Humber Teaching NHS Foundation Trust

Evidence appendix

Trust HQ
Willerby Hill, Beverley Road
Hull
North Humberside
HU10 6ED
Tel: 01482 301700
www.humber.nhs.uk

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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

The trust had 18 locations registered with the CQC (on 12 October 2018).

Registered location	Code	Local authority
Cottingham Clinic	RV970	East Riding of Yorkshire
Field House Surgery	RV9Y4	East Riding of Yorkshire
FitzWilliam Ward, Malton	RV91T	North Yorkshire
Granville Court	RV929	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
Peeler House	RV9Y5	East Riding of Yorkshire
Princes Medical Centre	RV9Y6	Kingston-upon-Hull
The Chestnuts Practice	RV9Y3	East Riding of Yorkshire
Townend Court	RV915	Kingston-upon-Hull
Westlands	RV933	Kingston-upon-Hull
Whitby Hospital	RV91W	North Yorkshire
Willerby Hill	RV936	East Riding of Yorkshire

The trust had 238 inpatient beds across 19 wards, none of which were children's mental health beds. The trust also had 40 outpatient clinics a week and 222 community clinics a week.

Total number of inpatient beds	238
Total number of inpatient wards	19
Total number of day case beds	6
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 mental health clinics per week	52
Total number of community physical health clinics per week	170

Is this organisation well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The trust board and the senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. The trust board had 12 members that included five non-executive directors, a chairperson and six executive directors. Since our last inspection, the trust had appointed one new non-executive director who had experience in finance and strategic investment, a director of HR and a chief operating officer.

Providers must take steps to ensure that both non-executive directors and directors are fit and proper for their role. This requirement was one of the regulations that was applied from November 2014. The trust provided us with details of all checks they had undertaken to meet this standard and we reviewed four personnel files of new and existing directors and found that checks, declaration of interests, appraisals and disclosure and barring checks were completed on appointment and regularly, in all but one file where the disclosure and barring check had expired. This was rectified immediately by the trust.

There was a board development programme, which was introduced for the senior management team. Board level posts and board members received an annual appraisal where professional development needs were identified and addressed. Board level succession planning took place within the remuneration committee.

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 trust had a distributed leadership plan that supported the overarching workforce and organisational development strategy.

The trust strategic plan to be a leading trust known for the quality of their integrated healthcare services, stakeholder engagement, commitment to staff and recognised as a valued partner in problem solving.

Medical staff including consultants attended a focus group and gave positive feedback about the current medical director who had been in post for 18 months. They felt they now had a voice and felt communicated to and referred to support received from the medical director.

The trust had a leadership development programme and managers were responsible for their staff's development, particularly those who demonstrated the aptitude and desire for promotion. Sixty Four staff were eligible for this programme and 61 had attended at the time of the inspection, which was an increase since the last inspection by 35 staff. Staff could also apply via a central training budget for external leadership and development opportunities. All key positions were defined with job descriptions and person specifications. The development of talent and succession planning was a key element within the workforce and business continuity plans. The trust's workforce and organisational development strategy outlined their priorities, which included succession planning.

In July 2018, the trust launched a 'shaping the vision – care services structure' consultation led by the chief operating officer. The aim of the consultation was to ensure that clinical services were grouped in ways that optimised service user care pathways, clinical effectiveness and clinical outcomes, whilst being aligned with efficient managerial and clinical leadership structures. This was in part also due to the recent acquisition of the Scarborough and Ryedale community services and the new CAMHS unit, which will open for the trust in summer 2019. Drivers for this work were:

- Sustainability
- Optimising pathways
- Clarity and consistency
- Effectiveness
- Financial sustainability

During the inspection, we identified that this consultation had raised anxieties for many staff that potentially would be affected by these changes, this was reported in core service inspections and staff focus groups that we undertook. This was especially so from the consultants and medical staff, who felt that there was a tendency to not involve medical staff in these processes, which were directly affecting them. The trust was not fully aware of the impact this consultation process was

having on staff. However, the trust felt that this consultation was a necessary piece of work and this would remove a level of management so ward to board communication would be clearer.

The trust board had a comprehensive programme of site visits. Executive and non-executive directors visited sites and wards as part of this programme. Despite the assurances from the trust board, there was still a mixed picture from staff who at times felt that the directors were not visible enough. In comparison, all staff felt that their immediate line managers were visible and ensured appropriate communication and support.

The executive lead for equality and diversity was the director of human resources and they were responsible for the annual equality and diversity report and workforce equality and diversity. The medical director was responsible for patient experience.

The chief operating officer held the portfolio for child and adolescent mental health, learning disabilities and autism.

The executive board had 0% black and minority ethnic (BME) members and 50% women.

The non-executive board had 0% BME members and 33.3% women.

	BME %	Women %
Executive	0	50
Non-executive	0	33.3
Total	**0**	**41.7**

The trust was working on its medicine's optimisation development plan 2017-2019. This was developed after external review of pharmacy services and pharmacy and medicine optimisation strategy 2015 – 2018.

An external review had also been completed on the CQC KLOEs (Key Lines of Enquiry) and an action plan was currently being developed.

The chief pharmacist reported to the medical director who represented them at senior level meetings.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

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 a valued partner”.

The trusts 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.

There was a robust and realistic strategy for achieving trust priorities and developing good quality sustainable care. Staff were consulted on this and agreed to the new core set of values.

The trusts current strategy was developed and approved by the trust board in April 2017.

The trust's key organisational strategies were as follows.

- The overarching trust Strategy
    - Estates
    - Safeguarding
    - Research and development
    - Workforce and organisation development
    - Risk management
    - Patient and carers strategy
    - Patient safety strategy
    - Procurement strategy
    - Recovery strategy
    - Suicide and self harm reduction strategy

The key points from the trust strategy include reinforcement of their mission, vision and values and the six organisational goals;

- Innovating Quality & 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 value

The trust leadership team had a comprehensive knowledge of current priorities, strategies and challenges and acted to address them.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. They could articulate them in interviews we conducted as part of the core service inspections and staff focus groups. However, within forensic services and community health adult services, there was mixed views about whether they felt involved or could influence any decisions and had limited understanding of the vision. We did find the vision on display in services.

The trusts current strategy was developed and approved by the trust board in April 2017. The strategy had been launched to the staff, partners and other stakeholders, including patients and their families, which enabled their involvement.

Following a well led external review, recommendations made were implemented within a trust strategy communications plan which outlined, key messages, target audiences, the range of communication activities, key communication channels, resources/budget and evaluation process.

The trusts business planning framework demonstrated the supporting delivery and development plans that aligned with all the organisational strategies and annual operational plans. Objectives for delivery were measured and monitored through this framework and any additional implementation plans. The trust had started to use statistical process control, which is a method of quality control, which employs statistical methods to monitor and control processes. This enabled better evaluation and moved away from cumbersome dashboards for the board.

The trust had a policy for meeting the physical healthcare needs of patients, which was dated for review in 2021. This policy described the minimum standard of physical assessment that a patient could expect and was be supplemented by additional guidance.
All patient's resident in an inpatient facility for more than 12 months would have a documented review of their physical health every six months, a full physical examination every year or more frequently if clinically indicated. The physical health work was overseen by the director of nursing and discussed at the physical health and medical devices group every six weeks. This group also encompassed, learning from incidents, looking at policies, NEWS scores, ongoing improvements, training, joint assessments and yearly reviews of the policy.

The NHS and local councils have formed partnerships in 44 areas covering all of England to improve health and social care. Each area has developed proposals built around the needs of the whole population in the area. These are known as sustainability and transformation partnerships. A multiyear plan was developed showing how the Humber, Coast and Vale services would evolve and become sustainable over the next five years. The trust remained part of the sustainability and

transformation partnership. The leadership team regularly monitored and reviewed the progress on delivery of this programme and how it aligned with the trust's strategy.

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care across all sectors.

Equality and diversity objectives were developed from the equality delivery system for the NHS. This tool was designed to help NHS organisations in partnership with local stakeholders, to review and improve their performance for people with characteristics protected by the Equality Act 2010. They also used the family and friends test and staff survey results.
The trust promoted equality and valued diversity, which were included in the healthy organisational culture pillar of the workforce and Organisational Development strategy. The annual report to the board of directors, included discussion about the gender pay gap. The trust however did not have a dedicated equality strategy but had an equality and diversity policy.

Workforce race equality standard indicators showed that 87% of the trust staff were white and 3.9% were BME staff compared with 5.1% in the local population.

27% BME staff felt bullied compared with 18% white staff.

In the trusts annual report there were some key objectives for equality and diversity for 2018/2019 that included developing an equality and diversity strategy, unconscious bias training and values based recruitment, work had started on these.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Since our last inspection, the trust had continued its work engaging and communicating with trust staff, yet there remained mixed views about whether staff felt supported, respected and valued. These views were once again collected via staff core service inspections and focus groups. In the forensic services, staff spoke positively about supportive team working at ward level. In other services, staff reported a strong sense of belonging within individual teams. However, staff lacked a sense of overall trust inclusion and ownership above this level.

This was especially so in Whitby and Scarborough where staff felt disconnected from the main trust as a lot of the services and training was provided in Hull. In these areas, morale amongst staff was variable and, in some areas, was particularly low. Some staff felt that changes had been

made or were planned but there had been poor communication about the changes and the impact this would have on staff.

In September 2018 the 16th staff survey was conducted. Humber Teaching NHS Foundation Trust surveyed all staff. Their response rate was 45% compared to a national average of 43%. This was also a 7% increase in last year's response rate.

The staff survey results for the year 2018 showed an increase in 51 points from the previous year, five that had no change and nine that had changed negatively.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.3	5.9	7.0	6.0	4.8	7.2	8.1	9.4	6.5	6.7
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	1,121	1,127	1,130	1,127	1,008	950	1,125	1,127	1,130	1,133

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

The trust scored between 87% and 93%, better than the England average for patients recommending it as a place to receive care for four of the six months in the period (April 2018 to September 2018). May 2018 saw the highest percentage of patients who would recommend the trust as a place to receive care with 93%, and each month in the period scored above 86%.

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.

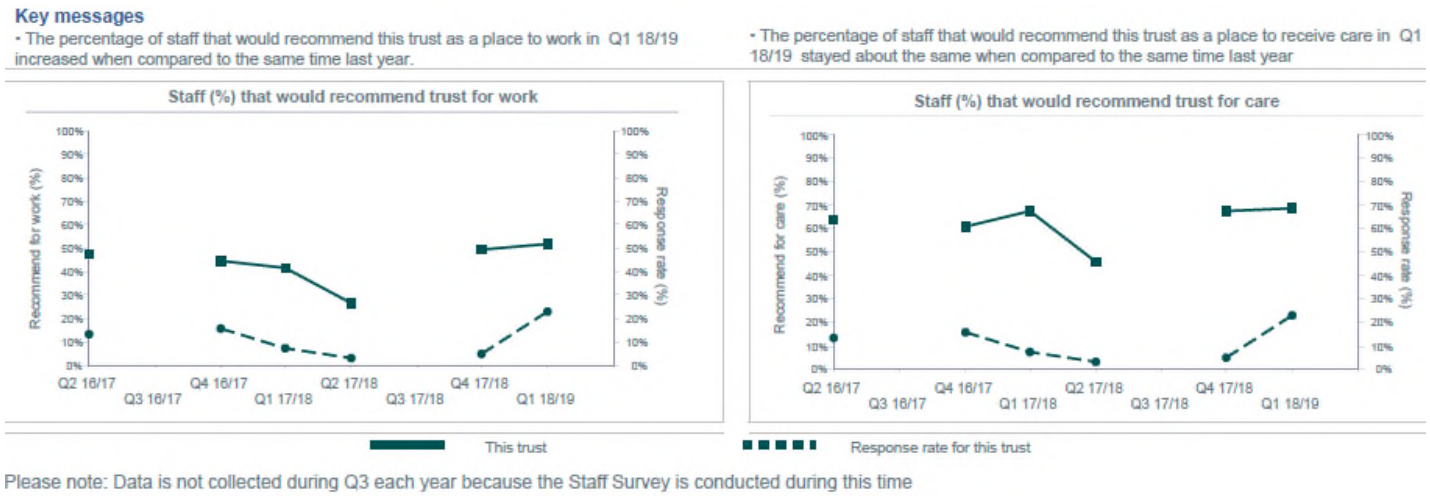
	Trust wide responses	England averages

	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Apr 18	4915	90	86.7%	3.3%	88.7%	4.2%
May 18	4821	186	93.0%	2.2%	88.9%	3.7%
Jun 18	4605	116	89.7%	5.2%	88.8%	3.8%
Jul 18	4847	133	90.2%	2.3%	88.9%	3.9%
Aug 18	4478	133	90.2%	2.3%	90.0%	3.5%
Sep 18	4192	104	86.5%	7.7%	89.6%	3.7%

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 no clear trend over the last six quarters. Quarter 1 18/19 had the highest scores for staff recommending the trust as a place to work. Response rates were the highest in this quarter and are therefore more likely represent the staff views overall.

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



Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

(CAVEAT: The trust changed their financial reporting system part way through the 12-month reporting period and therefore vacancy data is inconclusive).

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing reporting, to that provided in the RPIR. The previous relates to that received in the RPIR.)

