment in all the five premises we visited. Health and safety assessments and checks were up to date. Fire wardens had been appointed in each of the premises and they were clearly identifiable. Staff carried out regular fire alarm testing and random fire drills.

Each of the premises visited were secure, using coded keypads and intercom systems. A receptionist greeted visitors at the main entrance. Interview rooms were fitted with alarms and there were staff on site to respond to alarms. Staff carried a personal alarm when seeing patients.

Not all areas were clean or well maintained. The premises at Hull West and Driffield were clean and tidy. However, the premises at Pocklington, Goole and Bridlington were in need of refurbishment and redecoration. At Bridlington, wallpaper was peeling off the entrance hall and there were cracks in the meeting room wall. These premises were owned by the local authority. . At Pocklington, community mental health team there was an odour in some of the consultation rooms and corridors due to a lack of ventilation.

Each of the premises had its own cleaning schedule. There were arrangements with contractual cleaning companies, which included daily cleaning of the premises every evening after the offices had closed.

Clinic rooms were well equipped with the necessary equipment to carry out physical examinations and for taking blood. At the Bridlington service, a nurse and a care worker managed a clinic for patients who required regular blood monitoring. Staff calibrated equipment, such as the blood analyser, at each clinic session before a patient's blood was taken.

Staff maintained equipment well and kept it clean. There were sufficient in date blood containers and syringes. They used a logbook to record blood samples used to test the blood equipment and these records were complete. Staff checked and recorded the fridge temperature daily. However, they did not lock the fridge used specifically for blood samples when not in use. Although the clinic room had a keypad locking system, it was also used by other services. The team leader and clinical lead took immediate action to ensure the fridge would be locked at all times when not in use.

## Safe staffing

### Nursing

### Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many the trust want or think they need in post.

| Substantive staff figures | Date | Core service | Trust target |
|---|---|---|---|
| Total number of substantive staff | At 31 May 2017 | 114.5 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 12.3 | N/A |
| Average WTE* leavers over 12 months (%) | 1 December 2016 – 31 May 2017 | 11% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) (WTE*) | At 31 May 2017 | 13.4 | N/A |
| Total vacancies overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 10% vacancy<br>Range 0% to 20% vacancy | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 5%<br>Range 5% to 8% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |

| | | | |
|---|---|---|---|
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 66.67<br>Range 3.66 to 66.67 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 4.67<br>Range 0 to 4.67 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 3.25<br>Range 1.2 over-established to 10.0 vacancy | N/A |
| Number of WTE vacancies nursing assistants | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 0<br>Range 0 vacancies | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 6%<br>Range 2% over-established to 26% vacancy | Not provided |
| Nursing assistant vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | 0%<br>Range 0 vacancies | Not provided |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 0 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 0 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 0 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | Not provided | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | Not provided | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | Not provided | N/A |

*WholeTime Equivalent

The community mental health team had a vacancy rate of 6% for qualified nurses and 10% overall on 31 May 2017.

The average staff turnover was high at 11% over the period from 1 December 2016 to 31 May 2017, in part reflecting the uncertainty surrounding the Pocklington unit.

The average sickness rate for all staff was 6% for the period from 1 June 2016 to 31 May 2017.

All teams had a range of staff including nurses, social workers, care officers, support workers, clinical lead, and team lead. Some teams also had an occupational therapist. The Hull West community mental health team consisted of 32 members of staff. They had recently recruited a band 6 nurse who would soon commence working at the service. There were no other vacancies. Four members of staff had been on long-term leave and bank and agency staff with the relevant experience covered these vacancies. Staff from the Hull West Team said the existing number of staff were not adequate to meet demand. At the time of our inspection, there were 735 patients in total and each care coordinator had a caseload of at least 30. Staff we spoke with said there was a high level of pressure and stress in managing these caseloads.

The Bridlington team had 13 members of staff. Driffield had nine staff and there were no staff on long-term sick leave. There were two nursing vacancies (Band 6 and Band 5 positions) and the recruitment process was in progress. Driffield had a long-standing, stable work force for many years, although recently, some staff had left for personal reasons leading to vacancies. This team did not use agency workers to cover shortfalls in staffing.

The management team and the staff felt the staffing numbers were adequate to meet the demand. Due to the two vacancies, there had been additional pressures on the team as caseloads had increased and each member of staff had to cover as duty officer more often. The role of the duty officer was also to ensure colleagues were safe as lone workers each day. Staff also covered and supported both sites when needed.

The Pocklington team had 14 members of staff. There were no staff on long-term sick leave. There were two nursing vacancies. The trust was not filling these vacancies as they would no longer be running the Pocklington service from 1 January 2018. They had a temporary team lead two-three days a week in the meantime. The service had no clinical lead at the time of our inspection.

Staff at Pocklington felt that the staffing level was inadequate to meet demand as they had two nursing vacancies that were not being filled. The staff held caseloads of 25 and this covered a large geographical area similar to the other teams. At the time of our inspection, there were 90 patients in total. There was a high level of stress and uncertainty among the staff due to the recent management changes and the impending changes in management when the new trust was due to take over.

The Goole Team had a clinical lead who was also an interim team manager for Goole. The staff consisted of 14 members and there were no staff on long-term sick leave. Staff reported the staffing level was adequate at present. The caseload was between 25 -30.

The service had access to psychiatrists and psychology staff. The move of the Pocklington team to the new trust would have an impact on the Goole team as these services had shared professionals. To date staff had not been informed by the executive team what the future arrangements for these staff would be for the Goole service.

The service had introduced a caseload weighting and dependency tool to ensure each care co-ordinator had a manageable caseload. However this was not used consistently across the service. Staff said they were under pressure in dealing with the caseload they had, especially when they had a large geographical area to cover. Staff from the Goole and Pocklington team felt that the caseload weighting and dependency tool had not taken travelling time and distances into account. At Hull West, Goole, Pocklington, Bridlington and Driffield not all the care co-ordinators had had their caseloads weighted but this was in progress. The trust policy stated that caseloads should be reweighted every three months. It was not clear how many staff in the community mental health teams had had their caseloads weighted to this standard.

Overall as of 31 March 2017, staff in this service had undertaken 86% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% training target in three courses.

Safeguarding adults and information governance training had the highest training compliance with 100%. Infection prevention and control training scored the lowest out of all the training courses with 69%.

The trust provided an updated position as of 21 June 2017 that showed staff in this service had undertaken 78% of the various elements of training that the trust had set as mandatory. This was above to the overall trust average mandatory training rate of 74%. The staff in this service had not achieved the CQC 75% training target in six courses. These courses are indicated in the table below.

Conflict resolution training had the highest training compliance with 85%. Immediate life support scored the lowest out of all the training courses with 17%, followed by basic life support with 27% and management of actual or potential aggression training with 30%, however staff had not been required to complete these courses in previous years.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Basic Life Support | *Not provided* | *48%* |
| MAPA | *Not provided* | *63%* |
| Infection Prevention and Control | *69%* | *66%* |
| Information Governance | 100% | *67%* |
| Equality and Diversity | *70%* | *70%* |
| Display Screen Equipment | 84% | *73%* |
| Safeguarding Adults | 100% | 80% |
| Health and Safety | 77% | 80% |
| Moving and Handling | *74%* | 82% |
| COSHH | 94% | 83% |
| Safeguarding Children | 94% | 83% |
| Mental Health Act | *Not provided* | 90% |
| Fire Safety | 94% | 92% |
| Mental Capacity Act | 99% | 93% |
| Prevent | 94% | 93% |
| Conflict Resolution | 75% | 100% |
| **Core Service Total %** | **86%** | **78%** |

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Staff did a risk assessment of every patient on first assessment and updated this every six to 12 months, depending on the patient's needs. A crisis plan was formulated, together with a care plan. Staff said they looked into historical information and triggers to guide them to formulate the crisis plan. This was reflected in the records we examined.

We looked at 27 electronic patient records and found they were well completed. There was a risk assessment for each patient, which was kept up to date. Each patient had had regular physical health examinations, which were ongoing. Each patient had a crisis plan.

At the Goole service, we found two care plans were over four weeks out of date. Staff had assessed the needs of the patients and planned their care but had not updated the care plans, accordingly. This meant these patients might not have had their care needs met appropriately.

### Management of patient risk

At Humber West, two members of staff were always present on the first visit to a patient in their own home to ensure staff safety. The first meeting gave staff the opportunity to get to know the new patient and to explain the treatment programme and options. Staff carried out a first assessment, which included risk assessments and care planning with the patient's involvement

and took into account the patient's preferences and wishes. This ensured staff addressed the patients' care needs appropriately. Each patient was given the emergency and contact numbers of the relevant community mental health team and a follow-up meeting was also arranged.
Risk assessments included a crisis plan, where staff looked into historical information and triggers in its formulation. When there was a sudden deterioration in a patient's health, the rapid response team were contacted for assistance.

Staff adhered to the trust lone working policy. They carried a personal alarm when seeing patients either at the clinic or in patient's homes. Staff had a system to indicate they had a problem when the duty officer phoned them at the end of the day about their whereabouts. Members of staff were on a duty rota system to support other staff as the duty officer for the day.

## Safeguarding

Safeguarding training was mandatory for all staff. The trust data showed 80% of all staff had received training in safeguarding adults and 83% in safeguarding children

In Hull West, the data showed 100% of staff had received training in safeguarding adults Level1; 100% in safeguarding children level 2 and 81 % in Level 3.

In Bridlington and Driffield, 100% of staff had training in safeguarding children Level 2 and 77 % in Level 3.

In Pocklington, 100% of staff had training in safeguarding children Level 2 and Level 3.

Staff could access the adult safeguarding policy and the trust safeguarding team were available to provide advice and guidance, when required. Staff were able to identify the potential signs of abuse and they were confident about the process for raising concerns and making a referral. Three members of staff had reported safeguarding incidents using the online reporting system.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional abuse.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concern will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

The trust did not provide the core service allocations for safeguarding referrals made in the period, and so we were unable to identify any referrals made by community based mental health services for adults of working age.

The trust did not submit details of any external case reviews commenced or published in the last 12 months in relation to this core service.

## Staff access to essential information

All staff had access to relevant patient information to enable them to provide care and treatment. All patient records had been stored electronically since October 2016. Staff were required to update relevant information on the electronic information system when care and treatment were provided and when a patient appointment had been arranged.

## Medicines management

In some of the community mental health sites, we found medicines were not stored on the premises. However, medication storage facilities were available if required. Staff explained that the consultant psychiatrist faxed the prescription to the patient's own GP as part of the treatment pathway. The GP prescribed the medicines and arranged for the patient to collect them from their local pharmacy. These included injections, which staff administered in either the patient's own home or the clinic, by appointment.

Staff followed good practice in medicines management. At Hull West, medicines were stored securely in lockable cupboards and located in a locked clinical room. Records for room temperature and the drug fridge temperature were in order.

There was a patient safety in the Goole service relating to a medicine error six months earlier. However this appeared to have been dealt with in line with policy.

### Track record on safety

Providers must report all serious incidents to the strategic information executive system (STEIS) within two working days of an incident being identified.

The trust reported 19 serious incidents between 1 June 2016 and 31 May 2017 and 16 of these were 'apparent/actual/suspected self-inflicted harm.' The remaining three included a breach of confidential information and a diagnostic incident with delay and failure to act on test results.

The trust reported an increased number of serious incidents during the period 1 June 2016 to 31 May 2017 when compared with the six serious incidents reported at the last inspection.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

| Type of incident reported | Total |
|---|---|
| Apparent/actual/suspected self-inflicted harm | 16 |
| Confidential information leak/information governance breach | 1 |
| Diagnostic incident including delay (including failure to act on test results) | 1 |
| Other | 1 |
| **Total** | **19** |

### Reporting incidents and learning from when things go wrong

Staff knew how to report incidents using the online incident reporting system. They were able to give examples of incidents they had reported in recent months, such as a medication error. Staff confirmed they had not always received feedback of the outcome of incidents they had reported, apart from an automatic response when a reported incident had been dealt with.

There was some concern about patient safety in the Goole service relating to a medicine error six months earlier. A patient received an injection of the wrong dosage on one occasion. Another member of staff detected this error when they came to administer the next dose. There was no referral made to the safeguarding team at the time but staff reported the incident using the electronic incident reporting system. The investigation of this incident and subsequent actions, was appropriate and the lessons learnt were undertaken by the management team, this included information from staff involved and the pharmacy.

Staff said the trust had given feedback about lessons learnt from trust wide investigations via email.

Staff we spoke with said they received training in duty of candour. They had access to the trust policy on duty of candour and knew their responsibilities in regard to duty of candour. Patients and their relatives would be informed and kept updated of any investigation following an adverse incident.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths, which all contain a summary of Schedule 5 recommendations. These are made by local coroners with the intention of learning lessons from the causes of death and preventing deaths in the future. In the last two years, there had been no 'prevention of future death' reports sent to the trust which related to this core service.

## Is the service effective?

### Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient and ensured that any necessary assessment of a patient's physical health had been undertaken. Staff were aware of and recorded any physical health problems.

We reviewed 27 care plans and found all the patients had a personalised care plan that was up to date. The care plans also included management of risk and were recovery oriented.

During our inspection, we accompanied two members of staff when they visited a new patient and observed the staff carrying out a first assessment. We also observed a nurse and a support worker carrying out a first assessment on a new referral. In both cases, staff were courteous and thorough in their assessment, which included relevant risk assessments. Staff explained the options and involved the patient in planning their care. All aspects of the patient's care needs were discussed and the patient was encouraged to engage in discussing their wishes and preferences.

The team lead, the clinical lead, the consultant psychiatrists and the psychologists worked collaboratively with team members to develop appropriate care pathways for patients with the most complex conditions and developed protocols to improve work efficiency.

## Best practice in treatment and care

The trust followed national guidelines in its policies and clinical procedures. Staff said they followed the guidelines from the National Institute for Health and Care Excellence (NICE) in all care and treatment interventions suitable for the patient group. This included medication and psychological therapies, and, when needed, support for employment, housing and benefits. This also included interventions that enable patients to acquire living skills. These interventions were those recommended by National Institute for Health and Care Excellence and were delivered in line with National Institute for Health and Care Excellence guidance.

Throughout the trust, work was in progress to roll out dialectical behavioural therapy (DBT). This would involve group therapy managed by a psychologist and supported by nurses. Other services undertaken included the commissioning of an eating disorder service.

Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. If the GP was responsible for this, the staff assured themselves that it had been done.

Staff supported patients to live healthier lives, acting on healthy eating advice, managing cardiovascular risks, screening for cancer, participating in smoking cessation schemes and dealing with issues relating to substance misuse.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes, using the Health of the Nation Outcome Scales.

Staff also used technology to support patients effectively, such as online access to therapies and other resources and timely access to bloodtest results.
The trust participated in a number of national audits and the community mental health service had been involved in two clinical audits in the last 12 months as part of their clinical audit programme. One audit related specifically to the psychosis service for young people in Hull and East Riding, whereas the MH7 re-audit of electroconvulsive therapy documentation and adherence to clinical guidelines audit had been completed trust wide.

| Audit name/Title | Audit type | Date of Audit | Key actions following the audit |
|---|---|---|---|
| MH2 Monitoring of physical parameters in antipsychotic therapy (PSYPHER service) | Local clinical audit | 19/12/2016 | Health Improvement Profile Adjunct created in January 2017 and added to pro forma. Patients to be monitored yearly via health improvement clinic. Re-audit to be undertaken early 2018. |
| MH7 Re-audit of Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines | Local clinical audit | 10/03/2017 | Action on plan completed - new audit tool being developed for Re-audit March 2018.<br>ECT Policy revision. |

At Bridlington and Driffield there had been monthly case note audits, last completed in October 2017. Bridlington and Driffield team had implemented the health and safety executive (HSE) stress management standards. The Hull West team had participated in several audits, including medication, care plans and peer reviews.

## Skilled staff to deliver care

There was a good skill mix of nursing staff with experience in meeting the care needs of patients. Staff felt they received appropriate training to enhance their roles as mental health workers in the community. They had access to mandatory training and clinical training in all aspects of mental conditions of their client group, which included patients requiring ongoing specialist care for severe mental disorders associated with schizophrenia and bipolar disorder.

A new member of staff confirmed they had had an induction period and had attended mandatory training, which had included basic life support training, the Mental Health Act, the Mental Capacity Act and safeguarding for adults and children. Another member of staff said they had received mentorship training at Hull University as part of their personal development.

The trust's target rate for appraisal compliance was 85%. As at 31 May 2017, the overall appraisal rate for non-medical staff within this core service was 78%, which was lower than the 80% reported last year.

| | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 102 | 80 | 78% |
| **Trust wide** | **1243** | **1050** | **84%** |

The overall appraisal rate for medical staff within this core service was 80%, which was higher than the 75% reported last year but still lower than the trust target rate for appraisal compliance, which was 85%.

| | Total number of permanent medical staff requiring an appraisal | Total number of permanent medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 196 | 157 | 80% |
| **Trust wide** | **1106** | **888** | **80%** |

Between 1 June 2016 and 31 May 2017 the average clinical supervision rate across the teams listed in this core service was 88%, excluding medical staff.

Staff of various disciplines confirmed they had received clinical supervision with a more experienced and senior member of staff within the same discipline.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **Core service total** | 100% | 762 sessions | 88% |
| **Trust Total** | **100%** | **3244 sessions** | **69%** |

## Multi-disciplinary and inter-agency team work

The community mental health team held regular multi-disciplinary team and interagency meetings. External multi-disciplinary team meetings involved representatives from the various organisations concerned, including the trust and the local authority and psychiatrists and psychologists involved in the care of patients in the community.

The Hull West team reported that the trust needed to do more work to improve communication with the prison in-reach team. The team manager said there were no clear protocols for links between the trust and the prison in-reach services at the present time. Staff said they found it difficult to get through to the right person or to get phone calls returned. This meant it was hard to obtain sufficient information on offenders' mental health conditions.

The team held regular internal multi-disciplinary team meetings. Team leads had attended the monthly operational managers' meetings and service development meetings. Relevant information from these meetings had been cascaded down to frontline staff at local team meetings.

We observed a referral meeting held at Hull West attended by the team lead, the clinical lead, a representative from the substance misuse service and a trainee doctor. The team discussed all referrals in detail, including full demographics, care clustering, detailed risk assessments and substance misuse screening. The team formulated short-term actions which were all then agreed. The team also discussed other matters, including safeguarding, multi-agency public protection arrangements (MAPPA) and hospital discharges. They documented all discussions electronically.

Staff said they had a team meeting every morning to discuss referrals, relevant cases and other matters, including the medication due to be given, staff whereabouts and the lone working procedures. Staff felt there had been good multi-disciplinary team working in the community.

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

As of 21 June 2017, 90% of the workforce had received training in the Mental Health Act. This was a year to date figure spanning training compliance from 31 March 2017 to 21 June 2017 and so this figure should not be directly compared to the training compliance outlined elsewhere in this report (See 'safe' section). Training for the Mental Health Act was mandatory for all core services for all inpatient and community staff and was renewable every three years.

At our last inspection in 2016, we found that Mental Health Act training was not mandatory therefore, data was not provided to enable us to compare compliance to previous years.

Staff we spoke with said they had access to administrative support and legal advice on the implementation of the Mental Health Act and the Mental Health Act code of practice. Staff said the Mental Health Act administrators based at the trust Mental Health Act office were very supportive.

Staff said they had access to relevant trust policies and procedures that reflected the most recent guidance. This included the local Mental Health Act policies and procedures and the code of practice.

A community treatment order (CTO) is an order made by the responsible clinician for a patient under section to receive treatment in the community. The responsible clinician can order the patient's recall to hospital if necessary.

If the team worked with detained patients under the Mental Health Act or subject to a community treatment order, staff would explain to patients their rights in a way that they could understand. If necessary, staff would repeat and then record. Patients 'notes were examined and we found evidence that patients' legal rights had been explained to them when they were under a community treatment order.

Staff confirmed that when the team worked with patients detained under the Mental Health Act or subject to a community treatment order, the patients would have access to information about independent mental health advocacy (IMHA) services. Patients also had access to legal advice.

A member of staff explained that if a patient was subject to a community treatment order, a designated member of staff would complete the community treatment order document correctly and would make sure the document was signed, dated and stored securely. We saw evidence of completed community treatment order paperwork in all sites we visited.

Nineteen (70%) out of the 27 patients' records we checked were for patients who were under community treatment orders. We found that staff had completed the community treatment order documentation appropriately.

The care plans we examined reflected that the patients subject to community treatment orders were under Section 3 of the Mental Health Act, in which case Section 117 Aftercare services also applied to them. We saw the care plans listed explicitly the aftercare services that must be provided under Section 117.

We did not see evidence that regular audits had been conducted to ensure that the Mental Health Act was being applied correctly. Managers were not able to confirm that such audits were done when we asked about the types of audits that had been carried out. If the team worked with patients detained under the Mental Health Act or subject to a Community Treatment Order, the management should carry out regular audits to ensure that the Act was being applied correctly and there should be documented evidence of lessons learnt from those audits.

## Good practice in applying the Mental Capacity Act

As of 31 March 2017, 93% of the community mental health team had received training in the Mental Capacity Act 2005 (MCA). The Trust stated that this training was mandatory for all core services for all inpatient and community staff and renewed every three years.
The training compliance reported during this inspection was higher than the 57% reported in the previous year.

Staff were trained in and had a good understanding of the Mental Capacity Act, particularly the five statutory principles.

Staff were aware of the trust's policy on the Mental Capacity Act and they were able to access this policy.

Staff knew where to get advice from the provider regarding the Mental Capacity Act.

Staff supported patients to make their own decisions and gave patients every possible assistance to make a specific decision for themselves before concluding that the patient lacked the mental capacity to do so.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act.

We did not see any audit on the application of the Mental Capacity Act and staff were not able to confirm that an audit had been carried out.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

People we visited and spoke with gave positive feedback about the service and the care they had received. They said the care co-ordinators and support workers were all very supportive. Patients said they felt better and their condition had improved as a result of receiving good care, support and treatment from the doctors and staff.

Patients told us that they were grateful to the staff who visited them regularly. They were well supported and said that staff were compassionate and understanding, allowing them to talk about their issues. A patient told us they were “here today” because of the care they had received from the mental health team and said they “couldn’t thank the care team enough for supporting them”. Patients were given emergency numbers by staff to phone if they felt unwell. Patients said they sometimes phoned their care co-ordinator between appointments and that staff always returned their calls.

We accompanied staff on visits to patients in their own homes during scheduled visits. Staff were respectful and kind and allowed patients to express their wishes and preferences. Staff were attentive and listened to patients talk about their feelings.

The community mental health team gave patients a choice as to where they preferred to meet with their care co-ordinator. Some patients preferred to travel to the community health clinic where the team base was. Staff ensured patients’ privacy and confidentiality. The interview room was clean and comfortable and staff made patients feel welcome.

### Involvement of patients

Staff explained information sharing aspects to the patient and obtained the patient’s consent. The records included completed information sharing documents that patients had signed. During the inspection, we observed staff respecting patient’s confidentiality in line with their wishes. Patients were involved in their care and staff discussed their treatment options with them. Patients’ care plans were person-centred, signed by the patient and included input from family members and carers.

The service had carried out and reviewed service user surveys about the care in the last few months. They displayed the results on notice boards at all the sites that we visited. Between April 2017 and August 2017, 100% of patients at the Bridlington and Driffield service indicated they were involved in deciding their care and treatment. Over the same period, the figure for Hull West was 70%.

### Involvement of families and carers

The service used friends and family cards to provide feedback about the service. We saw the cards in the staff office. Staff said they gave the cards to every new patient and their family members when they visited the patient. The trust collated the results every month and shared the results with team leaders in the quarterly service report. Between April 2017 and August 2017, 93.4% of the Friends and Family Test cards returned to the Bridlington and Driffield service showed patients were likely or extremely likely to recommend the service to friends and family. Over the same period, 80% of the cards for Hull West were favourable.

Staff informed and involved families and carers appropriately and provided them with support when needed. During our inspection, we were not able to speak with relatives, so we were unable to report any relatives' feedback

Carers were provided with information on how to access a carer's assessment.

## Is the service responsive?

### Access and waiting times

Patients were referred to the community health teams through the rapid response team. Patients could be referred on discharge from inpatient services within the trust, by their GP, by other trusts or by the probation service.
The community mental health team did not carry out the initial assessment of patients, so did not measure this but did measure the target for the time from assessment to treatment.
Three out of the nine services managed by the community mental health team met the local assessment to treatment target of 14 days.

Out of the five services we visited, Bridlington & Driffield were non-compliant, with a waiting time of 62 days. Pocklington and Goole were non-compliant, with a waiting time of 20 days. All the teams were in the process of negotiating the local target with the clinical commissioning group.

| Name of team | Service Type | Days from referral to initial assessment | | Days from assessment to treatment | | Comments, clarification |
|---|---|---|---|---|---|---|
| | | Target | Actual (mean) | Target | Actual (mean) | |
| **Adult Mental Health Family Therapy Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 0 | Local target in process of re-negotiation with CCG |
| **Beverley Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 26 | Local target in process of re-negotiation with CCG |
| **Bridlington and Driffield Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 62 | Local target in process of re-negotiation with CCG |
| **Goole Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 20 | Local target in process of re-negotiation with CCG |
| **Haltemprice Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 32 | Local target in process of re-negotiation with CCG |
| **Holderness Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 89 | Local target in process of re-negotiation with CCG |
| **Hull East Community Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 1 | Local target in process of re-negotiation with CCG |
| **Hull West Community Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 0 | Local target in process of re-negotiation with CCG |
| **Pocklington Mental Health Team** | Adult Mental Health Community | N/A - Treatment Team Only | | 14 | 20 | Local target in process of re-negotiation with CCG |

The community mental health team held regular referral meetings to discuss referrals and to assess whether patients were suitable for placement with the team. The community mental health team also had a discharge consultation panel to decide whether a patient was suitable for discharge.

At Driffield there were 10 patients awaiting allocation to a care coordinator.

Bridlington had a waiting list of 29 patients. Fifteen patients had received appointments and were waiting for the community mental health team to assess their suitability for treatment. Six patients had been accepted and were waiting to be allocated to a care coordinator. Four recent referrals were waiting to be discussed. The team was waiting for further information following assessment

of four patients to decide whether to accept them. One patient's referral for attention deficit hyperactivity disorder had been forwarded to the consultant psychiatrist for assessment.

Hull West had a waiting list of 118 patients who were waiting to be allocated to a care coordinator. The team managed all patients on the waiting list collaboratively using the duty triage system, in which a member of the team regularly contacted people on the waiting list to assess their needs and risks and monitor their conditions. This had ensured patients were not at immediate risk while waiting to be allocated a care coordinator.

At the Goole and Pocklington service, there were no patients awaiting allocation. There were 10 patients waiting for psychological therapy. Internal multi-disciplinary working had recently reduced the waiting list for psychological therapy. The psychologist had identified ways to train and support care coordinators to support patients in their care needing psychological therapy, without the need for a referral to the psychologist. Suitable patients attended a psychology consultation group meeting led by a care coordinator instead of seeing the psychologist.

The Hull West team had recently started accepting referrals for patients who were prescribed medication for attention deficit hyperactivity disorder (ADHD).

## The facilities promote comfort, dignity and privacy

The consultation rooms and clinical rooms available promoted their comfort, dignity and privacy. The clinical rooms were suitably equipped with furniture, including a treatment couch.

The community mental health team saw patients on an appointment system, so the clinical room or consultation room was booked in advance and was readily available. The team shared some of the waiting rooms with other community clinics. Information leaflets were on display and magazines and refreshments were available in the waiting area.

At the Bridlington site, there was a therapeutic garden for patients. Staff supported patients in growing seasonal fruit and vegetables and flowering plants as part of their therapy session.

## Patients' engagement with the wider community

Staff supported patients to get involved in activities in the local community. There was information on education, social groups and community activities on display in the various community health centres. Patients' records evidenced patients' personal interests and goals.

A patient told us their support worker had encouraged them to pursue their interest in gardening and had accompanied them to local garden centres. The same patient also enjoyed shopping and had visited the supermarket regularly. Another member of staff had arranged to meet a patient at the local cafe. One patient had painted pictures that were on display in the local community health centre.

Staff arranged advocacy services for patients if required.

## Meeting the needs of all people who use the service

The community mental health team provided a range of mental health services for patients in the local community who met the criteria.

Staff told us that mental health patients were often discharged from the trust hospital without informing the community mental health team prior to the patients' actual discharge date. This had placed these patients at risk of not receiving appropriate follow-up care on time. Although this was a problem with the trust hospital, it would be beneficial for the patients to have this communication problem resolved quickly.

Staff told us the local demographic included many ethnic minority patients, some of whom required an interpreter. Staff confirmed that they arranged to provide an interpreter for the patient's first language. We saw that it was recorded in the care records for certain patients that the patient needed a translator, and staff attempted to obtain a translator for the patient.

Staff ensured that patients were given leaflets explaining their condition in the patient's first language.

Patients were also given leaflets about their legal rights and the names and contact numbers of mental health advocates.

Patients could access information leaflets in the clinics about community social and educational activities.

The premises had been adapted to provide easy access for wheelchair users.

Staff were able to communicate effectively with patients who had a learning disability or autism as well as a mental illness. We accompanied a member of staff to visit a patient with autism.

### Listening to and learning from concerns and complaints

Staff gave patients contact numbers to phone if they had any concerns. Staff said patients usually raised their problems and concerns with their care co-ordinator. There were complaints and suggestions boxes available in the reception areas and there were posters and leaflets about the complaints process. Staff said they would try to resolve any issues raised by patients or their relatives informally. Staff said they had learnt from concerns raised by patients or their relatives.

This core service received 41 complaints between 1 June 2016 and 31 May 2017, 31 of which involved a mental health patient. The greatest number of complaints were made in relation to two other locations that we have not inspected on this occasion.

The community mental health service had received 29 compliments during the last 12 months between 1 June 2016 and 31 May 2017, which accounted for 14% of all compliments received by the trust as a whole.