Substantive staff figures			**Trust target**
Total number of substantive staff	As at 31 August 2018	2091.3	N/A
Total number of substantive staff leavers	1 September 2017 to 31 August 2018	255.3	N/A
Average WTE* leavers over 12 months (%)	1 September 2017 to 31 August 2018	11%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	As at 31 August 2018	397.2	N/A
Total vacancies overall (%)	As at 31 August 2018	11%	Not Provided
Total permanent staff sickness overall (%)	As at 31 August 2018	3.9%	4.5%
	1 September 2017 to 31 August 2018	4.7%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	As at 31 August 2018	1082.7	N/A
Establishment levels nursing assistants (WTE*)	As at 31 August 2018	646.8	N/A
Number of vacancies, qualified nurses (WTE*)	As at 31 August 2018	149.1	N/A
Number of vacancies nursing assistants (WTE*)	As at 31 August 2018	126.9	N/A
Qualified nurse vacancy rate	As at 31 August 2018	14%	Not Provided
Nursing assistant vacancy rate	As at 31 August 2018	20%	Not Provided
Bank and agency Use			
Hours bank staff filled to cover sickness, absence or vacancies (Qualified nurses)	1 September 2017 to 31 August 2018	2753 (<1%)	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 September 2017 to 31 August 2018	934 (<1%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 September 2017 to 31 August 2018	18576 (2%)	N/A

Substantive staff figures			Trust target
Hours filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 September 2017 to 31 August 2018	7895 (1%)	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 September 2017 to 31 August 2018	377 (<1%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 September 2017 to 31 August 2018	34624 (4%)	N/A

*WholeTime Equivalent

The trust recognised staff success by staff awards and through ongoing feedback. They had a yearly awards ceremony, but throughout the year they also had smaller award ceremonies where those who had been nominated by their own wards or departments were awarded an accolade. They also congratulated long service and retirements at this ceremony. Staff could access support for their own physical and emotional health needs.
The pharmacy were also celebrating success as the pharmacy team were nominated as the 'unsung hero' in the recent staff awards.

We met with four trade unions as part of our well led review. As reported at our last inspection the unions still stated that there were difficulties in working with the trust. The main concern raised at this meeting was the ongoing consultation within the trust, issues with grievances and they felt that their members issues were not being listened to. They felt that there was much work to do in developing their relationship, as they did not feel the trust offered the level of transparency that was needed.

We reviewed six disciplinaries. These were undertaken appropriately and within the trust processes. Poor performance was addressed and 13 staff had been suspended or placed under supervised practice for the reporting period.

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 discussions with your manager. If this was not possible, the trust grievance procedure provided an effective channel for staff to raise any complaint formally. We were made aware by the trade unions that there were ongoing issues with the grievance procedure, so as part of our inspection we reviewed six case files. From reviewing these we found that these had followed due process and were resolved or nearing completion.

As at 31 August 2018, the training compliance for trust wide services was 85% against the trust target of 85%. Information governance had a target completion rate of 95%. Of the 29 training courses listed 13 failed to achieve the trust target and of those, five failed to score above 75%. Training completion was reported on a rolling month on month basis. The training compliance reported for the trust during this inspection was higher than the 73% reported at the last inspection.

Mental Health Act training was available to all clinical staff which was initially provided on induction with update training being provided at least every two years. The training compliance rate as of January 2019 was 81%.

The trust's target rate for appraisal compliance was 85%. As at 31 August 2018, the overall appraisal rates for non-medical staff was 77%.

Eight of the 19 services (42.1%) achieved the trust's target appraisal rate. The core services failing to achieve the trust's appraisal target were 'MH – Long stay/rehabilitation mental health wards for working age adults' with 70%, 'MH – Wards for people with learning disabilities or autism' with 75%, 'MH – Community based mental health services for adults of working age' with 68%, 'MH – Community mental health services for people with a learning disability or autism' with 72%, 'MH – Specialist community mental health services for children and young people' with 68%, 'MH – Mental health crisis services and health-based places of safety' with 82%, 'MH – Substance misuse' with 81%, 'MH – Other specialist services' with 75%, 'CHS – Community inpatients' with 36%, 'CHS – Adults community' with 53%, and 'Other – PMS service' with 73%.The rate of appraisal compliance for non-medical staff reported during this inspection is lower than the 83% reported at the last inspection.

In mental health services that we inspected, we found generally that appraisals were taking place, however we found that in some community health service teams these rates were lower than others. Following our inspection, we requested community health service locality performance reports. Appraisals were completed on a 12-month rolling programme however appraisal completion at December 2018 was 58% for Scarborough North and 38% for Whitby. Those who had an appraisal reported that these were supportive and they had the opportunity to discuss their learning

All pharmacy staff had personal development plans and an annual appraisal. This was supported with quarterly supervisions, monthly 1:1s and weekly team meetings.

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
MH - Community-based mental health services for older people	127	116	91%
MH - Secure wards/Forensic inpatient	196	179	91%
MH - Acute wards for adults of working age and psychiatric intensive care units	172	150	87%
CHS - Children, Young People and Families	215	185	86%
CHS - Urgent Care	7	6	86%
MH - Wards for older people with mental health problems	68	58	85%
MH - Mental health crisis services and health-based places of safety	88	72	82%
MH - Substance misuse	21	17	81%
Other	521	469	90%
Other - PMS service	91	66	73%
MH - Other Specialist Services	8	6	75%
MH - Wards for people with learning disabilities or autism	24	18	75%
MH - Community mental health services for people with a learning disability or autism	122	88	72%
MH - Long stay/rehabilitation mental health wards for working age adults	30	21	70%
MH - Community-based mental health services for adults of working age	303	206	68%
MH - Specialist community mental health services for children and young people	141	96	68%
Other - ASC service	55	51	93%
CHS - Adults Community	313	167	53%

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
CHS - Community Inpatients	83	30	36%
Total	**2585**	**2001**	**77%**

The trust has not provided data for medical staff appraisals.

The trust's target rate for clinical supervision was 80%. As at 31 August 2018 the overall clinical supervision compliance was 77%. However, there was no standard measure for clinical supervision and trusts do collect this in different ways.

Six of the 13 core services (46%) who provided data on clinical supervision compliance, achieved the trust's clinical supervision target. The core services failing to achieve the trust's target were 'MH – Acute wards for adults of working age and psychiatric intensive care units' with 65%, 'MH – Long stay/rehabilitation mental health wards for working age adults' with 51%, 'MH – Mental health crisis services and health-based places of safety' with 65%, 'MH – Secure wards/Forensic inpatient' with 73%, 'MH - Specialist community mental health services for children and young people' with 78%, 'MH - Wards for older people with mental health problems' with 63%, and 'MH - Wards for people with learning disabilities or autism' with 78%. The clinical supervision compliance staff reported during this inspection is higher than the 69% reported at the last inspection.

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Community mental health services for people with a learning disability or autism	551	586	94%
Other - ASC service	511	562	91%
MH - Other Specialist Services	25	28	89%
MH - Community-based mental health services for adults of working age	2241	2555	88%
MH - Substance misuse	417	477	87%
MH - Community-based mental health services for older people	661	806	82%
MH - Specialist community mental health services for children and young people	621	801	78%

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Wards for people with learning disabilities or autism	394	502	78%
MH - Secure wards/Forensic inpatient	1367	1874	73%
MH - Acute wards for adults of working age and psychiatric intensive care units	1183	1819	65%
MH - Mental health crisis services and health-based places of safety	434	667	65%
MH - Wards for older people with mental health problems	469	744	63%
MH - Long stay/rehabilitation mental health wards for working age adults	115	227	51%

The trusts complaints policy set out its timelines for investigating and reporting on complaints. We found, at our last inspection, the trust was consistently failing to achieve their targets for completing targets within 25 days, although had always responded to complaints within their three-day target. Following this, the trust board agreed to pilot a staged complaint process. Following a successful pilot, the quality committee agreed that the policy would be amended to include a 30, 40 or 60 working days to completions of complaints, dependant on number of issues within the complaint, number of teams it relates to and complexity of the complaint.

The trust was asked again to comment on their targets for responding to complaints and current performance against these targets for the last 12 months, this is reported in the table below. We reviewed six complaints as part of the inspection. All complaints had been completed within the trust timescales. The trust also applied duty of candour appropriately within these complaints, which is when NHS trusts are required to be open and transparent with people who use services in relation to care and treatment, particularly when things went wrong.

An in-house training programme on duty of candour had been developed. 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/ carers about what happened and the learning from the incident. Duty of candour was also covered in their preceptorship programme. Posters and leaflets on the application of duty of candour were available within the trust policy. Where new services were incorporated as part of the trust, induction training included duty of candour. Five training sessions had been delivered to the Scarborough and Ryedale teams in the past year. A duty of candour podcast was available for staff on the trust intranet. The governance and patient safety

team provided support to teams on individual cases as required to assist staff with the application of this statutory duty.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3	100%
What is your target for completing a complaint?	30	100%
If you have a slightly longer target for complex complaints please indicate what that is here	40/60	100%

* 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.

Top themes from complaints and the patient advice and service liaison over the past 12 months were communication and patient care. Patient care was predominantly about patients feeling their needs had not been met, admission/discharge was mainly about patients being unhappy at being discharged from services, complaints about appointments included appointments being cancelled, staff not turning up and delays in being seen.

The trust ensured learning from complaints by sharing any action plans with the team. The teams were then asked to produce evidence that these actions had been completed. Team meetings were used for sharing learning following investigations. Trust wide learning was disseminated via the patient and carer experience six monthly report which identified themes.

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	284	1 September 2017 to 31 August 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	0	1 September 2017 to 31 August 2018

**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

The trust received 442 compliments during the last 12 months from 1 September 2017 to 31 August 2018. This was higher than the 269 reported at the last inspection. ‘Other – PMS service’ had the highest number of compliments with 32%, followed by ‘CHS – Community Inpatients’ with 17% and ‘MH – Acute wards for adults of working age and psychiatric intensive care units’ with 11%.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. This was monitored through the NHS standard contract. Equality and diversity training was mandatory and had a 79% completion rate.

The trust had an equality and diversity policy but no strategy, this focused mainly on staff not service users and had no clear statement of what success would look like, this also lacked an operational plan to under pin its delivery. The trust's patient and carer experience strategy included consideration of equality and diversity.

The trust had a full-time chaplain who visited inpatient units on request. Where patients had no leave, the chaplain visited wards on a regular basis. On admission to wards, clinicians completed a spiritual assessment tool which identified patients spiritual and or religious needs, following this a care plan was developed.

Patients were supported through a person centred approach which considered individual needs around protected characteristics. All staff had access to trust policies and guidance for example the policy for supporting transgender patients, human rights, equality and diversity policy and transitions protocol from adult mental health to older people's services. The trust used translation services when there was difficulty in understanding each other language.

The Francis freedom to speak up review was published in 2015. This review response was set up to evidence that NHS organisations did not appropriately react to the concerns raised by staff including the maltreatment of those speaking up. Since 2017 all trusts had to have appointed a freedom to speak up guardian. The trust now had two staff in post to lead this work, a guardian and deputy guardian. Both had dedicated time to undertake this role and this included speaking at the induction programme for new staff to highlight the service, training, local and national events and developing the strategy further.

Generally, staff felt able to raise concerns without fear of retribution. Staff knew about the role of the freedom to speak up guardian and how to use the whistle-blowing process. We did find though in crisis and health based place of safety services that whilst staff understood the whistleblowing process and were aware of who the freedom to speak up guardian was and how to contact them, some staff said they would be reluctant to raise a concern with them as they felt historically the trust had not been very supportive of staff following incidents and it had felt like there was a blame culture. Staff acknowledged that the current chief executive was trying to change this but they were unsure how much had improved.

Twenty seven concerns were raised in the previous 12 months via the freedom to speak up guardian and three of these were whistleblowing. These were summarised and shared with the

board monthly. Monthly meetings were also held with the chief executive and guardian to report on concerns and monitor progress of any investigations. Quarterly meetings were also held with the trust chair, chief executive, guardian and senior independent director to report on concerns and escalate any issues. Following this each specific case was escalated to the relevant executive director and if an investigation was required this was actioned.

Duty of candour was part of induction and additional training had been given to pharmacists.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust had a board of directors who were responsible for safe delivery of services and committed to delivering the strategy. This board was made up of 12 members which included five non-executive directors, a chairperson and six executive directors. The chief executive and five executive directors delivered the strategy and the chairman and five non executive directors who were not employed by the trust, provided challenge and strategic leadership to the board.

We attended the last two board meetings and found these were well attended. The board had oversight at these meetings of other committees and their papers and progress, which included risk management, quality, audit and workforce. In addition, a reportable issues log was presented each month in the private part of the board meeting. This report identified ongoing concerns in relation to safeguarding, serious incidents, human resources investigations, inquests, freedom to speak up, complex complaints and claims.

Patient stories were heard by the board, positive and negative in nature. Messages go back to teams from the stories where positive to say thank you. Sometimes board members will go out to the service as well to say thanks. Any learning was recorded on an action tracker.

The trust provided their board assurance framework. This detailed any risk scoring eight or higher and gaps in the risk controls that affected strategic ambitions. The trust outlined six strategic ambitions:

1 - Innovating Quality and Patient Safety

2 - Enhancing prevention, wellbeing and recovery

3 - Fostering integration, partnership and alliances

4 - Developing an effective and empowered workforce

5 - Maximising an efficient and sustainable organisation

6 - Promoting people, communities and social values

The trust provided a document detailing its highest profile risks. Each of these had a current risk score of 15 or more. The trust had radically reviewed their risk register since our last inspection and had reduced the number of risks on the trust wide register, but local risks were reflected on the seven other service risk registers.

The risk register at Scarborough had only been in place for two weeks prior to our inspection and the service manager for Scarborough South and Ryedale told us that they had only recently received training on how to complete the risk register and therefore they had not added any risks on to the register. This meant that the risk register may not contain all identified risks.

In community child and adolescence mental health services staff knew how to escalate their concerns to risk registers when required. This was done through team meetings and supervisions. They were aware of local risk registers; their concerns relating to waiting times matched what was on the register. There were clear action plans for identified risks.