## Is the service well led?

### Leadership

The majority of staff reported that they had very little contact with the trust executive team and senior managers. Some staff said they had met the Chief Executive. Staff said they received updates on trust developments through the local team leads and via email and the intranet.

The team leaders had the skills, knowledge and experience to perform their roles. The team leads had an open door policy and made themselves available to staff and patients.

We spoke with team leads, clinical leads and a consultant psychiatrist. We found they had a good understanding of the services they managed. We met staff who had opportunities for leadership development and who had become team leads very recently.

Staff were well supported by the team leads, clinical leads, consultant psychiatrists and psychologists who worked at the respective sites. At the Pocklington and Goole service, staff morale was generally low because of the transfer of the Pocklington service to another trust. Staff said they were anxious and concerned about the forthcoming changes as the executive team had given very little information about the impact this would have on them. Some social workers had expressed their anxiety about the impending review of the section 75 agreement between the local authority and the trust.

The move of the Pocklington Team to the new trust would also affect the way the service was managed at Goole, as the consultant psychiatrist, the psychologist and the occupational therapist worked across both sites.

## Vision and strategy

The trust vision stated that the trust will 'work with accountability, integrity and honesty; nurture close and productive working relationships with other providers and our partners'. The service was partly achieving this, with community teams working side by side with social workers from the local authority.

Staff showed they were aware of the meaning of the trust's values of Caring, Learning and Growing. Caring meant caring for people while ensuring they were always at the heart of everything the staff did. Learning meant learning and using proven research as a basis for delivering safe, effective, integrated care. Growing meant growing the trust's reputation for being a provider of high-quality services and a great place to work.

The trust values further stated that the trust would 'unify and focus our services on early intervention, recovery and rehabilitation'. The service was working towards improving the health of patients in their care through early intervention, recovery and assisting them to re-establish their daily lifestyle and assisting them to maintain a good quality of life.

## Culture

During the last 12 months, there have been no cases where staff have been suspended or placed under supervision in this core service.

We observed a culture of openness and transparency at local level with good team support among the managers and staff. Several staff reported they had been under pressure due to high caseloads and large geographical areas. Staff at Pocklington and Goole were especially anxious due to the takeover of Pocklington, which had an impact on staff who worked at both sites.

Local leads gave staff support in a number of ways. At Hull West, the team lead had provided a monthly one-to-one 'Time Out' session, which was open to all members of the team; this gave staff the opportunity to discuss any issues that were of concern to them. Similarly, at the Bridlington and Driffield service, the team lead and clinical lead had an open door policy for members of staff, which had helped them overcome the pressure of work. The psychologists had held monthly staff support sessions on their respective sites.

## Governance

The trust's board assurance framework detailed any risk scoring 12 or higher and identified any gaps in the risk controls which could affect the trust's strategic ambitions. None of the six strategic ambitions outlined by the trust related to this core service.

The trust provided a document detailing their two highest profile risks. Each of these had a current risk score of 15 or higher. Neither related to this core service.

The trust had a clear framework of what should be standing agenda items at a ward team or directorate level meetings to ensure that essential information such as learning from incidents and complaints were both shared and discussed.

The trust had systems and procedures in place to ensure the premises were safe and secure. Staff were trained and supervised; patients were assessed and treated well.

Incidents were reported, investigated and learned from.
Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level.

Staff undertook regular audits of case notes, medication and peer reviews of staff performance to ensure good governance so that patients received high-quality care.

Staff understood arrangements for working with other teams both within the trust and externally, to meet the needs of patients.

## Management of risk, issues and performance

The trust had a risk register that was constantly under review. There was an associated action plan to drive improvement. Staff said they discussed risks at team meetings and were aware of the process to escalate a risk if needed.

Managers and team leads discussed risks in business meetings and partnership board meetings, with representatives of the trust and the local authorities present. Relevant information had been cascaded to frontline staff.

## Information management

The Trust had introduced an electronic patient record system from October 2016. However, the system was still under development to meet specific needs in the community. The trust had provided training and support to all staff and there was a staff champion on each site in the community mental health team to support individuals. However, some staff in the community mental health team found the system was not user-friendly.

Staff had to log in to the system and it was recorded when staff accessed to patient records. This had ensured unauthorised users could be traced. Staff were aware that patient information had to be kept confidential and that they must log out of the system when they were not using it.

Social workers and care staff said they had to enter the same information into two computer systems, one for the trust and one for their employer, the local authority. They said this was time consuming and took up time they could otherwise spend with patients.

## Engagement

Staff were consulted and involved in regular discussions about continuous improvement initiatives, such as the health improvement programme and the discharge-planning forum.

Staff demonstrated an enthusiasm to improve the way they work. The psychiatrists and psychologists worked well with the managers and other staff to find ways of improving the service to the benefit of both staff and patients. They offered help and support to the frontline staff, including one-to-one sessions to help staff overcome stress and anxiety due to the nature of the work.

Patients had been encouraged to give their views and feedback about the service through comment cards, meetings with their care co-ordinator and patient surveys.

## Learning, continuous improvement and innovation

The service had recognised that the patient electronic recording system required improvement for greater efficiency. Some staff had visited other trusts using the same system to look at how the system could be developed and used to improve performance.

The Bridlington and Driffield team also participated in the implementation of the stress management standards of the Health and Safety Executive.

The Bridlington Team was conducting a pilot scheme from September 2017 to February 2018 in which nurses from the Bridlington team were assessing all non-urgent cases previously assessed by the rapid response team. Patients then progressed to the Bridlington catchment area for allocation to their respective care co-ordinators. Nurses involved felt positive about taking on the additional role, as it would enhance their skills in undertaking the initial assessment. This would reduce pressure on the rapid response team for six months.

Hull West participated in a number of projects including the hospital discharge model; the sub-clinical network quality development plan, review of deaths (October 2016 to April 2017) and a gap analysis action plan, which was an Excel spreadsheet highlighting areas of non-compliance with National Institute for Health and Care Excellence guidelines, to minimise risk to patients.
NHS trusts were able to participate in a number of accreditation schemes. Services will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries a review date on which the service needs to be reassessed in order to continue to be accredited.

This core service was not currently involved in any accreditation schemes.

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

## Facts and data about this service

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| Miranda House | Rapid Response Service | N/A | Mixed |

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

The Rapid 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 Rapid 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 admission to hospital inpatient wards.

From triage of referrals, the service provides urgent mental health assessment and Mental Health Act assessments for people who are could be at 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 and provides signposting to and 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. The crisis pad is a place that provides immediate access to care and support for people experiencing severe distress. At the last inspection, the core service was rated as 'good' overall. We rated the key question 'safe' as 'requires improvement' and 'effective', 'caring', 'responsive' and 'well-led' as 'good'. At

this inspection, we inspected all of the key questions. Our inspection was short notice 'announced' by one working day (staff knew we were coming) to ensure that everyone we needed to talk to were available.

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 Rapid Response Service and place of safety at Miranda House and observed how staff were caring for patients
- completed four observations which included: a mental health assessment, a home based treatment appointment, an admission to the place of safety and a reflective practice session for staff
- interviewed the director and assistant directors of the care group with overall responsibility for the service
- interviewed eight other staff members including: service manager, team leader, consultant psychiatrist, approved mental health professional, nurses, social worker, health care assistant and a senior administrator.
- spoke with three former patients admitted to the place of safety
- spoke with three carers of patients using the Rapid Response Service
- spoke with two patients using the Rapid Response Service
- reviewed eight patient records of patients using the Rapid Response Service
- reviewed five patients records of patients who had used the place of safety
- reviewed a range of documents relating to the running of the service.

# Is the service safe?

## Safe and clean environment

### Mental health crisis service

The trust had ensured that the service had regular and up to date risk assessments of the care environments used by staff and patients at the Rapid Response Service.

The Rapid Response Service mainly saw patients in the community either at their own homes or at local clinics in the community. Staff could also see patients at Miranda House. Miranda House had four interview rooms and a police waiting room. All of these rooms were fitted with alarms. Staff told us that they responded quickly to the alarm when this sounded. Lights outside of the interview rooms showed where the alarm had been activated. The service did not have allocated responders so any staff member available usually responded to the sound of the alarm.

The Rapid Response Service did not have a dedicated clinic room. Staff used the clinic room of the Electroconvulsive Therapy department at Miranda House when needed.

All areas used by the Rapid Response Service were generally clean and the service had regular cleaners on site. The service had equipment available to maintain infection control principles for example, hand washing. Staff used this equipment appropriately.

Staff took equipment used for monitoring physical health out for use in the community at the beginning of each shift so this was not available for us to review during our inspection.

The service had interview rooms at Miranda House that were not well looked after. The walls had marks above radiators where paint had discoloured, scuffs and dark mark shapes left from previous items that had been hung on the walls. Walls had screw plugs exposed where items had previously been on the walls. Plastic trunking was in place on the walls with sockets at waist height from the floor. Carpets were worn and stained in places with black marks. Furnishings in interview rooms were worn and mismatched with chairs all different shapes and sizes. The estate strategy for the trust had not identified any planned works to improve these areas at Miranda House.

**Health Based Place of Safety**

The trust had one place of safety at Miranda House. Since our last inspection, the trust had undertaken work to refurbish and make improvements to the suite. The place of safety was well-maintained and the furniture was in good condition. The suite was fitted with anti-ligature fixtures and fittings. It also now had a toilet and shower area. This area of the suite was not monitored by closed circuit television, which promoted privacy and dignity. It was also an observation blind spot. Staff told is that they would monitor any patient who they assessed to be at risk in this area whilst they were using it. The suite did not have any other blind spots. Doors had large window spaces and close circuit television that enabled staff to observe patients using the suite. The suite had four seats that were appropriate and should not cause injury. Staff completed regular risk assessments of the environment.

Staff at the place of safety had access to mobile alarms and a mobile telephone. The Rapid Response service responded to provide assistance when required.

The place of safety was mostly clean. However, the chairs in the place of safety required cleaning as these were soiled. The cleaning roster for the section 136 suite stated that this area should be cleaned daily. If the suite was used more than once per day this would not be sufficient to ensure it was cleaned before each use.

The place of safety had a clinical assessment area. This area had a blood pressure monitor and a defibrillator. Prior to 28 August 2017, this had not been checked. A manager confirmed that the defibrillator was only in place from this date onwards. Before then the emergency equipment and medicines would be obtained from neighbouring wards. Staff had mobile alarms when working in the 136 health based place of safety to call for assistance when needed.

## Safe staffing

### Mental health crisis service

The trust reported the following key staffing indicators in relation to the Rapid Response Service compared with the trust target. Please see the table below:

**Definition**

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many the trust want or think they need in post.

| Substantive staff figures | Date | Core Service | Trust target |
|---|---|---|---|
| Total number of substantive staff (WTE*) | At 31 May 2017 | 74 | N/A |
| Total number of substantive staff leavers | 1 December 2016 – 31 May 2017 | 13 | N/A |
| Average leavers over 12 months (%)(WTE*) | 1 December 2016 – 31 May 2017 | 2% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | 1 June 2016 – 31 May17 | Average 8 (range 6 - 12) | N/A |
| Total vacancies overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 11%<br>Range 7% – 13% | Not provided |
| Total permanent staff sickness overall (%) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 8%<br>Range 1% - 21% | 5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 45<br>Range 37 - 53 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 7<br>Range 6 – 11 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 6<br>Range 4 – 8 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 1<br>Range 0 – 4 | N/A |
| Qualified nurse vacancy rate | At 31 May 2017<br>1 June 2016 – 31 May 2017 | Average 13%<br>Range 7% – 20% | Not provided |

| | | | |
|---|---|---|---|
| Nursing assistant vacancy rate | At 31 May 2017<br><br>1 June 2016 – 31 May 2017 | Average 12%<br><br>Range 0% – 35% | Not provided |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 June 2016 – 31 May 2017 | 380 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 388 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 June 2016 – 31 May 2017 | 320 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 253 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 13 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 June 2016 – 31 May 2017 | 151 | N/A |

*Whole Time Equivalent

The trust reported that the service had a vacancy rate of 12% for registered nurses and 16% for nursing assistants.

As of 31 May 2017, the staff sickness rate was 4% and staff vacancy rate was 13% for this service. Between 1 December 2016 and 31 May 2017, 13 staff left this service. This was staff turnover rate of 2%. We could not compare this data to that reported at the last inspection to see if this was better or worse.

The Rapid Response service had determined a minimum staffing level. These were:

- Days (8am until 8.30pm) nine staff that comprised two band six, two band five, one nursing assistant and an approved mental health professional. In addition, for home based treatment an additional nine staff that comprised : six qualified staff, three nursing assistants and a band 7 qualified staff.
- Nights (8pm until 8.30am) one approved mental health professional, two band six, one band five, one nursing assistant.

Staff did not hold individual caseloads; the service had a shift co-ordinator each shift that organised the assessments and visits required.

The service used bank and agency staff to provide cover for vacant posts and absences. Between 1 December 2016 and 31 May 2017, bank and agency staff covered 1034 shifts to cover sickness, absence or vacancies. A further 471 shifts during this period were not filled. At the time of our inspection, the service had escalated the staff recruitment difficulties to the trust risk register.

The service had a full time consultant psychiatrist and a full time associate specialist doctor. Between 6pm to 8am Monday to Friday and at weekends, the service accessed doctor through the out of hours on call system.

Overall as of 31 March 2017, staff in this service had undertaken 63% of the various elements of training that the trust had set as mandatory. This was similar to the overall trust average mandatory training rate. The staff in this service had not achieved the trust training target in five courses. These courses are indicated in the table below. The trust did not provide training to all staff in paediatric and adult basic or immediate life support and managing violence and aggression.

Safeguarding adults had the highest training compliance with 100%. Conflict resolution scored the lowest out of all the training courses with 68%.

The trust was unable to provide the data for five training courses within this timeframe.

Key:

*Below CQC 75%*

| Training course | This core service | Trustwide mandatory training total % |
|---|---|---|
| **Safeguarding Adults** | 100% | 99% |
| **Information Governance** | 99% | 98% |
| **Mental Capacity Act** | 96% | 97% |
| **COSHH** | 88% | 88% |
| **Health and Safety** | 87% | 86% |
| **Fire Safety** | 85% | 80% |
| **Display Screen Equipment** | 83% | 83% |
| **Prevent** | 81% | 84% |
| **Infection Prevention and Control** | 73% | 79% |
| **Moving and Handling** | 71% | 77% |
| **Safeguarding Children** | 71% | 81% |
| **Equality and Diversity** | 69% | 71% |
| **Conflict Resolution** | 68% | 70% |
| **Paediatric Basic Life Support** | Not required | Not required |
| **Mental Health Act** | Not required | Not required |
| **Basic Life Support** | Not required | Not required |
| **Immediate Life Support** | Not required | Not required |
| **MAPA** | Not required | Not required |
| Grand Total | 82% | 84% |

### Health based place of safety

The Rapid Response Service provided staffing for the place of safety at Miranda House. Each shift a staff member was allocated as the 136 co-ordinator and they ensured that the place of safety had sufficient staffing required. The Rapid Response Service had staff at Miranda House 24 hours per day and could provide staff to the place of safety at any time.