- The trust has provided a document detailing their highest profile risks. Each of these have a current risk score of 15 or higher.
- The trust has provided details of 3 high risks relating to finances and 2 high risks related to objectives.

Key:

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

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.
FII200	The Trust's cash position deteriorates adversely where day to day functioning is impacted and the organisation is no longer financially independent.	20	15	10	5

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.
FII202	Failure to achieve the organisations Budget Reduction Strategy for 2018-19 which may impact on the Trust's ability to achieve its control total.	20	20	8	5
FII203	Failure to achieve the organisations achieve control total for 2018/19 which may have a significant impact on Trust finances resulting in loss of funding and reputational harm.	20	20	8	5
FII205	Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	25	20	5	5
HR32	Significant staff vacancies and lack of suitably skilled staff in the right place may impact on the Trust's ability to deliver safe services resulting in diminished morale, potential increase in agency usage and associated financial impact for the organisation.	20	15	5	4

The trust risk management policy, incident reporting policy, serious incident policy and freedom to speak up policy all described the process for staff to raise concerns about quality and safety of services. Central to the reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Briefing reports were produced via the system where the incident or concern was deemed to be significant or serious. These were circulated to members of the clinical risk management group which met weekly to review the briefings and agree investigation methodologies, escalation of issues or any immediate actions required. This group commissioned thematic reviews when concerns regarding incident trends or themes were noted. The clinical risk management group reported six weekly to the quality and

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

The executive team were immediately notified of all incidents declared as a serious incident.

In forensic services there was a monthly clinical network meeting, attended by managers including charge nurses. Agenda items included learning from incidents and investigations, incident reporting, audit programme. However, we saw from minutes that assurance measures on these areas were not fully embedded. This resulted in a lack of oversight of incidents and sharing lessons learned within the service. We did not see evidence in this core service of trust-wide learning being shared.

Processes were in place to support delivery of the strategy. The trust had an operational board a council of governors and seven committees which included:

- Quality committee
- Finance committee
- Strategic investment committee
- Mental health legislation committee
- Audit Committee
- Charitable fund committee
- Remuneration committee

Each committee had its own reporting mechanism to ensure oversight by the board and ensure the dissemination of information to the staff groups. The trust had a clear framework which set out the structure of wards and teams, divisional meetings and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed.

We reviewed three sets of quality committee minutes and three sets of the audit committee minutes and these were of a high standard, papers and reports were presented and there were clear standing items, meeting items and whether the actions were resolved or whether further action was needed. In all the minutes we reviewed we found that the trust now included an item for escalation or inclusion on the risk register, before close of the meeting, which was helpful to ensure the flow of information.

CQC core service	Reference	Team/Ward	Actions
MH - Secure wards/Forensic inpatient	200142	Humber Centre	Ongoing – awaiting police investigation feedback
Not Provided	2018-11732		Due for completion 17/12/2018
Not provided	2018-2697		A comprehensive action plan was developed to address a number of recommendations made within the report. The key outcomes are: - Restrictive interventions – supporting staff to understand the application of the policy and within a medium secure environment to achieve a balance between least restrictive practice and maintenance of safety and security. - Substance Misuse - Additional training is required for staff at the Humber Centre in relation management of substance misuse. - Physical Health - To optimise physical health care provision through the Health Hub at the Humber Centre and ensure compliance with ILS training. - To ensure that Preceptorship policy is applied consistently within so that no nurses on preceptorship are left in charge of wards without direct supervision.
Not provided	1484914		Undertaken by the local authority safeguarding and access team. Actions identified: - For Westlands staff to continue to support the patient through any difficulties that arise. - To contact the safeguarding adults team should the need arise.

Humber Teaching NHS Foundation Trust has submitted details of four external reviews commenced or published in the last 12 months [1 September 2017 to 31 August 2018]. Details are provided in the table above.

The trust had an equality and diversity policy, which was due for review in January 2019. Equality impact assessments were undertaken on all policies, service developments and changes.

There was an executive and non-executive director lead for the Mental Health Act lead which ensured that the Mental Health Act was given appropriate oversight at board level.

The non-executive Mental Health Act lead was the chair of the mental health legislation committee. Following committee meetings, they drafted an assurance report to the board. There was also a non executive director lead for associate hospital managers, a member of audit, quality and remuneration and nomination committees and a non-executive director lead for emergency planning preparedness and resilience.

The executive Mental Health Act lead was responsible for patient experience (including complaints and PALs). Their role also included the medical directorate (pharmacy, medical education, role, medical recruitment). They were also an executive lead (but not operational line management of individuals) on recovery, the Mental Health Act, suicide and self- harm, psychology, and quality Improvement.

There was a Mental Health Act oversight and scrutiny committee which reported directly to the board on Mental Health Act work-streams, issues and risks. Some of the regular agenda items and functions of the non-executive lead included:

- Board assurance framework
- Mental health legislation quarterly performance reports- looking at issues such as illegal detentions, admin errors, identifying trends and ways to reduce these errors.
- Looking at the mental health assessment process and ensuring staff know the action to take (for example where patients are detained using holding powers).
- Reporting to the board and keeping the board updated
- Monitoring the use of the Mental Health Act, for example monitoring the use of section 62, 135/ 136 usage.
- Liaising with police around the processes for section 135/ 136.
- Restrictive interventions- implementing and improving these processes.
- Benchmarking – monitoring detentions and detention levels against the local population.

Use of the Mental Health Act was regularly reported on a quarterly basis. Mental Health Act reports included datasets on repeat admissions data.

There was a section 75 agreement in place with two local authorities which allowed resources and management structures to be integrated across the two organisations. The two agreements differed. The trust employed social workers directly in respect of Hull City Council, but not for East Riding of Yorkshire Council. There was a good arrangement in place between the organisations and we were told that a lot of work had taken place to ensure that staff at the local authorities were aware of their roles and responsibilities.

There was representation from partners on Mental Health Act working groups and committees, including approved mental health act professionals, local authorities, independent mental health advocates, police, and ambulance services.

There were many multi-agency policies and protocols in place which were developed in partnership with other organisations to ensure collaborative working

The trust had entered into service level agreements with many organisations to support Mental Health Act administration and clinical functions when detained patients needed physical care. For example, there was a service level agreement in place to provide a GP service on site. This service also connected to outside provision for primary care needs.

The approved mental health act professionals service at Hull City Council was identified as an area of concern, with the main issues being around the retention and recruitment of approved mental health act professionals. In addition, a number of approved mental health act professionals, were unavailable which contributed towards the issues. This had been escalated to the committee who had received assurances about it. The Hull approved mental health act professional's forum continued to meet monthly. There was a concern about the Hull approved mental health act professional's rota not being covered on a regular basis. The issue had been discussed with the chief operating officer. There were no concerns relating to East Riding of Yorkshire council's approved mental health act professional's rota.

There was a section 12 register in place but some concerns were raised around how assessments were arranged. Some section 12 approved doctors were being used for assessments less than others and some doctors would arrange the second doctor themselves, which meant that the assessments were not shared evenly between the pool of doctors. Changes have been made to the section 12 rota to ensure this was used correctly.

Mental Health Act related polices were up to date and in line with the Code of Practice 2015 and there was a robust process for developing and ratifying Mental Health Act related policies. All policies specified a review date and in the policies, that we looked at we saw that those dates were being met.

At the time of inspection, there were sufficient numbers of hospital managers. They were aware they did not reflect the diversity of the patient population, particularly in relation to age. The trust had recruited a younger age range of hospital managers but due to their work and other commitments we were told it was a challenge to retain these.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Senior staff and directors from the trust were interviewed as part of the well led review. Most still felt that the biggest risk to the organisation was staffing and workforce challenges. This issue remained on the trust risk register. The trust vacancy rate for qualified nurses was 14% and unqualified staff was 20%. Ensuring staffing establishments were maintained across all the trusts services was a high priority for the trust. The trust had undertaken a range of incentives to attract and retain registered nursing staff with success in some areas, however work remained ongoing with this as it does nationally.

Staffing was monitored daily and any staffing concerns escalated in line with the trusts safe staffing escalation policy. The trust had recently introduced a daily risk huddle where the assistant director of quality governance and patient safety, led the meeting attended by clinical care directors, medicines safety officer and a safeguarding lead. All incidents that had been reported in the last 24 hours were reviewed and specific actions were agreed. This ensured appropriate oversight from senior members of the trust.

The board received a monthly safer staffing quality dashboard in line with the national quality board safe, sustainable and productive staffing.

In forensic services staff felt strongly about being deployed onto other wards to contribute to safer staffing levels. A new centralised e-roster had been implemented for the deployment of bank staff. Staff had not felt consulted about this and had negative views of the new system. Staff felt that their specific skills and therapeutic relationships with patients were not considered when they were deployed on to other wards.

Care hours per patient day was collated and reported locally and nationally, in preparation for this being introduced as the safer staffing indicator in 2019. A review of the staffing levels on all in-patient services was undertaken using the national quality board guidance for learning disabilities and mental health services published in 2018.

Providers must report all serious incidents to the strategic executive information system (STEIS) within two working days of identifying an incident.

Between 1 September 2017 to 31 August 2018 the trust reported 20 strategic executive information system incidents. The most common type of incident was apparent, actual, suspected self-inflicted harm meeting serious incident criteria with 9 incidents. Three of these incidents

occurred in mental health crisis services and health-based places of safety and four of these incidents occurred in community-based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Humber Teaching NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to strategic executive information system.

Three incidents classified as environmental incidents on strategic executive information system were classified as other types of incidents on the incident reporting system.

From the trust's serious incident information, one of the unexpected deaths was an instance of sub-optimal care of the deteriorating patient meeting serious incident criteria and this occurred in acute wards for adults of working age and psychiatric intensive care units. One of the unexpected deaths was an instance of substance misuse whilst an inpatient, meeting serious incident criteria and this occurred in secure wards/forensic inpatient, and one of the unexpected deaths was an instance of Apparent/actual/suspected self-inflicted harm meeting serious incident criteria and this occurred in acute wards for adults of working age and psychiatric intensive care units.

Type of incident reported on STEIS	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Mental health crisis services and health based places of safety	MH - Wards for people with learning disabilities or autism	MH - Community-based mental health services for older people	MH - Community-based mental health services for adults of working age	MH - Secure wards/Forensic inpatient	CHS - Adults Community	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	3	0	1	4	0	0	**9**
Environmental incident meeting SI criteria	2	0	1	0	0	0	0	**3**
Sub-optimal care of the deteriorating patient meeting SI criteria	1	0	0	0	0	1	1	**3**
Operation/treatment given without valid consent	1	0	0	0	0	0	0	**1**

Slips/trips/falls meeting SI criteria	0	0	0	0	1	0	0	**1**
Substance misuse whilst inpatient meeting SI criteria	0	0	0	0	0	1	0	**1**
Unauthorised absence meeting SI criteria	1	0	0	0	0	0	0	**1**
Total	**6**	**3**	**1**	**1**	**5**	**2**	**1**	

Providers should report patient safety incidents to the national reporting and learning system at least once a month. They do not report staff incidents, health and safety incidents or security incidents to national reporting and learning system.

We reviewed six serious incident investigations and we found that since our last inspection the terms of reference were no longer generic and the quality and timeliness of these investigations had improved.

In forensic services there was a tracker system in place to monitor progress of actions resulting from serious incident and significant event analysis. However, we reviewed trackers and found these had not been updated and most actions had not been complete within identified timescales.

A serious incident investigation in Whitby community health services took place in March 2018. It was found that risk assessments and a holistic assessment had not been completed. Recommendations from this review also included introducing regular quality and safety audits of records and reviewing the process for creating alerts on the electronic patient record. However, these regular audits had not been carried out

The highest reporting categories of incidents reported to the national reporting and learning system for this trust for the period April 2017 to August 2018 were self-harming behaviour, other, and disruptive, aggressive behaviour (including patient to patient). These three categories accounted for 2640 of the 5054 incidents reported. Self-harming behaviour accounted for 22 of the 23 deaths reported.

Ninety-five percent of the total incidents reported were classed as no harm (71%) or low harm (24%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Other	Total
Self-harming behaviour	702	596	63	4	22	0	**1387**
Disruptive, aggressive behaviour (includes patient-to-patient)	608	132	7	0	0	0	**747**
Other	433	57	16	0	0	0	**506**
Access, admission, transfer, discharge	388	35	9	5	0	0	**437**

Incident type	No harm	Low harm	Moderate	Severe	Death	Other	Total
(including missing patient)							
Medication	397	24	1	0	0	0	**422**
Patient abuse (by staff / third party)	249	80	11	0	0	0	**340**
Treatment, procedure	114	129	84	0	0	0	**327**
Patient accident	168	103	13	0	0	0	**284**
Implementation of care and ongoing monitoring / review	133	27	8	2	1	0	**171**
Documentation (including electronic & paper records, identification and drug charts)	159	4	0	0	0	0	**163**
Infrastructure (including staffing, facilities, environment)	148	8	1	0	0	0	**157**
Consent, communication, confidentiality	44	9	0	0	0	0	**53**
Clinical assessment (including diagnosis, scans, tests, assessments)	13	9	1	1	0	0	**24**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	0	0	0	0	10	**10**
Medical device / equipment	8	2	0	0	0	0	**10**
Infection Control Incident	3	3	0	0	0	0	**6**
Environmental incident meeting SI criteria	0	0	0	0	0	3	**3**
Sub-optimal care of the deteriorating patient meeting SI criteria	0	0	0	0	0	3	**3**
Operation/treatment given without valid consent	0	0	0	0	0	1	**1**
Slips/trips/falls meeting SI criteria	0	0	0	0	0	1	**1**

Incident type	No harm	Low harm	Moderate	Severe	Death	Other	Total
Substance misuse whilst inpatient meeting SI criteria	0	0	0	0	0	1	1
Unauthorised absence meeting SI criteria	0	0	0	0	0	1	1
Total	3567	1218	214	12	23	20	5054

According to the latest six-monthly national patient safety agency organisational report (October 2017 – March 2018), there was no evidence of potential under reporting by this trust.

Figure 1: Potential under-reporting of incidents to the NRLS, October 2017 to March 2018

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Humber Teaching NHS Foundation Trust reported fewer incidents from October 2017 to March 2018 compared with the previous 12 months this reduction could be due to the loss of a community services contract and the subsequent transfer of 563 staff. Alongside fewer incidents overall, there were also fewer incidents resulting in death and moderate harm. However, there were more incidents resulting in severe harm.

Level of harm	October 2016 – March 2017	October 2017 – March 2018
No harm	1919	1489
Low	788	518
Moderate	238	88
Severe	7	8
Death	31	9
Total incidents	**2983**	**2112**

At our last inspection we found that not all staff had a completed disclosure and barring service check. The trust immediately acted and we found they now had system to ensure that these checks were completed and were in date.

The trusts complaints policy set out its timelines for investigating and reporting on complaints. We found at our last inspection the trust was consistently failing to achieve their targets for completing complaints within 25 days, although had always responded to complaints within their three day target. Following these delays, the trust piloted a staged complaint process. Following a successful pilot, the quality committee agreed that the policy would be amended to include a 30, 40 or 60 working days to completions of complaints, dependant on number of issues within the complaint, number of teams it relates to and complexity of the complaint.

The trust had a safeguarding policy for adults and children and this had been updated. The policy was comprehensive and showed clear lines of responsibility and accountability.

During the inspection we reviewed several safeguarding alerts and investigations, we found that these had been dealt with in line with the policy. The trust had a head of safeguarding adults and children and a deputy, who was also the named nurse for children. The trust had a named doctor as well.

The trust has a robust system for ensuring oversight of safeguarding alerts and investigations, including a duty team who could cover for safeguarding enquiries and a duty desk covered via a centralised number. There were also out of hours cover via line management and from the local authority.

Specialist advice from the safeguarding team was provided on complex cases, for example reviews of segregation, pressure ulcers and all under 18 admissions to adult wards.

The team had weekly peer review sessions to review all pending requests and had a live tracker for section 42 investigations.

Following a safeguarding investigation in the last 12 months, the team took some immediate actions, including staff training and supporting staff with their practice.

The team had also developed a safeguarding level 3 training package for adults and this was launched in 2018 and safeguarding level 3 for children was available for staff. Safeguarding level 2 training remained mandatory for all staff including agency and bank staff.

Peer reviews across services assessed the adoption of safeguarding practice supported by a programme of audit. A safeguarding forum chaired by the director of nursing met quarterly to review safeguarding practices in line with national and local policy and feedback from the trusts safeguarding information systems. The forum reported quarterly to the quality and patient safety group which reported directly to the quality committee for assurance purposes. Monthly

safeguarding data was reported directly to the board in the integrated performance tracker and the director of nursing's board report.

The trust had a clinical audit and effectiveness strategy 2016-2019. The audit committee fed directly to the trust board, but information was also fed directly to the audit committee from the other committees and sub committees.

The trust had an extensive audit programme and plan and held its first ever research and development conference in 2017, which was well received by trust staff and external attendees, with an array of speakers, showcasing the work the trust was undertaking, by itself and with partners. The trust had developed an extensive audit cycle and the trust were involved in 23 Audits including:

- Completion of Discharge Letters (Forensics) Re-audit
- Audit of MDT standards
- CQUIN audit of Lorenzo Records
- Driving risk assessment amongst inpatients with psychiatric disorders (Newbridges)
- Last Prescriber Review (Addictions)
- MCA Mental Capacity Act : knowledge of staff
- National audit of Unicef Baby Feeding Initiative
- National Clinical Audit of Psychosis
- Audit of General Liaison MDT sheets
- NICE CG146 Osteoporosis
- NICE CG16 Self-harm in over 8s - short term management
- NICE CG178, CG133, CG185, CG90, CG120
- NICE CG191 Pneumonia
- NICE CG192 Antenatal and postnatal mental health
- NICE CG53 Chronic Fatigue
- NICE NG10 Violence and aggression: short-term management
- NICE NG11 Challenging behaviour and Learning Disability
- NICE NG28 Type 2 diabetes in adults: management
- NICE QS138 Blood Transfusion
- Weight Monitoring in Psychiatric Inpatients (Westlands
- NICE CG142 Autism spectrum disorder in adults
- NICE CG90 Depression in Adults
- NICE NG97 Dementia: assessment, management and support

Pharmacy performance and quality was measured through internal and external audit including POMH-UK (prescribing observatory for mental health).

Medicines on the wards were audited through the perfect ward application. This was customised to meet the needs of the trust.

As well the trust risk register there were seven other local risk registers,

- Children and learning disabilities
- Specialist services
- Community services
- Finance
- Mental health services
- Pharmacy
- Primary care

At our last inspection in 2017, staff expressed risks and worries around staffing numbers, skill mix and change management. They reported the same at this inspection, but also reported the visibility of the executive team as an issue. The senior executive team reported similar worries and risks again and these matched those identified as high risk on the trust risk register. The trust had articulated the risk within the workforce strategy, trust strategy and the sustainability and transformation plan and the risk register contained both assurance and gaps in control.

The trust had a major incident plan which set out the organisational response to internal and external major incidents. The chief operating officer had oversight of major incident planning.

The major incident plan set out how the trust had planned and was prepared for all major incidents and would do this by

- Protecting life
- Managing injuries or continued ill health
- With others give special consideration to vulnerable member of the community
- Supporting staff, before, during and after any responses to a major incident
- Working with NHS England and public health England
- Co-operating with local resilience forum partners.

NHS organisations have used cost improvements programmes for many years to deliver and plan the savings they intend to make. However, funding growth over the last ten years has meant reduced pressure on some organisations to deliver these cost improvement programmes.

The trust had an operational financial plan, to enable them to deliver their cost improvement programme as outlined by NHS improvement. Care groups and corporate services were required to meet savings targets of £6.100m for 2018-19. The cost improvement given to all services was 1.5%.

NHS improvements reported that the trust was proactive in using benchmarking data to develop cost improvements programmes.
As at the last inspection all cost improvement programmes went through a robust internal assessment process, this process remained the same at this inspection. Each saving proposal was assessed in terms of a requirement to undertake a quality impact assessment (QIA). Those savings subject to a quality impact assessment were risk rated and were subject to approval by the director of finance, director of nursing and the medical director. The finance director and director of nursing told us that not all proposed cost improvement programmes were agreed and some were rejected if they significantly affected patient care.

All directorates in the trust put forward individual recurrent saving schemes that would make up the budget reduction schemes for 2018-19. These savings formed part of the overall Budget. Each recurrent saving was profiled to reflect when they would be achieved. Profiling remained under constant review by finance staff and budget holders.

In 2016, when new junior doctor contracts were negotiated nationally a guardian of safe working hours role was introduced to protect patients and doctors by making sure doctors weren't working unsafe hours. The guardian received reports and recorded hours against terms and conditions, they also reviewed risks to the doctor or patients and could undertake a work schedule review if there were persistent breeches to contracts. Initially the trust had a guardian forum every month, but as issues reduced this went to bi-monthly. The guardian linked with the freedom to speak up guardian and they shared soft intelligence.
Junior doctors had their own committee meeting, medical education committee and junior doctor operational meetings with managers. They all interlink together, along with a local negotiating committee. Junior doctors were interviewed as part of the inspection and they did not raise any issues with the new contracts.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust board received holistic information on service quality and sustainability.

The trusts business planning framework demonstrated the supporting delivery and development plans that aligned with all their organisational strategies and their annual operational plan. The trust board were responsible for overseeing strategic performance management. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.

The trust had a weekly clinical risk management group. This group fed directly to the executive team and had oversight of all clinical, quality and risk issues. All open incidents, serious incidents, serious events and mortality trackers were discussed and actions agreed.

Leaders used meeting agendas to address quality and sustainability throughout the trust. Feedback in some services from staff told us that they received regular updates from the trust by email. They also had access to the trust intranet page.

In forensic services at the time of the inspection, there was no clear framework of what should be discussed at ward team meetings. We reviewed minutes of ward meetings and found there was no standard agenda and the content of the meetings varied between wards. The quality of minutes and recording of action points was variable. Senior managers within the service had developed terms of reference and a standard agenda for ward clinical governance meetings. These were due to be introduced from February 2019.

In community child and adolescent mental health services staff attended weekly team meetings and monthly business meetings. They participated in discussions cascaded down from clinical meetings, transformation meetings and managers meetings. The agendas included training, team risks, patient risks, complaints and compliments, lessons learnt, staffing and administration.

Managers in the crisis and health based place of safety services, disseminated information to staff from the investigation of local incidents and incidents from across the trust 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 staff discussed incidents within meetings.

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

The Information Governance Toolkit is a Department of Health (DH) Policy delivery vehicle that the health and social care information centre was commissioned to develop and maintain. It draws together the legal rules and central guidance set out by Department of Health policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the information governance requirements. As from 26 February 2019, this would be known as the data security and protection toolkit.

The trust achieved level two and above in all requirements in the 2017/18 information governance toolkit for the sections, clinical information assurance, secondary use assurance and corporate

information assurance. Completeness and validity reports were produced which were currently showing an attainment level of three (the highest achievable). The trust used data quality reports produced by NHS Digital to monitor how they were performing with data submissions and the data quality maturity index data, a quarterly publication about data in the NHS to see how they were performing in comparison to other organisations.

The senior information risk officer or SIRO was the director of finance and he was the executive lead for information and technology. Staff training in information governance was 95% and the trust had recently undertaken work to ensure that bank workers had undertaken this training before starting work.

The trust had invested in data warehouse technology with system that used SQL 2012 R2 which is a reliable free data management system that delivered a data store for websites and desktop applications. This allowed one of the trust clinical systems data to feed directly into the data warehouse and provided data quality reports to operational teams to assist in the monitoring of care and providing assurance on data quality.

A patient search portal had also been developed which combined information from all main patient systems allowing clinicians to see who was involved with patients, for example, when a new referral was received.

Over the past 12 months the trust had also;

- Implemented the 'perfect ward app', a simple inspection tool that had a big impact on healthcare quality, quick and easy to use for all staff. Offering improved quality from ward to board.
- Implemented the functional analysis of care environments risk tool across the trust services electronically.
- The mental health clustering tool was now integrated within the patient record.
- Implemented e-prescribing in Whitby Community Hospital to improve medicines management.

The trust used an electronic patient care record system and at the last inspection we found varied implementation and that the system was very slow in practice. Unfortunately, in the core service inspections staff told us and we observed these issues had not been resolved and the system remained slow.

Staff also reported that they sometimes found it difficult to locate information on the system. In the acute wards for adults of working age and psychiatric intensive care units, staff had developed paper based summary files for patients because they could access these more quickly than the electronic system, which then meant there were duplicate paper files and an increased chance of patient information being lost. In crisis and health based place of safety services we found that information

was not being stored appropriately on the system for safeguarding information, and although the system did have an alert system on the contact page, it was difficult to find this information contained within contemporaneous notes.
In the child and adolescent mental health services community teams, staff used an electronic patient recording system. They reported that this was sometimes slow and that there were inconsistencies as to where some information was stored. We were not assured that the trust executive teams or information technology teams were appropriately sighted on the issues that care services were experiencing with the electronic patient record system.
Following a national virus attack the trust servers were not heavily affected and the trust were able to implement its major incident plan and limit any disruption to business. The trust was rolling out new networks and hardware which would in place by the end of March 2019, which would increase cyber security. Network security incidents were very low, with some connectivity problems, but this had improved recently with the introduction of the new network. The trust had rolled out guest Wi-Fi across all sites.

The trust was aware of its performance using key performance indicators and other metrics. This data was fed to the board and in to the board assurance framework. The trust had recently started to use statistical process control, which is a method of quality control which employs statistical methods to monitor and control processes. This enabled better evaluation of key performance indicators and moved away from cumbersome dashboards.

All pharmacy resources were available through the trust internet, which had been updated to enable easier searching via an index page.
National funding from NHS improvements had been secured for electronic prescribing through the Electronic patient notes system in March 2019. The trust had introduced electronic prescribing through another of these systems in Whitby community hospital and plans were in place to introduce this in Malton.
The trust had a medicine safety officer who reviewed all medicine incidents reported through The incident reporting online system. These were reviewed monthly by a multidisciplinary team to ensure learning was effectively shared. These incidents were also discussed if relevant at bi-monthly link practitioner meetings.
A central alerting system officer held a database of medicines alerts and recalls actioning new alerts and holding outcomes for future reference. Relevant alerts were discussed through the drugs and therapeutics committee.

The trust reported appropriately to the strategic executive information system and national reporting and learning system in a timely way and all notifications to the CQC were also reported appropriately.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively

The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives.

The trust had a patient experience strategy. In 2018 the trust developed an action plan and there were 12 priorities that aligned with the goals and had milestones set for the next five years. A small group of carers, patients and staff come together monthly and ask the trust how they were moving on with the action plan. So far, the trust had 70 out of 91 actions complete.

All teams handed out friends and family survey forms to patients and carers. The trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received. The information showed how the trust were performing at organisation, care group and team level. This live link was available via the trusts internet page and patients, carers and staff could access this immediately. The February 2019 response showed that 216 people had responded to the survey and that 94% of them would recommend their services to friends and family if they needed similar care or treatment. This innovative live data dashboard had been developed by the patient and carers lead in conjunction with the IT department. Other similar trusts were now in discussions with the trust to see if this could be shared further. The patient and carer experience team were also in discussions with the trust IT team to see if a further live tracker which included complaints and incidents could be developed.