**Assessing and managing risk to patients and staff**

## Assessment of patient risk

### Mental health crisis services

We reviewed eight patient records. All records contained an initial assessment of risk at triage stage and a full risk assessment completed at the assessment stage. Staff used a risk assessment

tool developed by the trust. This was integrated into the mental health assessment document. Staff had updated all risk assessments within the seven days prior to the inspection.

All the patient records reviewed had a brief crisis plan. This detailed the contact details for the Rapid Response Service which operated 24 hours per day. We saw that two records contained additional detail that referred to previous risk and relapse plans for patients that had previously accessed mental health services. These contained more detailed information about crisis reduction steps that patients could take. All patients and carers that we spoke with knew the contact details for the Rapid Response Service.

**Health based place of safety**

Each shift a registered staff member was allocated the 136 co-ordinator role from the Rapid Response Service. They completed a joint initial risk assessment with the police when people arrived at the health based place of safety. The risk assessment covered areas which could indicate a risk posed to or from the individual including: self-harm, suicidal thoughts or actions, substance use, self-neglect, physical violence and aggression, delusions and hallucinations, social circumstances, cultural or lifestyle factors and the views of others. Staff then used this information to categorise the level of risk as low, medium or high risk. Each risk rating had description of what factors indicated the level of risk and what action was required to manage and mitigate these risks. Where the initial risk assessment indicated a high risk, the police remained at the health based place of safety.

**Management of patient risk**

**Mental health crisis service**

Once staff had triaged and offered patients an assessment at the various targets, for example, within 4 hours, 24 hours or 14 days. They provided patients with the details for the Rapid Response Service for if their health deteriorated and the waiting time could be reviewed.
Staff observed and monitored patients in the health based place of safety. The suite had sufficient lines of sight and close circuit television enabled staff to observe the patient in the suite with the exception of toilet and shower areas.
The service had personal safety protocols in place for staff. The service standard operational policy outlined that staff had the right not to enter dangerous situations without adequate support. Staff worked in twos where there were potentially increased risks and used support from the emergency services for high risk situations. All staff had access to mobile phones and used a board to sign in and out of the service. Staff recorded the location, name of the patient they were seeing and their expected return time. Each shift a co-ordinator ensured that staff had returned from visits and staff maintained regular contact throughout their shift with the shift co-ordinator. The service had a risk assessment in place for student nurses to ensure that appropriate safeguards were in place.

**Health based place of safety**

For patients in the place of safety staff completed a 136 observation plan. This plan required staff to consider the risk that observation needed to manage and the support the patient required. Staff carried out observations at a maximum interval of 15 minutes. Staff discussed the observation plan with the senior crisis practitioner when the presentation of the patient changed to ensure that the level of observation was appropriate to safely manage risk.

Prior to patients' arrival at the place of safety patients should have had a physical health screen completed by the ambulance services. The trust's protocol for the place of safety outlined national early warning signs in line with guidance from the Royal College of Physicians on National Early Warning Scores. National Early Warning Scores involve using physical health observations to identify and detect acute physical illnesses in patients. Staff undertook six physical health observations that included respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness in order to identify scores. Staff combined the scores to provide an overall early warning score. The trust protocol provided guidance for staff on what action they should take when a score was low (one to four), medium (five and six) and high (seven or more). Staff could identify deterioration of patients' physical health through any changes recorded in the warning scores or observations.

The service allocated a band six 136 co-ordinator for the place of safety. They allocated a member of staff to be responsible for the place of safety when in use. When the place of safety was in use there was always at least one staff member allocated to the place of safety. The level of staff was dependent on the risk assessment completed when the patient arrived at the place of safety. Staffat the place of safety had access to a mobile telephone at all times and a mobile alarm. During our inspection, we observed the place of safety in use and saw that staff followed personal safety protocols in place.

## Safeguarding

### Mental health crisis services

Staff understood how to protect patients, adults and children at risk of significant harm. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff told us that they identified potential safeguarding concerns during their observations and interactions with people. They told us that they used their professional knowledge and followed the protocols in the training that they had attended. They discussed safeguarding concerns as a multi-disciplinary team and shared information between agencies. Where staff needed to seek advice they told us that they could speak to social workers in the team.

The training provided covered the Think Family agenda. The Think Family agenda is aimed at increasing the awareness of parental mental health on children's welfare and places an importance on a family approach.

The initial mental health assessment provided prompts for staff to gather information to identify adults and children that may be at risk of significant harm. Staff asked patients whether they had experienced past or present domestic violence, experienced abuse at any time in their lives, social circumstances and details of the children or expected children within the household.

The trust was unable to provide specific details on the amount of safeguarding referrals made by this service.

### Health based place of safety

The trust was unable to provide specific details on the amount of safeguarding referrals made by this service.

When patients arrived at the place of safety, staff ascertained whether they had responsibility for children or vulnerable adults. Staff ensured that alternative carers were in place in the immediate and short – term.

## Staff access to essential information

### Mental health crisis services and health based place of safety

The trust had an electronic patient records system. Some staff told us that this system was not user friendly because it was difficult to navigate. Staff mainly used electronic records. At times staff recorded information on paper records and the team later scanned these into the electronic system. Staff told us that there were differences in the way that some areas of the trust used the electronic record system and this meant that information was not always stored in the same place for each patient in their electronic record. This took staff longer to find the information they needed. A manager also told us that there had been issues with the electronic system not saving completed assessments. They had escalated this as an issue to the trust to consider whether this should be on the risk register.

## Medicines management

### Mental health crisis services

The service did not stock any medicines and did not have any patient group directives. The service had plans to introduce these in the future. This meant that when staff considered that patients might benefit from medication that they would be required to contact a doctor to organise a visit or appointment with the doctor for consultation.

Out of hours access to doctors was a shared on call doctor with other areas within the trust. This meant that a doctor might not be available to see patients urgently. The trust medication policy stated that prescriptions must only be given or accepted over the telephone in exceptional circumstances. This included when the nurse considered waiting for a prescription any longer was detrimental to patient care. The medication should have also been previously prescribed for the patient. Where the on call doctor prescribed, the trust had a service level agreement with a community pharmacy in Hull for prescriptions. This community pharmacy did not open past 10pm on weekdays and Saturdays and 8pm on Sundays. Some staff that we spoke with told us that if they required medication out of hours they had difficulty in accessing this and would have to access other NHS services for an urgent doctor who could visit out of hours and provide prescriptions.

Staff visited patients to ensure they managed their own medication safely in the community. When patients' had excess medication or it was not safe for patients to have medication, staff would remove medication from patients' homes for disposal and stored this securely when required in line with the trust medication policy.

Staff ensured that other healthcare professionals external to the service monitored patients' physical health including those prescribed anti-psychotic or lithium medicines. However, staff completed antipsychotic medication assessment tools with patients. The tool that staff used to assess the side effects of anti-psychotic medication was the Liverpool University Neuroleptic Side Effect Rating Scale.

### Health based place of safety

The place of safety did not stock any medicines and did not have any patient group directives. The service had plans to introduce these in the future.

### Track record on safety

### Mental health crisis services and health based place of safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 June 2016 and 31 May 2017 there were no serious incidents reported by this core service. This was less than the number of serious incidents reported leading up to the last inspection. The trust reported four serious incidents at the last inspection.

## Reporting incidents and learning from when things go wrong

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

All staff had access to the electronic incident reporting system used by the trust. Staff knew what incidents to report and described situations where they would report incidents. For example, anything that had or could have placed a patient at risk. The trust had an up to date policy on the duty of candour and staff demonstrated understanding of their responsibilities under this duty. They knew that this applied to situations where something went wrong and explained that this would involve informing patients, providing information and an apology.

Managers disseminated information back to staff from investigation of incidents in team meetings. The team discussed the overall findings of serious incidents, lessons learned and actions including changes to practice during team meetings. Team meeting minutes confirmed that managers had feedback to staff changes including the 'did not attend' appointment letter used, ensuring that staff recorded all interactions with internal and external services in the records. The team also discussed good practice identified during investigations. The trust also sent out emails to staff to inform them of any changes. For example, copies of updated policies. Staff told us that the trust had made changes following incidents. These included changes to documentation used and reviewing staffing levels.

Staff provided variable feedback about receiving debriefs and support following serious incidents. However, all staff said that they could ask for additional support should they require it. The trust also had an occupational health service that staff could access for support and they could access counselling sessions. The service also had a weekly reflective practice session with a psychologist.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been zero ‘prevention of future death’ reports sent to Humber NHS Foundation Trust.

# Is the service effective?

**Mental health crisis services**

The service had a comprehensive mental health assessment template for staff to follow when completing assessments of patients. Staff obtained information about patients’ mental health including history of presenting mental health issues, mental health involvement current and past, medical information, medication, substance use, personal history, mental state, cognitive ability, screening of risk factors historical and in the last six months. We reviewed eight records and all of these contained detailed information to assess patients’ mental health.

Staff asked patients for information about their physical health needs and communicated with patients’ local GPs. All of the eight records that we reviewed recorded whether patients had any known allergies, health conditions, and current prescribed medications and whether patients had a GP. Staff asked patients whether their GP had ruled out any physical causes during assessments and they sent correspondence to patients named GPs.

Staff created an initial plan of care with patients during their assessment. This formed an immediate and basic care plan aimed at meeting their individual assessed needs. Patients’ care plans were personalised and recovery oriented. The types of treatment and interventions agreed in care plans included: referral to community mental health teams, referral for emotional regulation sessions, referral for support with maladaptive behaviours, home visits and telephone calls from home based treatment, medication reviews with consultant psychiatrist and referral to external organisations for counselling. All of the eight care plans reviewed were recently created and within the review dates.

**Health based places of safety**

Staff searched for information about patients who used the place of safety. They identified whether patients were known to services and for any information about their care and support needs including their mental health background. Staff completed the initial screening tool that covered risk factors and warning signs. Approved mental health professionals completed mental health assessments.

We reviewed five records relating to patients who had used the place of safety. We found that all five records were incomplete. Examples of where staff had not recorded information included GP details, evidence that staff provided patients with a copy of their rights and departure time of the police. Staff submitted paper based records for scanning onto the electronic patient record system.

## Best practice in treatment and care

**Mental health crisis services**

The Rapid Response Service was the single point of access into mental health services. Staff triaged referrals and signposted some patients and referrers to access external organisations for specific support where referrals did not meet the urgent and non-urgent criteria. The Rapid Response Service completed mental health assessments and could offer immediate care and treatment interventions when required for example, accessing consultant psychiatrist appointment for medication and referral to talking therapies. Staff also referred patients on to community mental

health teams for specific interventions for example, emotional regulation and support with maladaptive behaviours and for the trust's recovery college sessions. Patients who received home based treatment from the Rapid Response Service received care and treatment interventions for a short period. These varied depending on the patients' individual needs. The team comprised registered nurses, healthcare assistants, social workers and an occupational therapist. This was in line with clinical guideline 133 from the National Institute for Health and Care Excellence.

Staff referred patients back to their GP for monitoring of physical health needs. We reviewed care records and found that staff checked whether patients had a GP and saw examples where staff had clarified whether the GP had ruled out physical health issues and followed up to check that patients were receiving medical treatment for physical health conditions disclosed.

Staff obtained information regarding patients' lifestyles including smoking cigarettes, consumption of alcohol and the use of substances and non-prescribed medicines during assessments. At assessment stage staff asked whether patients would like to access smoking cessation advice. Where patients had told staff they consumed alcohol or used substances staff completed a tool called the alcohol use disorders identification tool and a brief screening tool for substance misuse. The alcohol use disorders identification tool created a score that corresponded to best practice guidance from the National Institute of Health and Care Excellence and recommended interventions for staff to offer. Staff also referred patients to local services for support with alcohol and substance use.

Staff from the home based treatment team told us that they used an anti-psychotic assessment tool to assess side effects. Staff also used the Patient Health Questionnaire 9 and the Generalised Anxiety Disorder Assessment 7 to assess, monitor and measure outcomes for patient with depression and anxiety.

Information provided by the trust showed that the service participated in four clinical audits as part of their clinical audit programme 2016 – 2017. These can be seen in the table below:

| Core service | Audit type | Objective |
|---|---|---|
| **Trust wide** | Local clinical audit | To audit system one compliance. |
| **Crisis and Health Based Place of Safety** | Local clinical audit | To audit care review record keeping of patients who have risk indicators of self-harm and or suicide. |
| **Trust wide** | Local clinical audit | To re-audit Electroconvulsive Therapy (ECT) documentation and adherence to clinical guidelines. |
| **Trust wide** | Local clinical audit | To Audit clinical equipment on inpatient units |

We requested a copy of the audit completed into the care review record keeping of patients who have risk indicators of self-harm and or suicide. The trust told us that they had not carried out a specific audit into this but the service had developed an audit tool to look at this in the future.

### Health based places of safety

Staff ensured that on arrival at the place of safety that patients had had a physical health screen. On arrival, staff undertook physical health observations and used these to calculate early warning scores for any underlying acute physical health conditions.

Staff completed an outcome plan with patients before they left the place of safety. This discussed the outcome of the assessment and the details of ongoing support arrangements. The outcomes depended on the individual mental health needs and this could involve: discharge as the patient was not experiencing a mental disorder, referred to Rapid Response Service or community mental health team, an informal or formal admission to an inpatient ward.

## Skilled staff to deliver care

### Mental Health Crisis Services

The team had access to a range of staff required to meet the needs of patients that included: doctors, nurses, approved mental health professionals, social workers, an occupational therapist, healthcare assistants and administrators. The team also had access to a psychologist for one day per week. Staff told us that this was in relation to providing input to staff and we saw that the psychologist led a weekly reflective practice session for staff. Where staff identified that patients required the input from other specialists they could ensure that patients had access to this through external or internal services available within the local areas. Patient care records showed that staff referred patients to other teams within the trust to receive input for specific support and interventions.

Staff had experience and qualifications. The service had developed a local induction and this supported new staff including those working on bank and regular agency basis within the team. The local induction provided staff with: key information required, checklists of tasks staff should complete and supported learning competency assessments. On completion of the local induction, staff received a statement of competence that managers retained in the staff records.

The service had weekly team meetings and administrative staff had monthly team meetings. Most staff could attend team meetings when there was sufficient cover to maintain the service. Staff who did not attend team meetings had access to team meeting minutes. We reviewed the minutes and these showed that staff attended team meetings regularly. They recorded minutes to ensure staff had access to information discussed and actions to complete that they needed to know.

The appraisal rates for all staff fell below the trust target rate of 85% for appraisals of staff performance. At 31 May 2017, 79% of non-medical staff had received an appraisal. This was slightly higher than the trust average appraisal rate and since our last inspection; the service appraisal rate had improved by 7%.

Please see the table below which shows the appraisal rates for staff who worked in non-medical roles.

| | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service total** | 81 | 71 | 88% |
| **Trust wide** | 1339 | 1063 | 76% |

Managers and staff confirmed that they received supervision regularly. For the period between 1 June 2016 and 31 May 2017, the trust were unable to provide clinical supervision data for this service. At the time of our inspection, the service was organising clinical supervisors for staff to receive clinical supervision. Staff also had access to a weekly reflective practice session with a psychologist.