The child and adolescent mental health services eating disorder service handed out experience of service questionnaires on discharge. Consistent feedback highlighted that young people and their parents or carers felt listened to and supported and they had been offered the most appropriate support. Townend Court inpatient unit participated in the national always events programme and regularly surveyed patients and their families. A recent survey revealed that patients were not always able to contact people who were important to them 24 hours a day for various reasons including wi-fi connectivity and resources. Several of the trust teams used the perfect ward app to ask patients and carers questions on their experiences. Findings from Market Weighton surgery included, too long queuing on the phone, staff are lovely, location not central, patients want later appointments with clinicians. Findings from the improving access to psychological therapies services patient treatment questionnaire included, access to service needs improvement and more promotional information required.

Although staff felt isolated from the trust geographically in Scarborough and Whitby, they told us they received weekly updates on events, policy updates and things that were happening in the

trust. Staff told us the chief executive had attended away days, was present at their induction and had visited services.

The trust strategy was developed in 2017 and included feedback from patients, carers and staff. It also included consultations with the trust board, feedback from stakeholders and they actively engaged with people and staff who were in a range of equality groups.

The trust's strategy has been refreshed and had been circulated to all staff in an easy read format, for staff to understand and to identify how their role contributed to the success of the trust. The trust was improving the experience at work for its employees through this strategy.

There had been increased visibility and contact from the senior leadership across the trust, with regular blogs and tweets, up to date internet and intranet pages, scheduled visits across localities, opportunities for staff to meet with the chief executive and briefing or practice notes to circulate clinical issues to the trust staff. Despite these measures, feedback from staff including medical staff still suggested that not all of these communication channels were working effectively.

We spoke to external stakeholders and attended local quality surveillance groups. These stakeholders again reported an open and transparent relationship.

The leadership programme cohort had been extended and the distributed leadership model continued to be embedded within the trust.

The trust recognised there were challenges in recruiting to clinical and medical roles which was not just a local challenge but a nationwide one. To address this, the trust has attended the Royal College of Psychiatry conference to promote vacancies, promoted the trust at a local Hull event and planned a dedicated recruitment day to help try and fill vacancies.

The trust has been successful in securing funding for the advanced clinical practitioner programme and had seven places allocated. The trust was also participating in the Nursing Associate Programme with internal candidates on the programme.

The view of staff was that patient care remains the top priority for the organisation which supported the continued drive and commitment by leaders in the trust and supported the trusts strategy and objectives which continued to be shared with all staff.

Staff views were that the trust provided equal opportunities for career progression or promotion and in the previous national survey, the trust scored above national average.

One area of weakness was that staff believed that they were not able to engage in improvements at work. The trust had increased opportunities for staff to put forward their suggestions with dedicated pages on the intranet site. The trust was also embedding its distributed leadership strategy across the organisation.

We spoke to the trusts governors, including staff and partner governors. As an NHS foundation trust governor, the role was to hold the trusts non-executive directors to account for the performance of the board and represent the interests of members and the public.

Governors described a year of learning for new members. They were impressed by the openness and honesty of the trust and they had a rich and diversely skilled group of governors. They reported that they had met a significant number of people at all levels within the trust. They found them all are very motivated, wanting to do the best for patients. The trust recognised areas for improvement and were honest about what needed to be done. The governors were impressed by the quality improvements being led by front line staff. They felt that the non executive directors were very clear on their roles and responsibilities.

Whilst the governors reported positive changes within the trust, they recognised that there was a gap between the senior leaders within the trust and those on the ground. They felt staffing levels didn't feel as good as the safe staffing levels suggested and that clinical needs were not always met. Issues around middle management were being addressed within the consultation. The schedule of governance was clear, but still work to do. Governors felt that they had a voice now.

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care were legally required to follow the accessible information standard. The standard set out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Information was captured by the trust on initial assessment paperwork to inform teams of any communication needs. Both electronic systems have either accessible information template or a clinical data capture form, this alert is then placed on the patients record to inform staff of additional communication needs. The learning disability service had an accessible information focus group which had redesigned leaflets and waiting list letters to ensure that they were accessible. The community and inpatient learning disability staff had access to speech and language therapy services.

Accessible information standard specialist services were available for those patients with more complex needs within community health services. People's individual needs were considered.

Browsealoud was introduced to the trusts website in December 2018 which allowed the website to be translated into 99 languages and read aloud in 40 of the most common languages.

Browsealoud also enabled the reader to block or remove distractions from the page allowing them to focus on the most important parts and font size and colour could be changed to help communication for people with disabilities such as dyslexia, low literacy and mild visual impairment.

The trusts communication's team produced information to ensure any communication was easy to understand and produced information in larger font sizes for the visually impaired.
During this inspection we heard from many service users, carers and local user groups about their experience of care. Most people we spoke with were positive about their, or their loved ones, care and treatment and the service that had been received.

The pharmacy team engaged with patients through several ways. For example, with discharge information, with patients and carers on the wards and as part of multi disciplinary meetings.
The pharmacy department monitored the service level agreement with regards to the outpatients pharmacy with regular key performance indicators and this ensured effective oversight of this third-party provider.
Trust pharmacists were members of Hull and East Riding joint formulary committee and other regional groups.
The trust had a service level agreement with a community pharmacy in Hull for prescriptions for the health based place of safety. This community pharmacy did not open past 10pm on weekdays and Saturdays and 8pm on Sundays. Staff informed us despite the service level agreement and patient directives been in place there continued to be difficulties in obtaining medication out of hours.

Some staff that we spoke with told us that if they required medication out of hours they could have difficulty accessing this through other areas of the trust. This meant there may be a delay in patients receiving the medication they required. Whilst managers were aware of the issue and had included it on the service risk register, this was raised as an issue at the last inspection in 2017 and had not been fully resolved.

Learning, continuous improvement and innovation

	Historical data		Projections	
Financial Metrics	**Previous financial year (2 years ago)**	**Last financial year (1 April 2017 to 31 March 2018)**	**This financial year**	**Next financial year (1 April 2019 to 31 March 2020)**
Income	£142,939,000	£118,422,000	£126,267,000	£126,645,801
Surplus	-£1,737,000	£3,695,000	£851,000	£851,000
Full costs	£144,676,000	£114,727,000	£125,416,000	£125,794,801

	Historical data		Projections	
Budget	-£377,000	£233,000	£851,000	£851,000

The deficit for 2016/17 was after the net impairment costs of £2.942m in 2016/17 and the 2017/18 surplus was after a net impairment gain of £2.813m. Both the 2016/17 & 2017/18 figures were reported against the NHS Improvement control totals. The 2016/17, 2017/18 and 2018/19 figures also included sustainability and transformational funding of £2.496m, £2,597m and £2,012m respectively. The trust had embarked upon a three-year budget reduction strategy with total savings requirements of £8.8m in 2018/19, £4.0m in 2019/20 and £2.4m in 2020/21.
The trust had a capital programme of £8.629m, with the main part of that being the children's centre scheme. This had a total value of £7.750m.
The current position of the trust at month five was an underspend against budget of £0.114m
The trust accepted its control total in each of the last three financial years 2016/17-2018/19, submitting control total compliant plans representing a reducing deficit position pre-provider sustainability. The planned position in each of these years was a surplus including the provider sustainability fund.
The trust delivered it's 2016/17 and 2017/18 control totals and was forecasting to deliver its 2018/19 control total, but with significant risk.
The trust presented reliable financial information to NHS Improvement. These reports provided clear, concise and transparent financial information. These reports were monthly financial narrative statements explaining the financial submissions.

In 2018/19 the trust income increased by £10m primarily due to the acquisition of the Scarborough and Ryedale community services contract. Additional income streams were also expected from the following:

- Successful acquisition of two further GP Practices
- Further acquisition of GP practices
- Tender with NHS England for a child and adolescent mental health inpatient services, for which a facility was currently under construction
- Drug and alcohol treatment services

NHS trusts could take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasted 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 - PICU (Psychiatric Intensive Care Units)	MH - Acute wards for adults of working age and psychiatric intensive care units	PICU	September 2016
AIMS - AT (Assessment and triage wards)	MH - Acute wards for adults of working age and psychiatric intensive care units	Avondale	February 2016
AIMS - OP (Wards for older people)	MH - Wards for older people with mental health problems	Millview Lodge	Not provided
AIMS - Rehab (Rehabilitation wards)	MH - Long stay / rehabilitation mental health wards for working age adults	Hawthorne Court	January 2016
ECT Accreditation Scheme (ECTAS)	N/A	ECT	June 2016
Accreditation for Psychological Therapies Services (APPTS)	N/A	East Riding Emotional wellbeing service (IAPT)	April 2016

Following a successful launch of the trusts research strategy in 2017 at their first research and development conference the trust has a further conference planned for May 2019.

To support and maintain research and development in the trust the research department offered, research governance advice and support, research feasibility advice and support, contractual review and oversight for research studies.
The trust was currently involved in 17 National Institute for Health Research

projects and 17 non National Institute for Health Research projects including in older people's mental health services, specialist services, adult mental health services and children's services.

The principle pharmacy technician was enrolled in quality and service improvement and redesign college to qualify as a quality improvement coach.
All pharmacists were currently qualified or on a course to become non-medical prescribers to improve their clinical role on the wards.
In crisis and health based place of safety services there was a programme of clinical audits in place which were supported by service specific audits to monitor call volume, type of call and outcome. Managers used this data to support development planning and improve the quality of the service provided. Managers had used the data on calls received to amend staffing rotas to ensure more staff were available to answer calls at peak times.

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.
The trust had a mortality governance policy, learning from deaths of patients in our care policy and procedure ratified by the trust in 2018 and due for review in 2021.
Within the policy the trust had adopted the definitions for deaths and coding as outlined by Mazars (Mazars 2015).
The mortality steering groups was chaired by the medical director, who reviewed and oversaw the progress and strategic direction of the trust in learning form deaths. All expected or unexpected deaths were subject to a 72-hour initial reporting period and this initial report was then reviewed by the clinical risk management group, who in addition to this peer review, reviewed all of the coding of deaths and then confirmed within this meeting.
All six of the death reviews we undertook followed the agreed process and all serious incidents and serious event analysis deaths were signed off by either the director of nursing or medical director. Mortality reviews were then sent to the clinical risk management group to share the learning or escalate any concerns raised because of the review. Building upon the processes developed to date, the trust were extending the review of mortality rates to the GP practices.
The trust had developed a bereavement package for deaths that occurred because of physical ailments. As part of that bereavement package the charity health stars paid for bereavement cards to be printed. Patients and carers developed the messages inside the card. The bereavement package included a card, advice on how to deal with bereavement for the carers, a card from the clinician who dealt with the loved one, links to funeral homes. This package was developed following the trusts last CQC inspection as the trust recognised that when people were grieving they don't want to be asked lots of questions, so staff don't complete the survey when they are with the carers but do it afterwards to be respectful. The team are hoping to roll these packages out to children and mental health services.

Staff had opportunities to contribute to service improvement through care group meetings and through supportive relationships with line managers who could give protected time for professional development. Staff on Westlands had developed a toolkit for use with patients at risk of suicide and self-harm. They were in the process of providing training for staff on other wards. Some managers had applied for funding to create a low-stimulus room on their ward to benefit patients with high levels of agitation.

Staff had access to regular development days which they used to learn and share good practice with staff from across their care group. We spoke with some staff who had attended these and they had found them useful.

Due to staffing pressures, there were limited opportunities for staff to be given time to support and consider areas for improvements in the forensic service. However, the trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The Humber centre patient's council had developed standards for community meetings and is developing carer involvement. Co-production with patients including completion of a mural at the Humber Centre by patients and staff had improved the surroundings. A link role for patient and carer experience had been developed. Work was underway to improve the dining experience within the forensic services.

The forensic service was a member of the Quality Network for Forensic Mental Health Services and participated in peer reviews. Action plans were in place to improve areas identified in the most recent review which had taken place in October 2018.

Pharmacy staff provided medicines training to staff on wards. They also had regular slots at induction and at the clinical professional development slots for doctors**.** Every in-patient unit had a designated clinical pharmacist.

A pharmacy technician provided medicine optimisation services to the East and West community mental health services.

The pharmacy team had trained over 60 medicine optimisation assessors to assess nursing competency in practice on the wards.

The trust actively sought to participate in national improvement and innovation projects.

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

children and adolescent mental health services continue to rise, consistent with the national picture, the programme has delivered an accessible early intervention programme which has begun to reduce the numbers requiring access to specialist treatment.

The trust has developed a new role of primary care matron the first post-holder of this role was one of five finalists in the 2018 general practice awards. A practice nurse won practice nurse of the year in 2018.

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

The trusts perinatal mental health services service was recognised for their work in an award from the British Journal of Midwifery. The service continued to work closely with the University of Hull in developing perinatal services, contributing to research in this area and best practice. This work has been a major contributory factor in been awarded the contract through the sustainability and transformation partnership to deliver perinatal services.

The specialist services care group continued to work hard in reducing restrictive interventions and develop training for staff regarding self-harm and suicide. Both these areas of work were recognised by the Health Service Journal patient safety awards 2018 where we were highly commended in the changing culture and patient safety team categories.

The East Riding health trainer service offered opportunity for all East Riding residents looking to make and sustain a positive lifestyle change. The service supports individuals to live a healthier lifestyle through a person-centred, individualised approach. This was recently expanded to cover weight management services across Scarborough, Ryedale and Whitby.

Community health services

Community health services for adults

Facts and data about this service

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

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Willerby Hill	Whitby Neighbourhood Care Services	Mixed	12 - all other appointments are home visits	Whitby and Eskdale locality

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Willerby Hill	Tissue Viability Specialist Service (TSVN) (Scarborough & Ryedale)	Mixed	4	Scarborough & Ryedale
Willerby Hill	Tissue Viability Specialist Service (TSVN) (East Riding)	Mixed	Clinics held at Pocklington 16	East Riding, North Yorkshire, Hull
Willerby Hill	Stroke Service (Managed by Scarborough South Community Hub)	Mixed	Home visits only	Scarborough & Ryedale
Willerby Hill	Speech & language Therapist (Scarborough & Ryedale)	Mixed	12	Scarborough & Ryedale
Willerby Hill	Scarborough South Community Hub Services	Mixed	see list	Scarborough
Willerby Hill	Scarborough North Community Hub Services	Mixed	see list	Scarborough
Willerby Hill	Ryedale Community Hub Services	Mixed	see list	Ryedale
Willerby Hill	Respiratory Specialist Nursing (Scarborough & Ryedale)	Mixed	28	Scarborough & Ryedale
Willerby Hill	Pocklington Neighbourhood Care Services	Mixed	Approx. 40	Pocklington GP Practice area
Willerby Hill	Musculoskeletal Physio - Whitby	Mixed	40-50 per month	Whitby and Eskdale locality
Willerby Hill	Musculoskeletal Physio - Scarborough & Ryedale	Mixed	Approx. 265 over patch	Scarborough & Ryedale
Willerby Hill	Heart Failure Specialist Nursing (Scarborough & Ryedale)	Mixed	12	Scarborough & Ryedale
Willerby Hill	Health Trainers - Stop Smoking Service	Mixed	90 plus	East Riding
Willerby Hill	Health Trainers - Social Prescribing	Mixed	90 plus	East Riding
Willerby Hill	Health Trainers - North Yorkshire Weight Management	Mixed	50 plus	Scarborough & Ryedale
Willerby Hill	Health Trainers	Mixed	90 plus	East Riding
Willerby Hill	Dietician (Scarborough & Ryedale)	Mixed	20	Scarborough & Ryedale
Willerby Hill	Continence Specialist Nursing Service (Adults) Scarborough & Ryedale	Mixed	32	Scarborough & Ryedale
Willerby Hill	Community Diabetes Service	Mixed	30	Scarborough & Ryedale
Willerby Hill	Cardiac Rehabilitation (Scarborough & Ryedale)	Mixed	24	Scarborough & Ryedale
Willerby Hill	Outpatient services	Mixed	5	East Riding of Yorkshire, North Yorkshire

Is the service safe?

Mandatory training

The trust provided mandatory training in key skills to all staff. Work was ongoing to ensure that staff completed it, as there had been some discrepancies with the training received by the staff in the Scarborough and Ryedale services that had been taken over by Humber NHS

Foundation Trust in May 2018. Staff had not received the same training at their old provider as was offered at Humber.

The trust set a target of 85% for completion of mandatory/statutory training and a target of 95% for completion of information governance training. Their overall training compliance in community services for adults was 67% against this target.

A breakdown of compliance for mandatory/statutory courses between 1 April 2018 and 31 August 2018 for staff in community services for adults is shown below:

Core Services	Grand Total %
Prevent Awareness	95%
Moving and Handling - Level 1	89%
Infection Prevention - Level 1	88%
Information Governance	87%
Infection Prevention - Level 2	86%
Health and Safety	82%
Safeguarding Children - Level 1	79%
Safeguarding Adults - Level 1	78%
Safeguarding Children - Level 2	77%
Fire Safety - 1 Year	76%
Moving and Handling - Level 2	76%
Fire Safety - 2 Years	74%
Safeguarding Adults - Level 2	71%
Mental Capacity Act - Level 1	58%
Equality and Diversity	56%
COSHH Awareness	52%
Display Screen Equipment	51%
Mental Capacity Act - Level 2	45%
Moving and Handling - Level 3	43%
Prevent - WRAP	37%
Safeguarding Children - Level 3	0%
Core Service Average	**67%**

During our inspection we spoke with service managers and reviewed training compliance. The mandatory training compliance rates were increasing and for the majority of subjects, compliance was meeting the trust target. A small number of courses were not meeting the trust target. Some of the staff we spoke with told us they had difficulty accessing the training as courses were held at inconvenient times. This had been raised as an issue and further courses were being made available.

Most of the training courses could be accessed online. Most staff told us they had no problems accessing and completing mandatory training. However, staff in the central access service told us they found it difficult to complete their training as they were not given protected time to complete it and had to try to fit the training in whilst managing their workload.

Staff told us those courses that were completed face to face were normally held in Hull at trust headquarters, which could cause a problem for accessing the training as it was a distance away from their bases. Service leads told us they were arranging for more local training to be delivered.

Staff and managers received email reminders when mandatory training was due to be completed.

Following this inspection, we requested performance reports for each locality. These showed that at December 2018, compliance with mandatory training was improving for each team. Overall compliance for Pocklington was 90%, Whitby was 89%, Scarborough South was 80%, Scarborough North was 78% and Ryedale was 62%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff we spoke with were aware of their safeguarding responsibilities. They told us they had good support from the safeguarding team and would contact them with any concerns. A flowchart was available on the staff intranet for staff to follow the procedure for making a referral.

Most of the localities were meeting the trust target of 85% for compliance with safeguarding training, apart from Scarborough South and Scarborough North. Scarborough South compliance with safeguarding adults level two training was 71% compliance at December 2018 and Scarborough North had 79% compliance for safeguarding adults level two and 77% for safeguarding children level two

Safeguarding referrals

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.

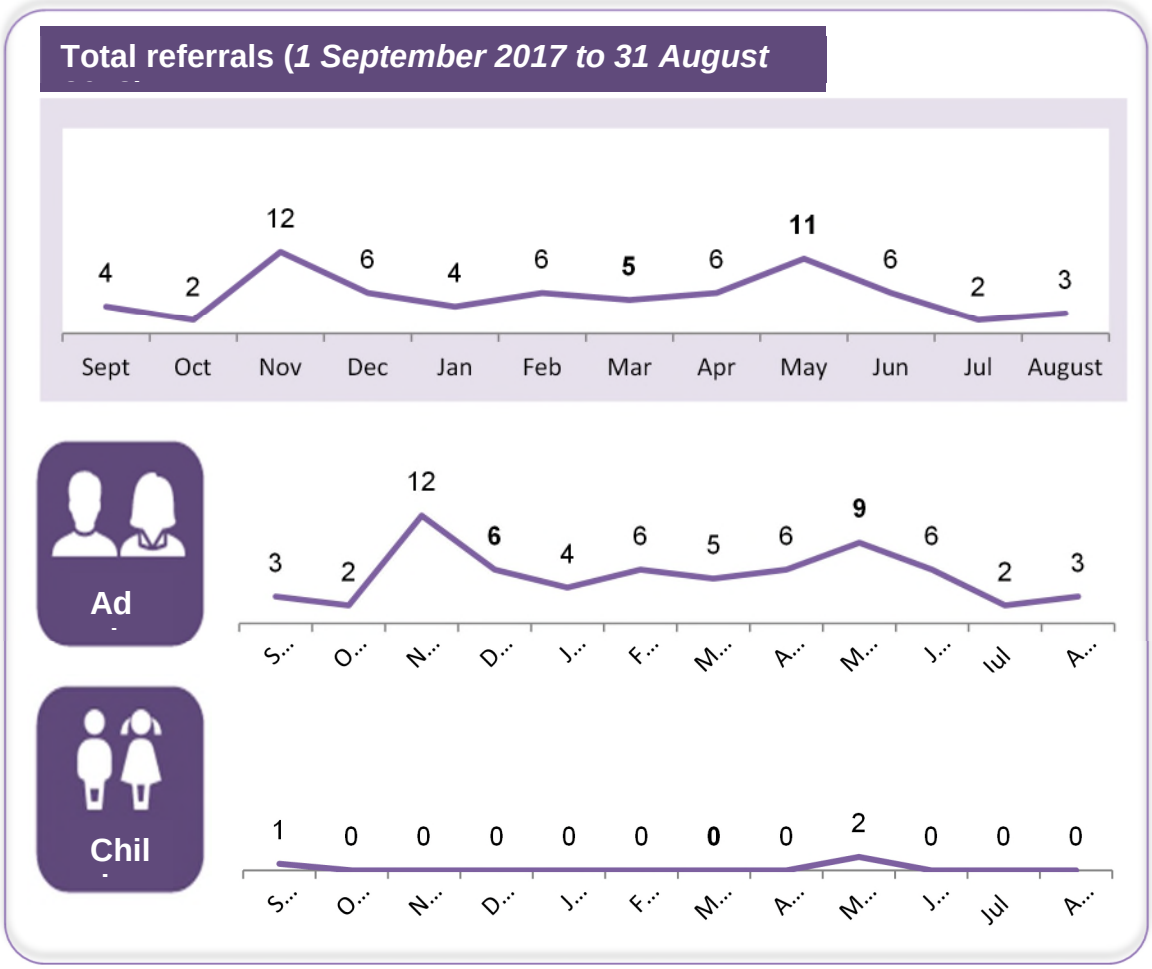
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine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

Community health services for adults made 67 safeguarding referrals between 1 September 2017 and 31 August 2018, of which 64 concerned adults and three concerned children.

Referrals		
Adults	Children	Total referrals
64	**3**	**67**

Looking at adult referrals across the 12-month period, there were peaks in November (12) and May (9).

There were two peaks identified in child referrals across the period in September (1) and May (2) as shown below



Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff were seen to adhere to the bare below the elbows policy. We observed staff cleaning hands appropriately and using personal protective equipment, such as gloves and aprons, as required.

We observed staff carrying out care in patient homes and procedures were carried out using good infection control techniques.

All clinic rooms that we saw during our visit were clean and had handwashing facilities. Disposable curtains were used and were visibly clean.

Staff told us regular infection control audits were not done. The team leader from the Pocklington team told us they had recently sent audits out for staff to complete by the beginning of February. We asked the trust to provide us with evidence of infection control audits for the last three months. They told us that infection control audits had not been done and that they were in the process of developing new audit tools.

Each team had infection prevention and control link practitioners.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the Whitby Community Hospital location scored higher than similar trusts for cleanliness and condition, appearance, and maintenance. The location scored lower than similar trusts for being dementia friendly and supporting those with disabilities.

The trust overall scored higher than similar trusts for cleanliness, but scored lower than similar trusts for condition, appearance, and maintenance, being dementia friendly, and supporting those with disabilities.

Site Name	Core Service(s) provided	Cleanliness	Condition Appearance and maintenance	Dementia Friendly	Disability
Whitby Community Hospital	CHS – Adults Community CHS – Community Inpatient	100.0%	96.3%	60.7%	60.8%
Trust Overall		**99.2%**	**95.1%**	**69.8%**	**79.7%**
England Average		**98.4%**	**95.4%**	**88.3%**	**87.7%**

Environment and equipment

The service had suitable premises and equipment. The community services staff were based in buildings not owned by the trust. Clinics that we observed were held in various locations.

At Malton Hospital, where one of the community teams were based, there was no reception area for patients to book in and they had to follow temporary signage.

At Pocklington, the team was based in a GP practice and used clinic rooms upstairs. The clinic rooms were bright and spacious and contained all equipment needed. There was adequate seating in the waiting area.

The service had a contract with an external provider for provision of equipment. Staff had access to a database so they could see the equipment that was in an individual patient's home. The external provider arranged for regular servicing and maintenance of the equipment.

One of the team leaders attended an equipment review group, made up of different clinical commissioning groups (CCG's) and providers, and a partnership board that looked at the commissioning and decommissioning of equipment.

Assessing and responding to patient risk

Staff in all teams did not always complete and update risk assessments. Staff in the Scarborough and Ryedale teams had moved over from another provider in May 2018 and they were still using some of the old systems and processes. Work was ongoing to develop the Humber electronic templates for use by the Scarborough and Malton teams.

An initial assessment form should have been completed for every patient. This assessment included assessment of mental capacity, consent, medical history, activities of daily living, mobility, accommodation and a baseline set of observations. Further risk assessments were undertaken if the nurse felt there was a need for further assessment, such as a falls risk assessment. Skin assessments, using the Walsall tool and nutrition assessments, using a malnutrition universal screening tool (MUST) were completed at further appointments. However, staff we spoke with told us that the electronic system was not set up to prompt staff when they needed to undertake a review of risk assessments. There was a risk that staff may not be aware that risk assessments needed to be completed, as mobile working practice was variable amongst staff. Some staff did not look at the electronic patient record until they returned to base to complete them.

Although we saw staff assessing risk in the home, we saw variation in the completion of risk assessments and care plans following visits. At Whitby, we saw a completed initial assessment, with timescales for the completion of further assessments. Care plans were in place and updated. In Pocklington, we reviewed three records and found that in one record the care plan did not have a review date. At Scarborough, we saw that assessments were not always completed. In two records we reviewed at Scarborough, there were no assessments evident, only progress notes. We reviewed two electronic records in Malton and found no care plans. Staff told us that since the move from the previous provider they were waiting for training and for the appropriate assessment and care plan templates to be uploaded to the electronic system. A paper record was seen in the patient's home, which contained a care plan. However, we saw this had not been updated since August 2018.

A serious incident investigation in Whitby, in to an incident that took place in March 2018, found that risk assessments and a holistic assessment had not been completed. Recommendations from this review included introducing regular quality and safety audits of records and reviewing the process for creating alerts on the electronic patient record. However, these regular audits had not been carried out. The new team leader at Whitby had been in post since October 2018 and had started to introduce regular audits.