Staff had access to additional training to develop their skills. At the time of our inspection, some staff were in the process of completing training, which included leadership, non-medical prescribing, best interest assessing and dialectical behavioural therapy. Managers had spoken to staff about their learning needs. At the time of our inspection, the service had identified that staff wanted more training in dealing with distressing and difficult telephone calls and had organised some training to support staff. The service had a development plan that outlined plans to provide additional training in personality disorder, self-harm and suicide, capacity and consent.

Managers explained how they dealt with poor staff performance through the trust's policies and procedures with support from human resources department within the trust.

### Health based places of safety

The Rapid Response Service had a 136 co-ordinator who was a registered nurse working in a band six post or above each shift. They had the skills and experience required to ensure the correct arrangements for the prompt assessment of patients detained under section 136 of the Mental Health Act.

## Multidisciplinary and interagency team work

### Mental health crisis service

The service had daily multi-disciplinary meetings. The shift co-ordinator and team set out the assessments and appointments for each shift. The Rapid Response service staff and the home based treatment staff each attended a shift handover twice daily. Staff who provided home based treatment worked between 8am and 8.30pm each day. They ensured at the evening handovers that staff working on rapid response knew information about patients who may need out of hours crisis and urgent assessment and interventions.

Similarly, at the morning handover, staff who worked in rapid response ensured that staff from home based treatment were informed of involvement during the night for patients that were in receipt of home based treatment.

The service had a clinical lead who worked within a bed management role for inpatient services. Each morning staff from the Rapid Response Service attended the morning meeting for the acute inpatient wards.

Staff worked closely with community mental health teams. The Rapid Response Service received all contacts through the single point of access. They completed non-urgent mental health assessments and passed these to community teams for treatment and interventions. The Rapid Response Service provided home based treatment and out of hours crisis for patients receiving services from community teams. When patients had completed their home based treatment, staff worked with community teams to support patients' transition to their services. If patients had input from mental health crisis services out of hours, staff from the Rapid Response Service would ensure they communicated to staff at the community team.

External agencies reported some barriers to interagency teamwork with the Rapid Response Service. This included difficulty in contacting the Rapid Response Service for non-emergencies, more than one staff requesting updates on the same assessments and limited information to complete Mental Health Act assessments.

### Health based place of safety

The service also had close working links with external services including local authorities, the police and ambulance services. Managers from the service regularly met with the local police service to work together on the provision of the health based place of safety. Minutes from these meetings showed that these agencies worked together to identify any issues and discuss the provision of the place of safety and resolve these issues. Examples of issues discussed and resolved included: ensuring staff from each agency were clear on their role and the expectations of their responsibilities and managing the access to the service by telephone and through the introduction of a police waiting room.

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

### Mental health crisis services

Staff understood their roles and responsibilities under the Mental Health Act. Although, the trust did not provide Mental Health Act training as a mandatory requirement, they reported that as of 21 June 2017, 76% of staff had had training in the Mental Health Act. The trust was unable to provide Mental Health Act training figures as of 31 May 2017. Staff could renew their training in the Mental Health Act every three years. We could not compare the data from this inspection to that reported at the last inspection to see if this was better or worse.

Staff explained that they could seek advice from the central mental health legislation office at the trust. This was only accessible within working hours and the Rapid Response Service team worked 24 hours per day.

Staff could access any of the trust policies and procedures online at any time. The team did not frequently work with patients detained on community treatment orders or those subject to guardianship under the Mental Health Act. Staff sign posted patients and other contacts to independent mental health advocacy services.

The service had oversight over patient aftercare. The patient electronic records had capacity for previous detention history and this indicated whether a patient was eligible for section 117 aftercare services in line with the Mental Health Act and the code of practice.

### Health based places of safety

The service had a protocol for the implementation of Section 136 of the Mental Health Act document. The trust had ensured this was up to date with relevant policies and procedures that reflected most recent guidance. The trust ratified the policy with changes due to take place with the introduction of the Policing and Crime Act 2017 and indicated what the changes would be from late 2017. For example, that the section 136 detention at a place of safety should not exceed 24 hours. The protocol also referred various best practice guidance from the National Institute for Health and Care Excellence.

Staff told us that patients detention to the 136 health based place of safety was for the shortest time possible and staff aimed to complete a Mental Health Act assessment of the patient as soon as possible. They told us that detention rarely reached 72 hours that was in line with guidance in the Mental Health Act code of practice effective at the time of the inspection. We reviewed five section 136 monitoring forms and these showed that all Mental Health Act assessments took place promptly from the patient arriving at the health based place of safety.

Staff told us that they routinely informed patients detained under section 136 of the Mental Health Act of their rights on their arrival at the health based place of safety. We reviewed five section 136 monitoring forms these confirmed that staff informed patients of their rights. However, only two out of five patients' records showed evidence staff offered patients a copy of their rights.

Staff supplied information to detained patients in the 136 health based place of safety. This leaflet stated that a copy of the leaflet would be provided to the patient's nearest relative unless patients told staff that they did not consent to this. The Mental Health Act code of practice does not require staff to inform the person's nearest relative that they have used the 136 suite.

The service did not complete regular comprehensive audits to ensure that staff applied the Mental Health Act correctly for patients detained under section 136 of the Mental Health Act. The service submitted data to the trust and they used this to measure performance for example, the time from detention to assessment, the time spent in the health based place of safety and the level of use. It did not consider any other aspects to ensure the appropriate application of the Act. For example, whether patients had been informed of their rights, had access to legal advice and if treatment was provided whether appropriate consent was sought. Senior staff including managers told us that they had started to collect data for auditing purposes. The service development plan also recorded actions in relation to recording and using section 136 information.

## Good practice in applying the Mental Capacity Act

### Mental health crisis services

Staff understood their roles and responsibilities under the Mental Capacity Act. The trust set training in the Mental Capacity Act as a mandatory training element that staff renewed every three years. As of 31 May 2017, 96% of the workforce had received training in the Mental Capacity Act. We could not compare the data reported at the last inspection to this to see if it was better or worse.

Staff had an understanding of the five statutory principles of the Mental Capacity Act. They said they would support patients to make decisions and where patients lacked capacity they would take into account their wishes, feelings, culture and history. The trust had a policy available for staff to access online at any time. Staff told us that they could seek advice from within the team from Approved Mental Health Professionals and within the trust from mental health legislation office and the safeguarding team. A manager told us that the service was developing some service specific scenario examples to support staff when they may experience contact with people who may lack capacity to make a particular decision.

During mental health assessments, staff asked patients for information about their cognitive functioning. This included considering their capacity. We reviewed eight records and saw in seven of these that staff had recorded information about patient's capacity to consent to the assessment. None of the records that we reviewed indicated that any patient might lack capacity to consent to the assessment. Therefore, we did not see any completed mental capacity assessments or best interest decisions.

Staff also checked whether patients had an advance decision in place to refuse treatment.

**Health based place of safety**

The section 136 protocol outlined that staff could not treat patients for mental disorder without their consent under part four of the Mental Health Act as this is not applicable to 136 detentions. The protocol explained that staff could treat patients where they provided consent and had the capacity to consent. The protocol explained what action staff should take to assess patients' capacity in line with the Mental Capacity Act where someone may temporarily not have the capacity to make a particular decision. The protocol also explained that staff should try to ascertain whether the patient had a lasting power of attorney (for health and welfare). A patient with capacity can arrange for a lasting power of attorney (for health and welfare) to make decisions on their behalf at a time when they do not have the capacity to make decision for themselves.

# Is the service caring?

## Kindness, privacy, dignity, respect, compassion and support

**Mental health crisis services**

During our inspection, we observed interactions between patients and staff. We saw that staff introduced themselves, gave patients enough time and provided the right advice including sign posting patients to external services where needed. They spoke in a respectful way and checked that patients understood what they had discussed and agreed.

We spoke with two patients and three carers of patients who were using the Rapid Response Service. We received variable feedback from patients and their carers. Positive feedback included staff were understanding, flexible and protected their privacy by ensuring their identification badges could not be seen by the local neighbourhood. However, we also received feedback that raised concerns. This included that patients and their carers felt that some staff had been abrupt, condescending and challenging towards patients. They also said that a few staff had been uninterested in the patient during visits. They also told us that there was an issue with communication between the team and this meant they repeated the same conversations with different staff members and missed appointments, as they were not aware when the appointment was.

### Health based place of safety

During our inspection, we observed an interaction between patient using the place of safety and staff. We saw staff introduced themselves, provided information to orientate the patient and provided information of their rights and an explanation of the process. We spoke with three patients who had used the place of safety. They told us that staff treated them with respect and were discreet. They said that staff asked for their consent before speaking to their relatives and were responsive in ensuring they had enough food and drinks. Two patients that we spoke with told us that staff explained their rights but they did not fully understand these.

## The involvement of people in the care they receive

### Involvement of patients

### Mental health crisis service

Staff included the views of patients in mental health assessments. Staff asked patients for their perception of their needs, what the patient wanted from the referral and their preferred options for treatment or interventions. Patients told us that they had care plans and most patients had a copy of their care plan. Patients told us that they were involved in their care plans. However, two patients told us their care plan contained things staff had not discussed with them, for example, eating healthily and exercising.

The trust sought the views of patients and carers using the friends and family test. This was based on one question, which was: how likely would you be to recommend this service to other patients? Between 1 April 2017 and 31 July 2017, five people had completed this survey. Three people had responded to say that they were ‘extremely likely/likely’ to recommend the service and two people had responded that they would ‘neither/don’t know’ if they would recommend the service to other patients.

Patients could access local advocacy services.

### Health based place of safety

Staff provided people in the 136 health based place of safety with an information sheet that explained why they had been brought to the place of safety under section 136 of the Mental Health Act, how long they would be there for, what happens next, appeal rights, treatment, informing nearest relative, changing nearest relative, letters, code of practice and complaints. Two of the patients that we spoke with told us that even though staff explained their rights to them they had not fully understood these.

### Involvement of families and carers

### Mental health crisis services

We spoke with three carers of patients using the service. Two of the carers that we spoke with told us that they felt that staff did not always actively listen to them, use and value their information and experience of the patient enough. They felt that when the patients’ were in crisis that they found it difficult to access a crisis assessment and felt unsupported. However, the mental health assessment document provided prompts to staff to include the views of families and carers. One of the eight records reviewed showed that staff spoke with the patient’s family or carer after the assessment to obtain their views. Staff had recorded on one other patient record that the risk to

the patient did not outweigh the need to maintain their confidentiality as the patient wished not to share information with their family or carers.

The trust sought the views of patients and carers using the friends and family test. This was based on one question, which was: how likely would you be to recommend this service to other patients? Between 01 April 2017 and 31 July 2017, five people had completed this survey. Three people had responded to say that they were 'extremely likely/likely' to recommend the service and two people had responded that they would 'neither/don't know' if they would recommend the service to other patients.
We spoke with three carers and they all told us that staff did not offer them a carers' assessment. One carer told us that they received information that explained they could ask for a carers' assessment. However, staff had prompts to provide carers with information about carer's assessments during mental health assessments. They had set questions to ask carers about their role and any impact caring had on their emotional and physical well-being. Where a carer was aged less than 18 years old, staff considered referring the young carer to an external organisation for support.

**Health based place of safety**

We spoke with three patients who had used the place of safety. One of the patients that we spoke with told us that staff sought their consent before they spoke to their relative. They told us that they did not have the opportunity to speak to their relative before entering the place of safety.

# Is the service responsive?

## Access and waiting times

**Mental health crisis services**

The Rapid Response Service had staff available to assess patients immediately at any time during the day or night in a crisis. The trust target aimed that staff responded to all crisis referrals within four hours. The service maintained a core staffing level at all times during the day and night at Miranda House to respond to incoming contact through the single point of access.

The Rapid Response Service had a standard operational policy which outlined the criteria for who would be offered a service. Staff used a decision matrix for referrals to prioritise referrals into crisis response (within four hours) urgent response (within 24 hours), non-urgent assessment (within 14 days) or if none of these were appropriate signposted to an external relevant organisation.

The Rapid Response Service offered urgent and crisis responses within four hours where patients:

- Had active suicidal ideation with a plan or partial plan or a history of suicidal ideation
- Had rapidly increasing or developing symptoms of psychosis or severe mood disorder
- Exhibited high risk behaviours linked to thought disturbances including self-harm or harm towards others
- Were unable to care for self or dependents, complete daily living activities due to acute mental health presentation
- Required urgent intervention to prevent or contain a relapse.

The Rapid Response Service provided a non-urgent assessment within 14 days where patients:

- Displayed significant client or carer distress associated with serious mental illness with no active suicidal signs.
- Had early symptoms of psychosis
- Required a face to face assessment for diagnosis
- were known to services and required priority treatment or review.
- were stable patient but required specialise mental health assessment
- Other service able to manage the patient until the assessment
- Early cognitive changes in an older person.

Where patients could not wait 14 days for a non-urgent assessment staff in the Rapid Response Service could escalate referrals up for urgent assessment where needed.
Staff triaged referrals and sign posted referrals onto other organisations. This occurred in the following circumstances: where primary care or the voluntary sector would be more appropriate, symptoms of mild to moderate mental health issues, contact required advice or someone to talk to and when providing advice to service providers and issues that do not require mental health services.

The trust target for urgent and crisis response was four hours and for non-urgent assessment was 14 days.

The Rapid Response service also provided home based treatment and they offered this to those:

- Aged between 18-65
- Registered with GP in the Hull or East Riding Clinical Commissioning Group area
- Considered to be at significant risk, for example of self-harm or harm towards others due to mental ill health
- Where the alternative would involve potential inpatient admission and escalation of crisis
- Seen by the referrer on the same day

The team responded promptly when people telephoned the service. The telephone activity reports showed that between December 2016 and August 2017, the Rapid Response service received 46,077 contacts. This was an average of 5,120 contacts per month. The trust provided details of the average telephone wait time between December 2016 and August 2017 for contacts to reach administrators who took initial details. These showed that the waiting time was consistent and all averages were less than one minute waiting time. The trust also provided details of the average telephone wait time for clinical staff between July 2017 and August 2017 and this showed a waiting time of less than one minute. However, feedback from external agencies reported that staff experienced delays in the service answering their calls for non-urgent matters.

The Rapid Response Service's standard operating policy provided a process for staff about disengagement of patients with the service. This explained the action that staff should take when patients did not attend appointments. Staff were required to record the attempted contacts and escalate these to the clinical lead or psychiatrist. Dependent on the patients' individual circumstances staff completed unannounced visits to check patients' welfare and sent out letters to the patient to ask them to contact the service.

During our inspection, we observed staff working flexibly to promote engagement of patients with the service. They saw patients at the service when they arrived even if this was sometime after their agreed appointment.

At times, the home based treatment part of the service worked with patients that required treatment from acute hospitals. Staff working in home based treatment kept in contact with acute hospitals to agree the level of care required whilst the patient was receiving treatment elsewhere. The patients' case would remain open to the team even though they may not have received an active service.