We saw completed risk assessments for therapy teams. These were completed for home visits and for clinics.

Safety huddles had been introduced in each community team. Community nurses and therapists discussed any patient risk and could escalate concerns. However, staff told us that in some teams this appeared to be more community nurse focussed.

Most referrals went through a central access team. This was led by administrators who recorded referrals on the electronic system and passed them to the most appropriate team. A decision-making tool was available for nursing staff to determine the level of intervention required following referral, such as an urgent visit. However, when we spoke to staff in every team, they told us that there were no criteria for what constituted an urgent visit and that decisions were based on the nurse's experience. There was therefore a risk that different nurses may prioritise patients in a different way if they were not using the tool.

Community therapy services used a caseload risk stratification/ prioritisation matrix. This included scoring guidance for patients deemed high priority or routine. Fast response (within 24 hours) was indicated for hospital admission prevention, unsafe hospital discharges and broken essential equipment.

At our last inspection, in September 2017, there were no specific tools used for monitoring a deteriorating patient. At this inspection, they had started to introduce a national early warning score (NEWS2). Staff told us they would obtain a baseline set of observations at the first visit and took further observations if they felt a patient was unwell. Staff contacted the patient's GP if they had any concerns or called for an emergency ambulance if required. We saw a deteriorating patient pathway for staff to follow.

Staffing

Although staff had the right qualifications, skills and experience to provide the right care and treatment, the service did not always have the right amount of staff due to vacancies, sickness and reduced numbers of staff. No caseload management tool was used to determine the number of staff required for each locality.

The community services were separated into three localities - Scarborough and Ryedale, Whitby and Pocklington. The Scarborough and Ryedale locality was then separated in to three different hubs - Scarborough North, Scarborough South and Ryedale. A staffing review had been carried out in November and December 2018 to ensure that staff were distributed in the hubs according to patient need.

There were three band eight service managers - one for Whitby and Pocklington, one for Scarborough South and Ryedale, and one for Scarborough North. Each locality had a band seven

team leader and a band seven clinical lead, except Pocklington, which had a combined team leader and clinical lead role.

Staff in the different teams told us they had a minimum number of staff needed on a shift to ensure a safe service was run. However, when we asked how this number was decided, staff told us it was historical rather than based on complexity of patients. Team leaders told us that if they had more complex patients then they would increase the number of staff. The team leader from the Whitby team told us they were looking at introducing a caseload management tool.

Staffing levels in the Whitby team were low due to maternity leave and staff leaving. There were five band five vacancies. At the time of our inspection there were four band six nurses but one was due to go on maternity leave and one was leaving. This would leave two band six nurses. The team leader told us there were plans in place to get extra staff through using agency nurses. There was a band five nurse due to start at the end of January and two healthcare assistants were starting in February. An experienced nurse was going to be moved from another locality to support the team as a more senior team member had been suspended.

Budgeted therapy staffing levels in Whitby had significantly reduced in the last five years, since the change from a previous provider, and this had caused some difficulties managing those patients who required long term specialist rehabilitation, such as stroke patients. This issue had been raised at the business and clinical network meetings. At the time of our inspection, an audit was being completed in to the staffing and number of stroke patients and their outcomes.

In the Scarborough North team, there were three band five community nurse vacancies, two band six physiotherapist vacancies and one band six occupational therapist vacancy. Scarborough South had two band six physiotherapist vacancies.

Pocklington had one band five community nurse vacancy and one band six physiotherapist vacancy.

Following our inspection, we requested figures for planned versus actual staffing. The numbers for community nursing teams can be seen in the table below:

Locality	Staff Group	Budget WTE	Actual WTE
RYEDALE HUB NURSING	Healthcare Asst Band 3	13.00	12.51
	Modern Apprentice (NVQ) - A&C	0.76	0.76
	Nurse band 5	8.44	8.37
	Nurse band 6	2.50	2.50
SCARBOROUGH SOUTH HUB NURSING	Bank nurse band 3	0.00	0.06
	Bank nurse band 5	0.00	0.51
	Healthcare Asst Band 2	1.20	1.22
	Healthcare Asst Band 3	10.38	9.31
	Nurse band 5	6.59	6.66
	Nurse band 6	3.09	3.09

	Nurse band 7	2.00	1.00
SCARBOROUGH NORTH HUB NURSING	Bank nurse band 2	0.00	0.26
	Bank nurse band 3	0.00	0.96
	Bank nurse band 5	0.00	1.67
	Bank nurse band 6	0.00	0.14
	Healthcare Asst Band 2	0.80	0.67
	Healthcare Asst Band 3	16.57	14.53
	Healthcare Asst Band 4	0.60	0.60
	Nurse band 5	17.61	14.42
	Nurse band 6	10.00	9.81
	Nurse band 7	7.89	7.20
WHITBY NURSING	Healthcare Asst Band 3	9.93	8.19
	Nurse band 5	15.81	10.28
	Nurse band 6	3.39	4.80
	Nurse band 7	1.20	2.00
POCKLINGTON NURSING	Healthcare Asst Band 3	3.00	3.00
	Nurse band 5	4.60	3.60
	Nurse band 6	2.60	2.60
	Nurse band 7	1.00	1.00

The number of planned versus actual staffing for therapists can be seen in the table below:

Locality	Staff Group	Budget WTE	Actual WTE
RYEDALE HUB THERAPIES	Occ Therapist band 5	0.80	0.00
	Occ Therapist band 6	3.55	3.55
SCARBOROUGH SOUTH HUB THERAPIES	Occ Therapist band 6	1.78	1.78
	Occ Therapist band 7	0.00	1.00
	Physiotherapist band 5	1.00	0.00
	Physiotherapist band 6	3.90	1.90
	Rehab Assistant band 3	1.00	1.00
	Speech & Lang Therap band 6(AfC)	1.00	0.00
	Speech & Lang Therap band 7(AfC)	1.00	1.00
SCARBOROUGH NORTH HUB THERAPIES	Occ Therapist band 6	2.60	1.60
	PAMs band 2	0.96	0.96
	PAMs: Bank Staff	0.00	0.04
	Physiotherapist band 6	11.78	9.44
WHITBY THERAPIES	Occ Therapist band 5	1.00	0.80
	Occ Therapist band 6	1.10	1.10
	Occ Therapist band 7	2.00	2.00
	Physiotherapy band 3	2.00	1.64
	Physiotherapy band 4	0.00	1.00
	Physiotherapist band 5	1.00	0.80
	Physiotherapist band 6	2.55	2.32
	Physiotherapist band 7	1.00	1.00
POCKLINGTON THERAPIES	Occ Therapy band 3	0.60	0.60
	Occ Therapist band 6	0.80	0.80
	Physiotherapist band 6	1.40	0.40
	Physiotherapist band 7	0.80	0.70

Vacancies

Between 1 September 2017 and 31 August 2018, the trust reported an overall vacancy rate of 11% in community services for adults.

Staff group	Total number of WTE establishment staff	Total % vacancies overall (excluding seconded staff)
Medical and dental staff	0	0%
NHS infrastructure support staff	72.2	1%
Qualified allied health professionals	100.8	6%
Qualified nursing and health visiting staff	222.7	13%
Support to doctors and nursing staff	194.7	16%
Core service total	**590.4**	**11%**

(CAVEAT: The trust changed their financial reporting system part way through the 12-month reporting period and therefore vacancy data is inconclusive).

Turnover

Between 1 September 2017 and 31 August 2018, the trust reported an overall turnover rate of 12% in community services for adults.

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Average % of staff leavers in the last 12 months
NHS infrastructure support	2.0	0.0	0%
Other qualified scientific, therapeutic, and technical staff	3.0	0.0	0%
Qualified allied health professionals	43.6	3.0	7%
Qualified nursing and health visiting staff	81.9	10.5	12%
Support to doctors and nursing staff	81.2	13.5	16%
Support to ST&T staff	22.7	1.5	6%
Core service total	**234.4**	**28.5**	**12%**

Sickness

Between 1 September 2017 and 31 August 2018, the trust reported an overall sickness rate of 4.5% in community services for adults.

Staff group	Total % permanent staff sickness most recent month	Total % permanent staff sickness overall
NHS infrastructure support	0.0%	0.3%

Other qualified scientific, therapeutic, and technical staff	0.0%	0.0%
Qualified allied health professionals	0.5%	2.8%
Qualified nursing and health visiting staff	3.2%	6.3%
Support to doctors and nursing staff	4.6%	4.3%
Support to ST&T staff	2.9%	2.3%
Core service total	**3.0%**	**4.5%**

Following our inspection, we requested performance reports for each locality. Absence rates for Whitby, Pocklington and Ryedale at December 2018, were below the trust target of 4.5%. Scarborough North had an absence rate of 7.6% and Scarborough South had an absence rate of 7.4%.

Nursing – Bank and Agency Qualified nurses

Between 1 September 2017 and 31 August 2018, the core service reported an overall bank usage rate of <1% and an agency usage rate of 0% for qualified nursing staff.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank or Agency Staff	% NOT filled by Bank or Agency Staff
116854	135	0%	0	0%	236	0%

Nursing - Bank and Agency Healthcare Assistants

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing reporting, to that provided in the RPIR. The following relates to that received in the RPIR).

Between 1 September 2017 and 31 August 2018, the core service reported an overall bank usage rate of <1% and an agency usage rate of 0% for healthcare assistants.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank or Agency Staff	% NOT filled by Bank or Agency Staff
52901	96	0%	0	0%	393	1%

Suspensions and supervisions

During the reporting period, this core service reported that there was one staff member that had been moved wards.

Quality of records

There was variation in the standard of record keeping.

Patient records were held electronically, but there were also some services that continued to use paper records. Staff had access to laptops and could access patient records when they were out of the office. However, we saw variable practice when it came to completion of records. We did not see any electronic records completed in the house, some staff completed them in the car after the visit and some staff completed them when back at base. We observed two clinics. One practitioner documented directly on to the electronic patient record during the consultation, whilst another practitioner took notes during the consultation, which were transferred on to the electronic patient record following the clinic.

We observed that some patients had paper records held in the home, along with having an electronic record. Other patients had no records held in the home.

Completion of risk assessments and care plans varied in the records we reviewed. All records we reviewed had progress notes recorded following the visit. Staff we spoke with told us there was still work to be done with adding appropriate templates to the electronic patient record.

Documentation audits had not been regularly completed. An online tool was used historically within the trust, but this was not used consistently. Some teams had used the online audit tool and others had developed a local audit tool. We were told there was a new approach to record keeping audits being developed within the trust.

We reviewed results of a local documentation audit carried out in the Whitby team. This showed compliance with completing risk assessments and updating care plans was lower than the 100% expected from the service. Out of 10 records that were audited, five did not have up to date care plans.

Medicines

The service followed best practice when prescribing and giving medicines.

There were a small number of community nurses that were nurse prescribers. We saw that prescription pads were kept locked away. Staff told us they had annual prescriber updates. Staff told us they did not use patient group directions (PGD's). Individual prescriptions were prescribed.

In Pocklington, we saw medicines stored securely in the musculoskeletal physiotherapy room. Medicines and needles were kept in a locked cupboard, with the key kept in a key lock safe. The

temperature of the cupboard was monitored and we saw completed checklists to indicate this checking had taken place.

Controlled drugs, used by community nurses, were not kept on site and were collected as needed on a named patient basis and kept in a patient's home. We observed controlled drugs being administered in a residential home. Appropriate checks took place.

On visits with community nurses, we saw insulin injections administered safely and competently.

Safety performance

Safety Thermometer (September 2017 – September 2018)

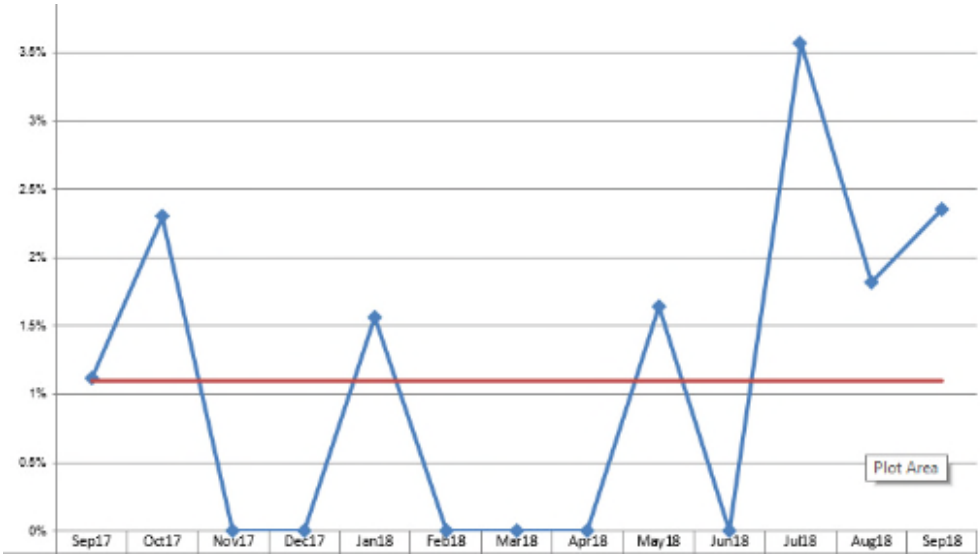
The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

The trust reported 17 new pressure ulcers, during the period September 2017 to September 2018.
The trust reported 49 falls with harm between September 2017 to September 2018.
The trust reported 11 Catheter & UTI's.
Between September 2017 and September 2018, the trust recorded 1160 cases of 'harm free' care.

New Pressure Ulcers

The trust reported 17 new pressure ulcers between September 2017 and September 2018.