The service met their target times from referral to initial assessment and assessment to treatment. The table below show this information. The time from referral to initial assessment and assessment to treatment is better than that reported at the last inspection.

| Name of hospital site or location | Name of in-patient ward or unit | Service Type | Days from referral to initial assessment | | Days from assessment to treatment | | Comments, clarification |
|---|---|---|---|---|---|---|---|
| | | | Local target | Actual (mean) | Local target | Actual (mean) | |
| Willerby Hill | Rapid Response Service Urgent Care | MH Assessment Services | 1 | 1 | 14 | 0 | Local target in process of re-negotiation with CCG |

**Health based place of safety**

Section 136 of the Mental Health Act is an emergency power used by police officers to remove people from a place that the public have access to, to a place of safety in specific circumstances. Section 136 should only be applied when a person appears to be suffering from a mental disorder and in need of immediate care or control where the police officer believes it is in the interests of the person or for the protection of others.

The place of safety accepted patients detained under section 136 of the Mental Health Act. The service allocated a 136 co-ordinator every shift. The police had a dedicated option on the single point of access number, which went through to the 136 co-ordinator. They ensured that the place of safety was ready to accept the patient. In the event of more than one patient requiring a place of safety at the same time, the 136 co-ordinator would prioritise and keep agencies informed when the place of safety would become available. Alternative places of safety would involve the local emergency department and a waiting room at Miranda House was available so that when the place of safety was in use there was somewhere patients could wait in private with the police until the place of safety was available.

The service ensured that detentions did not exceed the maximum time limits in line with legislation and ensured prompt assessment of patients detained under section 136. At the time of our inspection, the maximum time for detention under section 136 of the Mental Health Act was 72 hours. We completed this inspection prior to the Policing and Crime Act 2017 changes to legislation. The Mental Health Act code of practice outlines that assessments by a doctor and interview by an approved mental health professional should be completed as soon as possible after the person is brought to the place of safety. The trust set a target of commencing

assessment within three hours. Between April 2017 and July 2017, performance reports showed the average time spent in the place of safety was under 5 hours and the average time between detentions to assessment was 2.5 hours. Across the same period, the longest stay at the place of safety lasted 31 hours and the longest time between detention and assessment was 13 hours. In some circumstances, assessments would take place later than three hours for example, where the patient was not fit for assessment. In these situations, staff sought advice whether patients required medical treatment and staff reviewed their fitness for assessment regularly to ensure this was not delayed for longer than necessary.

The Rapid Response team had bed management gate keeping responsibility and if required could organise admission to inpatient wards at any time, they could also provide home based treatment to prevent an inpatient admission.

**The facilities promote comfort, dignity and privacy**

**Mental health crisis services**

Staff could see patients at Miranda House. The service had four interview rooms that they could use to see patients. The service did not have a dedicated clinic room and used a clinic room from a different department within the building. Staff did not report any issues with sufficient space and we saw there was an adequate amount of space for staff to see people. Interview rooms were sound proof. The service had sufficient chairs in the waiting area.

**Health based place of safety**

The 136 health based place of safety was situated on the ground floor. The trust had undertaken work to ensure this was accessible by a dedicated access. This meant that people arriving at the 136 health based place of safety would have privacy and dignity as they would not be seen by other patients or visitors to the service.
The service had a police waiting room where patients waiting to use the section 136 health based place of safety could wait until this was available. This meant that patients could wait somewhere private.

## Patients' engagement with the wider community

**Mental health crisis services**

The Rapid Response Service gate kept access to a crisis pad, which patients could access in the local area. The service also provided information to patients and their carers about other organisations and services in the wider community that they could access.

**Health based place of safety**

On discharge from the place of safety, staff provided patients with an outcome plan that outlined any ongoing support arrangements.

## Meeting the needs of all people who use the service

**Mental health crisis services**

Staff saw patients in the community in their own homes, local clinics or at Miranda House. Miranda House had four interview rooms on an upper level which patients and visitors could access using a

lift or stairs. The upper level had an evacuation chair that meant that in the event of a fire disabled patients or visitors could be evacuated safely when the lift could not be used.

Staff gathered information on patients in line with the accessible information standard. Staff asked patients for information during mental health assessments about any specific requirements for accessing, understanding, support and information. The assessments also asked for information on how staff would meet these needs. Staff had not identified any additional needs in any of the records that we reviewed.

Staff could access information in different languages from the trust for patient using the Rapid Response Service. The trust also had access to interpreters and signers who could assist communication between staff and patients.

#### Health based place of safety

The place of safety at Miranda House had ground floor level access. The place of safety did not have any information leaflets; however, staff could access information leaflets for patients from within the service. Staff could access information in different languages. The trust had access to interpreters and signers who could assist communication between staff and patients.

### Listening to and learning from concerns and complaints

#### Mental health crisis services

Between 1 June 2017 and 31 May 2017, the service received 16 complaints. The amount of complaints received was lower than the amount reported at the last inspection. The trust did not provide information to show the outcome of complaints and if any complaints were referred to the ombudsman. Patients that we spoke with told us that they could complain by using the patient advice and liaison service and they could access information about this in the waiting room at Miranda House. Staff told us that the service took complaints seriously, investigated these and fed back the outcome to the complainant and staff. The trust ensured that they communicated changes to practice to staff through team meetings and emails. Staff gave an example of how the service had changed the phrases in the letters sent to patients who had not attended appointments within the service. They told us that they had amended the wording into a more empathetic way.

#### Health based place of safety

Between 1 June 2017 and 31 May 2017, there were no complaints made regarding the place of safety. Patients who used the place of safety told us that staff provided then information on their admission that explained how they could raise a complaint. We saw the information sheet provided to patients also showed information on how patients could raise concerns.

## Is the service well led?

### Leadership

#### Mental health crisis services and health based place of safety

Leaders had the skills, knowledge and experience to perform their roles. Managers and directors of the service had a good understanding of the Rapid Response Service and the 136 health based place of safety. They had been involved in the transformation of the service and its redesign. They

explained how the team worked to provide the service and were aware of the development and improvement plans for the service.

Staff told us that managers up to the service manager level were very visible in the service and present most days per week. Service directors also visited the service, but less frequently. All staff that we spoke with felt that leaders up to service manager level were approachable and most staff felt that leaders at director level were approachable.

Staff had opportunities for leadership development. They told us that the service had opportunities for career development and more senior roles for staff to apply for. Managers had expectations that staff would take on leadership roles to set an example for staff with less experience. Team leaders had the opportunity to undertake a leadership qualification provided by the trust.

## Vision and strategy

### Mental health crisis services and health based place of safety

The trust had a vision statement that was: “we aim to be recognised as a leading provider of integrated health services, recognised for the care compassion and commitment of our staff. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with problem solving approach.” The trust had values and explanation of what the values meant in practice. The trust values based on quality and sustainability.

During our inspection, we saw that the service had the trust vision and values displayed. Managers told us that they embedded the trust values into documents and team meetings to make these apply practically to the services provided. Our observations of staff during the inspection confirmed that staff demonstrated the trust values. They worked flexibly and saw patients outside of agreed times.

Since our last inspection, the trust had redesigned mental health crisis and health based place of safety services. The trust invited staff to participate in the design of the service at different stages of the process. After the opening of the Rapid Response Service, the service held development days where staff could attend and share their vision and ideas about the development of the service in the future. These sessions feed into an overall development and improvement plan for the service with clear actions, dates and identified staff to oversee.

Staff told us that they thought the service provided the best care they could within the resources they had. Sometimes they felt that it was not always possible to deliver high quality care because of shortages in staffing. The service had a difficulty in recruiting staff and hey had escalated this to the trust risk register.

## Culture

### Mental health crisis and health based place of safety

All staff told us that they felt respected, supported and valued by their colleagues and managers up to the service manager level. Some staff felt supported and valued by the trust. The results from the last staff survey were not available at this core service level.

Staff understood what whistleblowing was and where they could access the policy. However, two of the staff that we spoke with told us that would be reluctant to raise concerns, as they would fear retribution. None of the staff up to the director and assistant director of the care group level knew

what or who the Freedom to Speak Up Guardian was. It is a requirement for all NHS trusts to have a Freedom to Speak Up Guardian. A Freedom to Speak Up Guardian work with trust leaders to create a culture where staff can speak out safely to protect patients and other staff. Freedom to Speak Up Guardians listen to concerns raised and raise these to the trust on behalf of staff. The trust had recently appointed a new Freedom to Speak Up Guardian before our inspection.

During the reporting period, no staff had been either suspended or placed under supervision including restricted practice. Managers told us that they worked with the trust's central human resources department and followed the trust policies when they needed to manage poor staff performance. They could give us an example of how they had done this.

Staff and managers told us that their development including career progression was discussed in appraisals. Staff told us that they had access to additional training to increase their skills and knowledge. The service had vacancies and in some cases, staff had progressed to the next band of the NHS pay scales.

On 31 May 2017, the service's average sickness rate was 8%. This was similar to the trust average sickness rate of 5%. The range of staff sickness between 1 June 2016 and 31 May 2017 showed that sickness rates varied between 1% and 21%. This meant that there were periods where sickness fell below the trust average and above four times the trust average.

The trust had an occupational health programme for all staff for support with their physical and emotional needs. Staff could refer themselves to this service. The trust ran an employee of the month and an annual staff awards programme.

## Governance

### Mental health crisis and health based place of safety

There were systems and procedures to ensure that patients received prompt assessments and treatment, incidents were reported investigated and learned from, and improvements were made to the place of safety to address the breach of regulation from the last inspection. The trust was trying to increase the recruitment of staff to fill vacancies and had used bank and agency staff to fill shifts. They had taken action and escalated this to the trust risk register. Staff mostly received sufficient training and an appraisal of their performance; however, some of these training rates and the appraisal rate fell below the trust target.

Staff met regularly and discussed items on a set agenda. The meeting minutes showed they discussed essential information including the outcome of investigations of incidents and complaints, good practice and lessons learnt. Lessons learnt led to changes in practice that staff discussed and put into practice.

The service had not participated in any service specific clinical audits. They had developed a tool to audit the care record keeping of patients at risk of self-harm and suicide. The trust did not have a comprehensive clinical audit schedule for the service.

Staff worked with other internal and external services to meet the needs of patients. Staff worked with community and inpatient wards within the trust and various external services and agencies to ensure that people had access to the services that they needed.

## Management of risk, issues and performance

### Mental health crisis service and health based place of safety

Managers had access to the directorate level risk register and they discussed this with staff during team meetings. Staff could escalate concerns to managers. Staff told us that they felt supported by their service managers. The service had three items on the risk register. These related to: the service had one place of safety for the Hull and East Ridings areas, the impact of the Policing and Crime Act 2017 through reforming the police powers of section 135 and 136 of the Mental Health Act and the difficulties in the recruitment of staff. None of the staff that we spoke with raised concerns about the place of safety. Staff and managers told us that they provided the best service they could within the resources available.

The service had a business continuity plan. This covered flooding, pandemic, gridlock, staff shortages and loss of communications. This document had contact details of the relevant staff in the trust and staff had a clear protocol to follow which showed the response required between 3 hours up to 7 days and longer.

The service was not subject to any cost improvement initiatives.

## Information management

### Mental health crisis services and health based place of safety

The service provided information to the trust to monitor their performance. The trust used this information to create performance reports. Information submitted fed into a dashboard that provided a colour coded assurance level. This rated performance as good, fair or weak and advised if the performance indicated monitoring or development was required. Team managers had access to this information to support them in the management of the service. The reports provided clear assessment of performances showing areas of strengths and weaknesses.

Staff had access equipment and information to complete their work. They had mobile phones and laptops they could use when working in the community. The office base at Miranda House had sufficient equipment to enable staff to complete their work. The service had telephone system that enabled the trust to monitor performance. This measured call waiting times, durations and the system recorded all calls for quality and monitoring purposes. Staff described the patient record system as not user friendly. They told us that staff used the system in different ways and this meant that information was not always in the same place in the patient records and could take longer for them to locate.

## Engagement

### Mental health crisis services and health based place of safety

Staff told us that they received regular updates from the trust by email. They also had access to the trust intranet page. Patients and their carers did not receive information from the trust. They told us that they could visit the trust website that contained information. Patients and their carers could provide feedback to the service using the friends and family test, information was displayed in the service to promote this. However, there had been limited feedback obtained using this method. Managers told us the service was developing two specific questions to ask all patients at assessments. The feedback from patients and carers was part of the service's performance reports and this showed trends across the months.

Patients and carers told us that they were not involved in decision making about changes made to the service. Directorate leaders had formed relationships with local Healthwatch where they met and told us they discussed changes to the service through established forums. Patients and carers we spoke with did not know who senior leaders were and had told they did not know if they could meet with them.

## Learning, continuous improvement and innovation

### Mental health crisis services and health based place of safety

The Rapid Response Service had gone through a service transformation. During these changes, staff had opportunities to take part in working groups to share their views and contribute to the improvement and innovations in the service. Following this staff could take part in task and finish groups to be involved in developing the service. Senior leadership figures discussed how the service was continually improving and changing through feedback and refining since the changes in November 2016. Senior leaders told us that they continued to seek feedback from staff and people who use the service and they were open to changes that would be beneficial for the services provided.

None of the staff that we spoke with told us that they had participated in research.

Staff attended development days to provide their views on how the service could improve and develop further. Following this a development and improvement plan was implemented which showed areas for improvement, actions and who oversaw the changes.

The service provided data to national audits completed into the use of section 136.

The service did not participate in any accredited schemes relevant to this service like the Home Treatment Accreditation Scheme.

# Substance misuse services

## Facts and data about this service

Humber NHS Foundation Trust deliver community substance misuse services for adults across the East Riding of Yorkshire in partnership with the Alcohol and Drug Service (ADS).

The service, part of the East Riding Partnership, is contracted to support people who have difficulties with their drug or alcohol use. Services delivered are as follows:

**Open Access Service**

This is the first point of contact for all people who are misusing any substance and entering into treatment. Drop in services are available at a variety of locations to people living in the East Riding area. Staff assess patients who can then be offered brief interventions, advice and signposting or be referred onto the community drug and alcohol teams for longer periods of treatment and clinical interventions if required.

**Addictions Recovery Team**

This is located in central Hull. The addictions recovery team provide support for patients requiring intensive clinical support referred from open access, the community drug and alcohol teams or from primary care. At the time of our inspection, staff were seeing five patients at this location.

**Community Drug and Alcohol Teams**

These teams work from three locations, central Hull, Bridlington and Goole. They provide clinical and psychological interventions for patients with drug and alcohol issues. Staff from these teams also deliver treatment at ten outreach locations.

**Shared Care Service**

Additionally, staff from the community drug and alcohol teams may work alongside the patient's own GP to deliver support. The clinics are delivered at the locations of participating GP's. At the time of this inspection, the service was working with patients from 16 participating GP surgeries.

**Aftercare**

Staff provide a period of structured appointments for patients following their discharge if required. This is predominately for alcohol users.

At the time of our inspection, the service was working with approximately 500 patients.

# Is the service safe?

## Safe and clean care environments

All locations visited were clean and tidy with fresh furnishings. Cleaning schedules showed that domestic staff cleaned all base locations each day of opening. The host organisations of outreach venues was responsible for ensuring a clean environment, for example, GP surgeries.

The rooms used for patient appointments at the central hub and at Goole had alarm panels to ensure staff safety. Staff at these locations also had personal alarms. In Bridlington, staff could alert others in an emergency by pull cord alarms. However, these were not in all patient areas or as accessible to staff as personal alarms. The team leader had escalated these concerns onto the service's risk register to be addressed.

Staff carried out routine health and safety risk assessments and checks. On our inspection in 2016, we identified that actions recommended in a fire risk assessment had not been actioned. These related to suitable signage for fire doors and assembly points and regular fire drills. Staff had rectified these concerns prior to this visit. Teams had fire wardens on duty who were clearly identifiable.

Clinic rooms were well equipped with the necessary equipment to carry out physical health checks. Records showed that equipment was checked and calibrated regularly. This included blood pressure monitors, emergency resuscitation bags and thermometers. Staff recorded fridge temperatures in the central hub and Goole; the fridge in Bridlington was broken with a replacement on order. There were no medications requiring refrigeration in Bridlington at this time. Drug testing equipment was all in date. The service had their clinical waste collected on a weekly basis. Sharps bins awaiting collection were labelled and closed.

Premises displayed infection control guidelines and anti-bacterial hand gels were available throughout. Staff had access to protective personal equipment, for example, gloves and aprons for drug testing.

## Safe staffing

Humber NHS Trust provided 21.5 staff for the service. Please refer to the below table. The Alcohol Drug Service provided the remaining staff, of approximately equal numbers. There was a full time consultant psychiatrist and a trainee doctor employed through the trust. A medical locum was also covering three days per week and had been for over 12 months. For the period between 1 June16 and 31 May 17 this equated to 156 shifts. The post was vacant and the trust were struggling to fill it. There was one recently qualified non-medical prescriber and two more staff commencing training for this qualification.

Each team comprised a team leader, nurses, practitioners and administrative staff. The trust mainly provided clinical staff and the Alcohol Drug Service provided the practitioners. However, both job roles provided the same support to patients. This was apart from some clinical duties, for example, vaccinations, which nurses delivered. Teams were mixed with staff from both organisations.

The East Riding Partnership provided peer mentors to support staff in the service. Peer mentors are people who have experienced problems with alcohol or drugs and are in recovery themselves. They give their time to support and encourage others who may be struggling. The service utilised 20 peer mentors provided by the partnership.

| **Substantive staff figures** | | |
|---|---|---|
| Total number of substantive staff | 1 June16 – 31 May17 | 21.5 WTE |
| Total number of substantive staff leavers | 1 June16 – 31 May17 | 3 |
| Average WTE* leavers over 12 months (%) | 1 June16 – 31 May17 | 14% |
| Vacancies and sickness | | |
| Total vacancies overall (excluding seconded staff) | 1 June16 – 31 May17 | 1.2 WTE |
| Total vacancies overall (%) | 1 June16 – 31 May17 | 5% (range 10% oversubscribed to 21% vacancy) |
| Total permanent staff sickness overall (%) | At 31 May17 | 14% (range between 1% and 14%) |
| Establishment and vacancy (nurses and care assistants) | | |
| Establishment levels qualified nurses (WTE*) | At 31 May17 | 14 |
| Establishment levels nursing assistants (WTE*) | At 31 May17 | 0 |
| Number of vacancies, qualified nurses (WTE*) | At 31 May17 | 1 |
| Number of WTE vacancies nursing assistants | At 31 May17 | 0 |
| Qualified nurse vacancy rate | At 31 May17 | 7% |
| Nursing assistant vacancy rate | At 31 May17 | 0 |

There was an overall vacancy rate of 5% for registered nurses as of 31 May 2017. This was similar to the rate reported at the last inspection. This core service had three (14%) staff leavers between 1 June 2016 and 31 May 2017. This is slightly lower than the 23% reported at the last inspection (from 1st Dec 2014 to 30 Nov 2015).

The sickness rate was 14% between 1 June16 and 31 May 17. There were two staff on maternity leave and two staff on long term sick. Bank staff who had previously worked within the service were filling these shifts.

| | Substantive staff | Substantive staff Leavers | Average % staff leavers | Total % vacancies | Total % staff sickness | Ave % permanent staff sickness (over the past year) |
|---|---|---|---|---|---|---|
| **Core service total** | 21.5 | 3 | 14% | 5% | 13.6% | 6.1% |
| **Trust Total** | 2415.5 | 728 | 30% | 5.9% | 5.6% | 5.5% |

Caseloads varied between staff depending on complexities. All staff told us that their workload was manageable and that team leaders regularly reviewed caseloads. Both patients and staff told us that the service rarely cancelled appointments and that they were able to access a doctor if required between appointments.

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The service's overall compliance for mandatory training was 77%; this is above the overall trust compliance of 70%. There were three mandatory training units below 75% compliant. Please refer to below table.

Overall as of 31 March 2017, staff in this service had undertaken 88% of the various elements of training that the trust had set as mandatory. This was better than the overall trust average mandatory training rate of 84%. The staff in this service had not achieved the CQC 75% training target for two courses which are shown in the table below.

Control of Substances Hazardous to Health training had the highest training compliance with 100%.

The trust provided us with a compliance rate of 0% for staff completing conflict resolution training. However, the trust amended their minimum requirement for the management of violence and aggression from conflict resolution to management of actual or potential aggression following a review in 2016. This meant staff compliance figures in conflict resolution were inaccurate. The compliance figure provided for management of actual or potential aggression training was at 21%. Staff were still compliant in conflict resolution waiting retraining in management of actual or potential aggression. The service had booked staff onto a management of actual or potential aggression training course for October 2017. Following this, the compliance rate for staff in the service completing management of actual or potential training would be 92%.

The trust provided us with a compliance rate of 33% for staff completing basic life support training. However, although intermediate life support was not mandatory for this service (with the exception of the consultant psychiatrist), several registered nurses had elected to complete intermediate life support training for their professional practice. As intermediate life support supersedes basic life support they had not completed the basic life support training unit and were therefore not included

in the figures provided. Some staff were also booked onto a course in October 2017 for either basic or intermediate life support. This meant that from October 2017, the service would be 92% compliant for staff having completed either unit.

Additionally, the service had Naloxone on site and available for patients at risk of overdose to take away. Naloxone blocks or reverses the effects of opioids and is used to treat an opiate overdose in an emergency. All nurses had received training in order to administer and supply naloxone. This training included enhanced airway management and tailored intermediate life support specific to substance misuse. Staff from the Alcohol and Drug Service had also completed training in basic life support and for the management of violence and aggression further ensuring the safety of patients.

Key:

*Below CQC 75%*

| Training course | Compliance at 31 March 2017 | Compliance at 21 June 2017 |
|---|---|---|
| Health and Safety | 91% | 95% |
| Information Governance | 95% | 76% |
| Mental Capacity Act | 94% | 86% |
| Mental Health Act | Not provided | 0% |
| Basic Life Support | Not provided | 33% |
| Conflict Resolution | *64%* | 0% |
| Control of Substances Hazardous to Health | 100% | 95% |
| Display Screen Equipment | 91% | 86% |
| Equality and Diversity | *73%* | 81% |
| Fire Safety | 95% | 100% |
| Immediate Life Support | Not provided | 50% |
| Infection Prevention and Control | 86% | 76% |
| MAPA | Not provided | 21% |
| Moving and Handling | 82% | 95% |
| Prevent | 91% | 100% |
| Safeguarding Adults | 100% | 81% |
| Safeguarding Children | 77% | 95% |
| **Core service total** | 88% | **77%** |

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Staff working in the open-access drop in locations completed a risk assessment as patients entered into treatment. The assessment identified potential risks including drug and alcohol use, personal safety, risks to others, children, injecting behaviours, housing, occupational risks, previous compliance, sexual behaviours and mental health. We looked at 23 patient records; 21 records contained risk assessments with all but two of these being completed and reviewed in the last three months. Four risk assessments had not captured all risks identified by staff in their keywork notes.

### Management of risk

Of the 21 risk assessments seen, 20 had plans to manage or mitigate the risks. Actions in the plans varied in detail. We saw two actions that staff had not followed up in an appropriate period.

The service did not agree plans with patients in advance to record what actions staff should take in the event that the patient unexpectedly disengages from treatment.

Staff gave patients information on emergency contact numbers and harm minimisation from their first engagement and regularly throughout their treatment. Staff discussed safe storage of medications at home with patients on take away medications that had children. They also covered the implications of driving whilst misusing drugs or some prescribed medications. The service offered Naloxone kits to patients deemed at risk of overdose. Staff issued these with training for the patient and any involved carer or relative.

Staff managed risks relating to conflicts between patients by offering separate appointment times and by using alternative location options to avoid altercations. The service did not have a formal agreement with patients about expectations, for example, not to bring alcohol or drugs on the premises and violence and abuse.

Staff saw the majority of patients at venues where other staff were present. In extreme cases, staff would visit a patient in their own home. If this occurred, the first visit would always involve two members of staff. Staff would follow the trust's lone working policy if attending alone for any subsequent visit.

**Safeguarding**

Staff from the service identified and managed safeguarding concerns appropriately. They were able to give good descriptions and examples of what constitutes a concern and what actions they would take. The service explained to patients their safeguarding responsibilities at the first engagement. The local safeguarding authority and the trust trained staff in both safeguarding adults and children. They used the multi-disciplinary team meeting, general team meetings and supervisions to discuss any concerns they had. Teams also had safeguarding leads that could give advice as well as trust leads.

Managers had identified that there were a low number of safeguarding referrals from the service. The care group director had included this to the service's risk register whilst some analysis was being done to explore the reasons and ensure its accuracy.

## Staff access to essential information

All information needed to deliver patient care was available to all relevant staff. The service maintained patient records on an electronic system. They had moved from paper records to the trust's electronic system in October 2016. Staff working at the various outreach locations used laptops to access patient records from the system when needed.

**Medicines management**

The service followed good practice in transporting, storing, dispensing and administering medicines. Staff from the three community drug and alcohol teams either took prescriptions directly to the pharmacy or handed them to patients on their appointments. The Addictions Recovery Team based in the central hub dispensed from site. Controlled drugs at this location were stored correctly, in date and dispensed with two nurses present. Staff carried out weekly stock checks and the trust pharmacist visited approximately every three months. The service had a policy in place for staff to follow in the event of a patient reporting a lost prescription. This aimed to reduce the potential of a patient receiving two amounts of controlled drug medication.

## Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. There had been no serious incident for this service in the 12 months leading up to this inspection.

## Reporting incidents and learning from when things go wrong

Staff were confident what incidents to report and how to report them. They were able to give examples of reported incidents and demonstrate their understanding of their duty of candour. Team leaders fed back from internal incident investigations through emails, supervisions and team meeting. The trust fed back lessons learnt from trust wide investigations via emails and blue light alerts to all staff. Staff mostly felt that they received support and were debriefed following an incident. However, the team leader and staff from Goole recognised a delay in this following a recent serious incident. This was being addressed to ensure that debriefs and staff support was available without delays.

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there had been no 'prevention of future death' reports sent to the trust related to this service.

# Is the service effective?

## Assessment of needs and planning of care

The service used the recovery star to assess a patient's needs. The recovery star prompts a worker to explore different aspects of a patient's life in order to identify treatment plans and goals. These areas include drug and alcohol use, physical and emotional health, use of time, social networks, accommodation, money, offending and relationships. The assessment enables the worker to also identify a patient's recovery capital. Recovery capital are the resources a person needs in order to achieve and maintain recovery, for example, family support, good health and aspirations. Completion of the recovery star then enable staff and patients to agree a recovery plan detailing their goals and how they plan to achieve these. Staff told us that they would review recovery plans at a minimum of every 3 months. The Department of Health's UK Guidelines on Clinical Management for Drug Misuse and Dependence 2017 recommends reviews every 3-6 months but sooner for patients with complex needs, not benefitting from treatment or significant changes in their life circumstances.

We looked at 23 records. Of these, 17 records included a recovery plan. However, only 12 of these were no more than 3 months old and a further three no more than six months old. This meant that of the 23 records looked at, 11 records did not contain a recovery plan or the plan was over three months old and outside trust targets. This meant that the service was not ensuring that clients had effective plans of care that reflected their circumstances and needs. The recovery star did ensure that the plans seen were holistic, recovery orientated and individualised. However, interventions to achieve the goals lacked detail in that they did not include clear actions of who should do what and when. This meant that clients were not assured of receiving appropriate interventions and support.

## Best practice in treatment and care

The service prescribed medication as recommended by the UK Guidelines on Clinical Management for Drug Misuse and Dependence 2017.The service offered substitute medication for patients with an opioid dependence. Treatment services use substitute prescribing as an important element to help support patients on their road to recovery. It can be used for maintenance or detoxification purposes with an aim that leads to complete cessation of illicit use. The Department of Health had recently updated this guidance in 2017. All staff were aware of, and had access to the updated version.

Managers told us that they would expect the prescriber to review all patients receiving clinical interventions every 3 months as a minimum. This was not reflected at the time of our inspection in any policy or standard operating procedure. The service was waiting for a policy to be signed off which reflected the new guidelines and detailed such elements as review expectations. The new guidelines recommend that longer prescribing interventions should be reviewed at least every three months as a minimum. We looked at 22 prescribing records. Of these, ten patients had not been reviewed within the 3 months prior to our inspection and six of these did not evidence that a review had taken place in the last 12 months. This meant that the service was not effectively monitoring risk or treatment effectiveness for clients being prescribed medication.

Staff from the service ensured a patient's physical healthcare needs were being met. They carried out annual health checks. Of the 23 patient records looked at, 19 patients had received a physical health and wellbeing check within the last 12 months. Staff followed up identified physical health needs through referrals and recovery plans.

Staff conducted drug testing using three different options. These were urinalysis, instant mouth swab tests and swab tests for the staff to send for laboratory analysis. They tested patients as recommended by guidelines and used their professional judgement to determine the testing method and regularity of each test based on a patient's individual circumstances.

Nurses carried out screening and immunisations for blood borne viruses if the patient agreed to this. Patient records confirmed that staff offered this to all patients.

The guidelines recommend that all treatment for drug misuse should always involve a psychosocial component to help support an individual's recovery. Appointments attended, patients we spoke to and records showed that staff used evidenced based interventions such as cognitive behavioural therapy, motivational interviewing and brief solution focused therapy. Patient told us they could take home workbooks for completion; staff would then use the workbooks for discussion at their next appointment. We also saw evidence of staff and patients using mapping tools to support a reflective and collaborative approach enforcing the therapeutic alliance between patient and worker. Mapping provides a visual tool for clarifying information shared between worker and patient. It provides a model to consider cause and effects and aids with problem solving.

The Strang Report 2012 (commissioned by the National Treatment Agency) detailed the need for treatment trusts to focus on recovery rather than maintenance on medication. The report detailed that recovery is best defined by factors other than medication status and hinges on broader achievements in health and social functioning. Since our last inspection in 2016, the service had worked with staff and patients to visibly change the culture from a clinical maintenance prescribing service to one focused on recovery. Staff were using the recovery star to explore all domains rather than prescribing alone. Patients talked about their recovery goals and records reflected

discussions around encouraging patients to improve their health and wellbeing. Peer mentors supported open access clinics so patients could visibly see and discuss recovery as an achievable option and patients were encouraged to attend mutual aid groups such as SMART recovery.

The service used various tools to measure patients' dependencies and monitor outcomes. These included:

- The alcohol use disorders identification test, a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence.
- The severity of alcohol dependency questionnaire, used to measure the severity of alcohol dependence.
- The drug abuse screening test, used to assess drug use, not including alcohol.
- Treatment outcome profiles, used to monitor progress and outcomes. Developed by the National Treatment Agency (now part of Public Health England). Staff throughout the treatment system collect this which reports into the National Drug Treatment Monitoring System to provide a national and local picture of drug use. Staff also used this tool on an individual basis to monitor progress.

Clinical staff carried out internal audits relating to controlled drug use and opioid overdose training. The service had recently developed a records monitoring tool for staff to monitor recovery plans, physical health screens, risk assessments etc. The tool, aimed to ensure patient reviews are timely, is then to be used in the supervision process and fed into team leader meetings. This tool was not yet in use at the time of our inspection.

## Skilled staff to deliver care

The service included appropriate roles to meet the needs of patients. The trust provided all the clinical roles; the Alcohol and Drug Service provided practitioners, and managers and administrators were from both organisations. Teams also included leads in dual diagnosis and alcohol.

Staff had the right skills and knowledge necessary for the patient group. All staff were able to access training from both the trust and the Alcohol and Drug Service above the mandatory requirements. The service also brought in organisations to provide additional training if required. Staff told us that training was good, easily available and they could request additional training if needed. Training completed included psychosocial interventions, motivational enhancement therapy, mindfulness, steroids, new psychoactive substances, overdose response and naloxone.

Staff felt supported in their development and regularly received supervision from their direct line manager. Some staff received separate clinical and managerial supervisions depending on whether their line manager was a clinical trust employee or a non-clinical Alcohol and Drug Service manager. Staff from Humber working in the service were 80.5% compliant in receiving supervision. The trust's target rate for appraisal compliance is 85%. As at 1 April 2016 to 31 March 2017, the overall appraisal rates for non-medical staff within this service was 81%. This was due to staff on long-term sick and maternity leave.

Peer mentors received training and supervision through the Alcohol Drug Service.
Staff from the teams attended fortnightly team meetings. The meetings discussed safeguarding, staff cover, training, feedback from complaints and lessons learnt and guidance updates.

### Multi-disciplinary and inter-agency team work

From July 2017, the service had changed the focus of multi-disciplinary team meetings, which had previously focussed on mainly clinical changes. Discussions now captured a patient's journey focussing on the recovery star assessment, patient choice, risk and evidence based guidance. We observed two meetings attended by the consultant, trainee doctor and the care co-ordinator. The meetings involved all staff in discussions ensuring a holistic approach focussing on recovery. The care co-ordinators attended any clinical reviews as an addition to the multi-disciplinary meetings where prescribing was the focus.

Teams held fortnightly multi-disciplinary meetings, apart from the Alcohol Recovery Team who also had a weekly meeting at the start of each week. Staff from the community drug and alcohol teams attended the meetings if they had a patient they wanted discussing. There was no system in place to ensure all patients were discussed in meetings routinely. This meant some patients might never be reviewed with a multi-disciplinary approach.

The service had formed good relationships with a variety of different organisations, for example, mental health teams, domestic violence services and criminal justice services. Staff worked well with the pharmacists dispensing substitute prescribing to their patients to ensure there was good communication relating to any risks.

### Good practice in applying the Mental Capacity Act

Mental Capacity Act awareness training was mandatory for staff. Staff from the service were 86% compliant with this. They had a good understanding of the Act and were aware of the trust policy. All staff knew the basic principles and who to speak to if they needed advice.

Staff assessed capacity as part of the initial comprehensive assessment. If a patient attended the service either intoxicated or under the influence of substances, staff would postpone any decisions until they regained capacity. If they had concerns, they would refer to the GP, consultant or speak to the trust leads.

We saw evidence of a capacity assessment, capacity discussions in multi-disciplinary meetings, safety plans, carer's referrals, multi-agency meetings and safeguarding involvement for a patient where capacity was a concern.

## Is the service caring?

### Kindness, privacy, dignity, respect, compassion and support

Staff showed a caring and empathic attitude to patients. They talked about patients in a respectful manner. We observed staff treating patients with dignity and respect and with consideration to their confidentiality. On our previous inspection, we saw evidence of letters sent to patients worded in a punitive manner. On this inspection, staff used recovery focussed language improving the therapeutic relationship and resulting in greater honesty from patients. Patients told us that staff were compassionate, polite and genuine. They said that they were able to phone their care co-ordinator in between appointments and that their worker would always return their call.

Interview rooms offered patient confidentiality and at the start of treatment, patients completed information sharing agreements. However, not all information sharing agreements were readily accessible by staff. The majority of patients had been with the service prior to the introduction of

the trust's electronic recording system. The service had not scanned agreements made prior to this date onto the system and the trust had archived paper copies. This meant that if a carer, relative or other organisation contacted the service for information about a patient, staff would be unable to provide this without ensuring patient agreement. Staff informed us that they were able to request the archived notes to check this and that they would not give out information prior to this. They told us this could take up to three days. There was no evidence to suggest the service had shared information against a patient's wishes.

### The involvement of people in the care they receive

#### Involvement of patients

Patients felt involved in their care. We spoke with 17 patients using the service, 15 of these told us they were fully involved in building and maintaining their own recovery and that staff discussed the treatment options with them. Recovery plans seen, showed individual goals specific to the patient and reflected patients issues discussed in keywork sessions. Records did not evidence whether staff had offered patients copies of their recovery plans. However, patients told us that staff did offer these in appointments.

Staff enabled patients to give feedback on the service they received. In the month prior to our inspection, the service had conducted a survey to gauge patient satisfaction. They received 106 feedback forms from patients. Of these, 83% were very satisfied with the service, 84% felt involved in their care, 92% were encouraged to talk about short and long term goals and 91% felt involved in their risk management. Staff had collated all comments from the survey for further discussion with teams.

#### Involvement of families and carers

Records showed, and patients told us that family members often attended appointments with patients and were involved in their care if the patient had agreed to this. The service offered various locations and flexible appointment times in order to accommodate this if needed. The East Riding Partnership provided family and carer groups that staff referred carers and family members to.

## Is the service responsive?

### Access and waiting times

The open access team was the first point of contact for a person who was experiencing difficulties with drug or alcohol misuse. There were various drop-in locations throughout the East Riding of Yorkshire and in central Hull. Although the service did not serve the population of Hull, patients living in the geographical East Riding area often found it easier to access Hull than other outlining areas.

People were not required to make an appointment. GPs, other professionals and the patients themselves referred into the service. Staff assessed patients at the drop-ins. If the patients' treatment needs did not require clinical interventions, staff would mostly deliver brief keywork sessions and discharge. This would mostly be relevant to those patients not misusing opiates or alcohol, for example, cannabis, cocaine or new psychoactive substances.

For those patients who required clinical interventions, i.e. opiate or alcohol users, staff from open access would refer them to either the addictions recovery team or the community drug and alcohol

teams. This would be following a multi-disciplinary team discussion and dependent on complexity and need. The service aimed to commence a patient's treatment journey with a care co-ordinator within a week of initial referral. Staff met this target on most occasions. Staff prioritised patients with high risks, for example pregnancy or hospital release. Occasionally, the team would transfer low risk and stable patients directly to their GP. This would be dependent on the patient's GP participating in the shared care provision and in agreement by all involved.

Staff offered patients a choice of locations to be seen. Each community drug and alcohol team offered differing late night opening times meaning patients could attend around other commitments, for example, employment. Staff offered patients commencing clinical interventions appointments with the addictions recovery team in central Hull to enable their medication to be titrated to their required levels in a timely manner. This was because the consultant was available on a daily basis at the central hub to enable daily dose increments. If this was inconvenient, patients could attend the hubs in either Bridlington or Goole where the consultant attended at least twice per week meaning their medication increases would not be as quick, as the consultant would need to see the patient before increasing the dose. However, the service reimbursed travel costs for patients attending the central hub and who were on benefits. Medication titration took approximately two weeks. Once patients had reached their needed prescription level, their appointments for key working sessions reverted to locations of their choice.

Staff took proactive steps to contact people who missed appointments. They did this through phone contact, letters and by using a patient's pharmacy to encourage engagement and ensure safety. If this was unsuccessful, the multi-disciplinary team would discuss the patient before discharging from the service to ensure staff had taken all possible steps and to inform other organisations if this was appropriate.

Staff managed transfers for patients between treatment services effectively to ensure there was minimum disruption in a patient's recovery particularly continuity of prescribing. We saw evidence of smooth transitions for a patient leaving prison, a pregnant patient moving areas and a patient entering into an inpatient facility.

Staff provided a period of structured appointments for patients following their discharge if required. This was predominately for alcohol users.

## The facilities promote comfort, dignity and privacy

The service's hubs had a range of rooms to support treatment and care. These included suitably equipped clinic rooms, adequately sized waiting areas and interview rooms providing confidentiality. The facilities were welcoming with well-maintained furniture. Artwork was displayed which had been done by patients in recovery. Patients were able to help themselves to water while waiting for their appointment. We saw books and magazines available.

There were no activities provided directly by the service. However, patients were able and encouraged to attend recovery groups provided within the partnership. Bridlington were beginning a breakfast club the week following our inspection. This was to introduce patients to peer mentors and inspire them to become involved in wider activities.

## Patients engagement with the wider community

Staff supported patients to engage with the wider community. The services displayed local information about education, activities and community groups. Records evidenced goals for

patients to become involved in their personal interests, for example, we saw one goal in a recovery plan for a patient to join a local wild life group. We also observed discussions in a multi-disciplinary meeting regarding a referral of a patient to a structured day programme.

### Meeting the needs of all people who use the service

All services were accessible for patients using wheelchairs or with mobility difficulties. Waiting areas, clinics and interview rooms were located at ground floor level. Offices for staff were mainly on upper floors meaning that the service would need to make arrangements if staff had accessibility requirements. The community drug and alcohol teams had facilities for patients with hearing difficulties. The service used interpreters when this was required.

Waiting areas displayed information for patients, this included drug alerts, drug and alcohol information, safeguarding, information on capacity, blood borne virus leaflets and details about local groups and clinics. Staff issued free condoms and promoted the sexual health clinic.

### Listening to and learning from concerns and complaints

Patients knew how to complain if needed and felt comfortable to do so. They told us they would speak to their care co-ordinator in the first instance. Complaints and suggestions boxes were available in the reception areas of the hubs as well as posters explaining the complaints process. The service aimed to resolve complaints informally in the first instance.

There had been four formal complaints received by the service between 1 June 2016 and 31 May 2017. Two of these related to prescribing, one for patient care and one with no subject. Managers investigated complaints and fed lessons learnt back to staff in team meetings.

Staff gave an example where the service referred a patient to an inpatient detoxification unit and the patient complained that they had not been sufficiently prepared. Managers investigated the complaint and shared lessons learnt. Staff now visit units that they refer patients to. This means they are able to explain what expectations are, describe the environment and therefore better prepare the patients prior to transfer.

Staff were able to describe their duty of candour and gave examples.

## Is the service well led?

### Leadership

The service was managed by staff that had a good understanding of substance misuse and were able to clearly explain how teams were working to provide good treatment and care. They had a good oversight of performance and used their skills and experience to guide the service in a positive direction for the benefit of patients. They took responsibility and recognised areas where they could achieve improvements.

All staff knew the service's care director and the assistant care director.

The trust offered team leaders additional training to gain qualifications in leadership if this was required and to provide opportunities for further development.

## Vision and strategy

Staff knew the trust's values to be caring, learning and growing. The values were on display throughout the locations, discussed in business meetings and reflected in emails. Our observations during inspection showed staff reflected these values in their behaviours.

Since our last inspection, the service had a complete change of ethos embracing recovery. Staff could explain how they were working to achieve this and had the opportunity to contribute towards discussions.

## Culture

The service had experienced many changes since our previous inspection in April 2016. This involved changing the culture from a mainly clinical provision to one that offered choice, a holistic approach and promoting visible recovery. Additional to this, the trust had re-configured the service and introduced electronic recording. Many patients had been with the service for a long period. This meant that staff also had to promote and encourage the change in culture with patients. All staff we spoke with told us they were positive about the new direction of the service. Staff morale within the whole service was high. We observed commitment and an excellent team attitude between trust staff and staff from the Alcohol and Drug Service.

Staff respected managers and were well supported. They felt able to raise concerns without fear of retribution and knew how to use the whistle-blowing process. Staff had an understanding about the role of the speak up guardian. Staff sickness and absence rates were maintained similar to the trust average and had not increased since our previous inspection. The service offered mindfulness training to support the staff's emotional health.

Staff had completed training in equality and diversity and could explain how they promoted this in their day-to-day work.

## Governance

The service had a partnership board to consider policies and assurance frameworks and a partnership agreement stating expectations. This included the expectation that the Alcohol and Drug Service were compliant with the trust's governance system. The trust had effective systems in place to enable managers to effectively monitor performance. This included staffing, supervisions, training, incidents and complaints. We spoke to the care director who could explain how governance systems worked to ensure communication was effective from board to general staff and vice versa. This enabled a good oversight of the service's compliance. Team meeting minutes showed there was a good framework to ensure essential information was shared and discussed. The service also held monthly business meetings and a clinical network meeting. Both organisations attended and contributed to all the service's meetings.

## Management of risk, issues and performance

The service had a risk register that reflected the risks detail by staff. Staff discussed service risks at team level and were aware how these were then escalated if needed.

Managers and team leaders discussed risks in business meetings and partnership board meetings, which had representation from both organisations.

## Information management

There was sufficient equipment and information technology for staff to do their work. The service had introduced an electronic system for patient recording in October 2016. This was still being developed to meet the specific needs of the service. For example, the system was not being used effectively to generate performance reports.

The electronic system protected the safety of patient information. Staff were required to pass security settings to access the system and only permitted to view or add to individual records in a professional capacity. The system was able to monitor a patient's record to see which staff had viewed the content.

## Engagement

Public Health England commissioned the service through the East Riding of Yorkshire local authority. Commissioners had a good relationship with the service and contributed to discussions relating to improvements. For example, commissioners attended a full service away day about changing the model.

Staff had access to the trust's intranet and received internal bulletins and newsletters about the trust. The trust had a website providing information for staff, patients and carers. However, the trust had not ensured the information displayed was up to date as it still showed the previous address for the open access team.

Patients had an opportunity to give feedback on the service through key work sessions and through patient surveys.

## Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation. In April 2017, all staff attended a service away day to look at the new recovery focussed model. Staff felt able to contribute their thoughts and felt that their input was valued. Staff used team meetings to escalate ideas to clinical networks and team leader forums for consideration.

The service had recognised improvements were required relating to their patient electronic recording system for greater efficiency. They had identified 'super users' to visit other trusts using the same system to learn what changes were needed and how the system could be used to improve performance.

The service was not involved in any accreditation schemes relevant to substance misuse.