The most number of new pressure ulcers was reported in October 2017 and September 2018 with 4 (2.30% and 2.35% prevalence rate). However, the highest prevalence rate occurred in July 2018 with 3.57%.

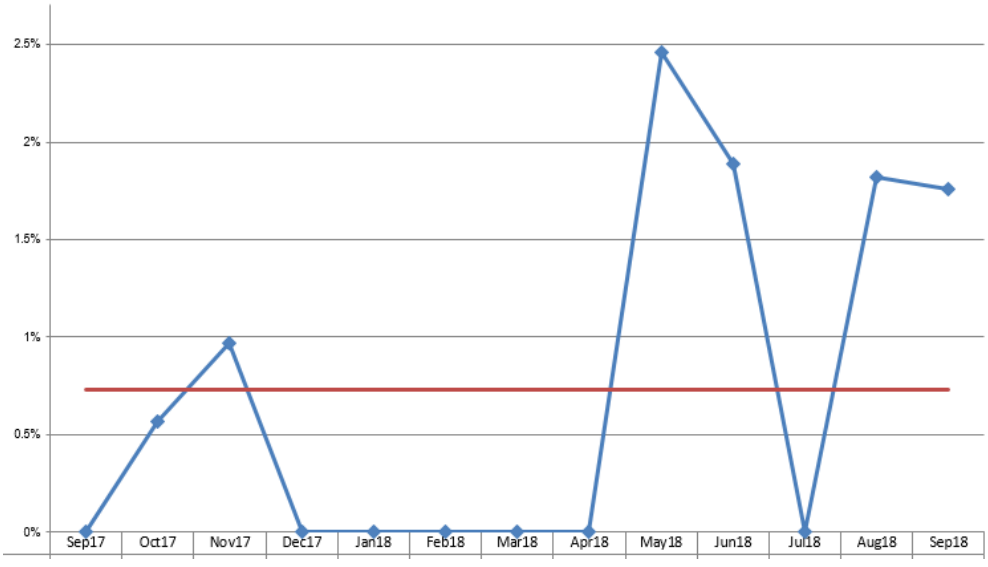


	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18
Prevalence %	1.12	2.30	0.00	0.00	1.56	0.00	0.00	0.00	1.64	0.00	3.57	1.82	2.35
No	2	4	0	0	1	0	0	0	2	0	2	2	4

Catheter & UTI

The trust reported 11 catheter & UTI between September 2017 and September 2018.

The most number of catheter and UTI's were reported in May 2018 and September 2018 with three each. The highest prevalence rate occurred in May 2018 with 2.46%.

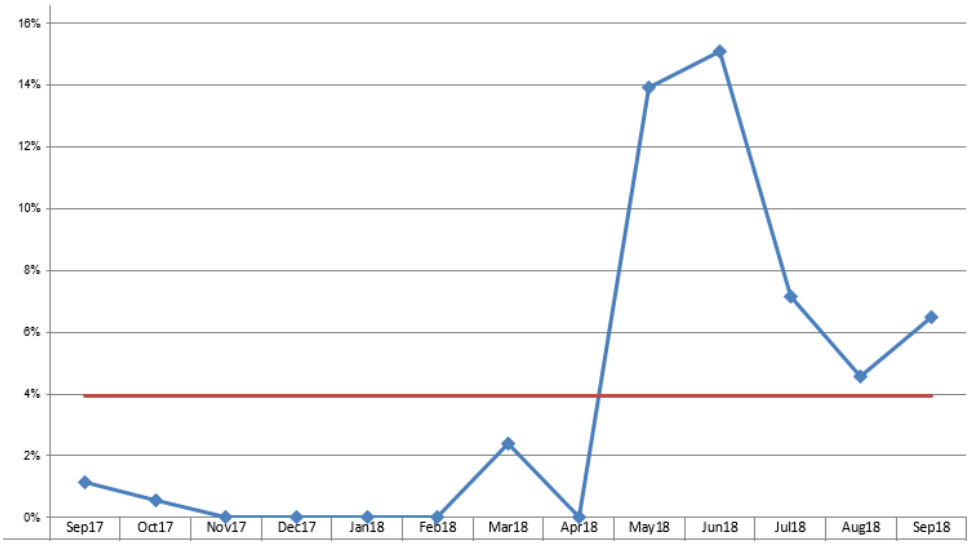


	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18
Prevalence %	0.00	0.57	0.97	0.00	0.00	0.00	0.00	0.00	2.46	1.89	0.00	1.82	1.76
No	0	1	1	0	0	0	0	0	3	1	0	2	3

Falls with Harm

The trust reported 49 falls with harm between September 2017 and September 2018.

The most number of falls with harm were reported in May 2018 with 17. The highest prevalence rate also occurred in May 2018 with 13.93%.

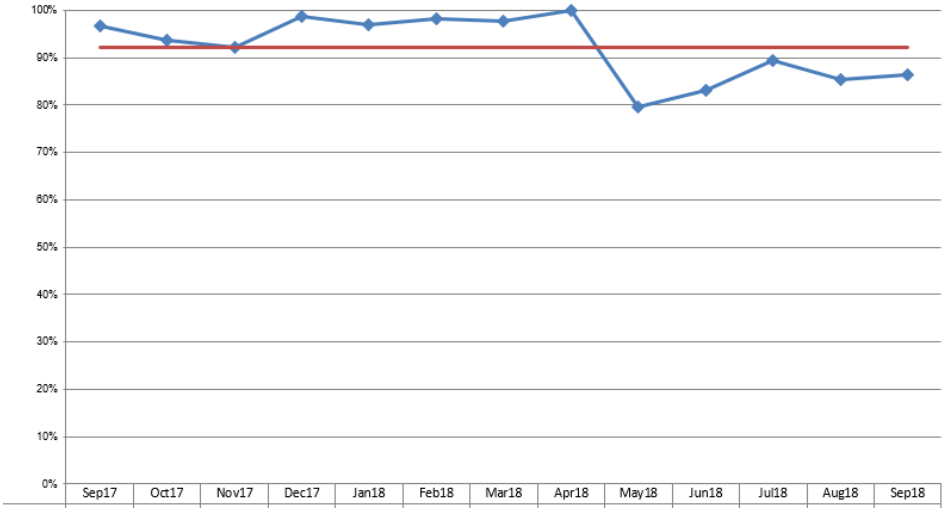


	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18
Prevalence %	1.12	0.57	0.00	0.00	0.00	0.00	2.38	0.00	13.93	15.09	7.14	4.55	6.47
No	2	1	0	0	0	0	1	0	17	8	4	5	11

Harm Free Care

The trust reported 1160 cases of harm free care between September 2017 and September 2018.

The most number of harm free care instances were reported in September 2017 with 173. However, the highest prevalence rate occurred in April 2018 with 100%.



	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18
Prevalence %	96.65	93.68	92.23	98.72	96.88	98.18	97.62	100.00	79.51	83.02	89.29	85.45	86.47
No	173	163	95	77	62	54	41	63	97	44	50	94	147

Incident reporting, learning and improvement

The service did not always manage patient safety incidents well. We found that action plans were not always completed in a timely manner.

Staff used an electronic incident reporting system to report incidents. Most of the staff we spoke with were aware how to report incidents, but a small number of administration staff told us they did not know how to report incidents and had not received any training on the electronic reporting system.

Staff told us that any learning from incidents was shared at team meetings. Incidents were also discussed at business meetings. We reviewed meeting minutes and found that incidents were a standing agenda item.

Specialist nurses told us they reviewed all incidents related to their speciality. For example, the tissue viability nurse reviewed all incidents related to tissue viability and the bladder and bowel nurse reviewed all incidents related to continence.

Staff could tell us about learning from a serious incident that had occurred in March 2018. We looked at the incident report and found that the incident had been thoroughly investigated and recommendations for changes in practice made. An action plan had been produced with target dates for full completion by September 2018. However, the pace of change appeared to be slow as during our inspection we found that not all the actions had been completed or fully imbedded.

Most of the staff we spoke with had a good understanding of the duty of candour. 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. Staff told us they were encouraged to be open and honest when mistakes were made.

Serious Incidents - STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community services for adults, which met the reporting criteria, set by NHS England between, 1 September 2017 to 31 August 2018. This incident was in the category of ‘Sub-optimal care of the deteriorating patient meeting SI criteria.’

Incident Type	Number of Incidents
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Core Service Total	**1**

Serious Incidents (SIRI) – Trust data

Between 1 September 2017 and 31 August 2018, trust staff in this core service reported one serious incident.

The incident did not involve the unexpected death of a patient.

The serious incident fell into the category of 'Sub-optimal care of the deteriorating patient meeting SI criteria.'

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Core Service Total	**1**

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance. However, staff told us there were no pathways in place for them to refer to for the management of specific conditions, for example end of life care, wound care or falls.

Policies were in place on the trust intranet and reflected national guidance. Polices that we reviewed were all up to date.

Senior leaders told us that pathways were available on the trust intranet for the tissue viability team and the falls pathway was under review. However, staff we spoke with could not show us any pathways and there was therefore a risk that patients would not receive consistency of care.

The health trainers weight management service used a weight management programme based on the national NHS weight loss plan, which was developed with advice from the British Dietetic Association.

The bladder and bowel services practitioner had contributed to writing Royal College of Nursing (RCN) guidance.

Nationally recognised assessment tools were used, such as the malnutrition universal screening tool (MUST) and the Walsall risk assessment tool.

We saw evidence, in clinical network meeting minutes, of discussion of National Institute for Health and Care Excellence (NICE) guidance.

Nutrition and hydration (only include if specific evidence)

Where appropriate, patients were given advice on nutrition and hydration to meet their needs and improve their health.

Staff used a nationally recognised risk assessment tool, the malnutrition universal screening tool (MUST) to assess patients at risk of malnutrition. Staff told us they completed these if the initial assessment suggested there were concerns.

Dieticians held clinics in various locations.

Pain relief

Staff assessed and monitored patients to see if they were in pain**.**

We observed staff asking patients about their levels of pain, but did not see them using any particular assessment tool.

Staff administered pain relief as prescribed. We saw a staff member changing a morphine infusion for a patient, to keep them comfortable.

Patient outcomes

The effectiveness of care and treatment was not always monitored and findings used to improve.

Therapy services used outcome and objective measures specific to patient need, muscle function, functional assessment and personal activities of daily living. These were used to monitor progress.

There was limited participation in regular audits to monitor the effectiveness of care. Most of the staff we spoke with told us they did not undertake any audits, apart from the safety thermometer.

We saw that audits had been started in the Whitby team. We saw results of a nursing documentation audit completed at the beginning of January 2019, which had appropriate actions and timescales for completion.

The community therapy team based at Whitby Hospital had audit and effectiveness projects planned for 2018-2019. They had started to complete audits including an audit of physiotherapy (CSP) standards 2018 for hip fracture rehabilitation, an audit of stroke standards and an audit of

OA knee class, which used a patient outcome measure to monitor progress and response to treatment. At the time of our inspection, these audits were ongoing and no results were available.

We saw three community specialist nurses' audits that had recently been completed. This included a cardiac rehabilitation audit, which showed that the cardiac rehabilitation programme was meeting six out of seven required key performance indicators (KPI's). The heart failure specialist nurse had done a preferred place of care/avoided admissions audit, which showed that preferred place of care had been achieved for 58% of patients on the caseload. The tissue viability nurses had completed a wound care audit in the Scarborough and Ryedale teams in October 2018 to establish baseline data. This found that compliance with a wound assessment CQUIN requirement, of having a full wound assessment was 50.4%. Recommendations from this audit were to pilot a template on the electronic patient record with training for staff to use the template, wound assessment training to be delivered to staff using a competency framework and a review of all wound care records to ensure data quality issues resulting from the service transfer were addressed. However, there were no timescales documented for any of these actions.

An audit was also carried out for completion of Walsall risk assessments, in December 2018. Ten patients from each district nursing caseload were reviewed and only 29% had a Walsall completed.

The weight management service delivered by the health trainers had started in February 2018 and had reduced more than 400kg in total.

Competent staff

The service did not always make sure staff were competent for their role. Regular appraisals and supervision were not taking place.

Therapy staff told us they had regular managerial and peer supervision every four to six weeks. Nursing staff had not attended regular supervision sessions. When they had attended clinical supervision sessions there was not a centrally held record. Service leads told us that they were planning to introduce this and wanted staff to attend supervisor and supervisee training.

The service manager for Ryedale told us they were looking at more integrated teams of nurses and therapists. The plan was to have generic support workers, who could work across the team. Competencies were being developed for the generic support workers.

Staff used the Leicester Clinical Assessment Tool (LCAT) to assess competencies. The LCAT is a nationally recognised tool used to assess competency in the majority of clinical procedures.

Specialist services were available to support staff and patients. Specialist services included heart failure, cardiac, respiratory, stroke, continence, tissue viability and diabetes. Staff from the specialist services provided training to community teams.

Appraisals for permanent non-medical staff

Between 1 September 2017 and 31 August 2018, 53% of permanent non-medical staff within the community services for adult's 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
313	167	53%

Following our inspection, we requested locality performance reports. Appraisals were completed on a 12-month rolling programme. Appraisal completion at December 2018 was 100% for the Pocklington team, 83% for Ryedale, 75% for Scarborough South, 57.7% for Scarborough North and 38.1% for Whitby.

Staff in the central access team at Scarborough were new to the role. They had previously been administration staff for different specialities when working for the previous provider. When they were taken over by Humber, the clinical commissioning group (CCG) wanted a central point of contact and the administration staff took on the role of the central access team. Staff in the central access team told us they did not have any standard operating procedures to follow and they had minimal training to do the job.

Multidisciplinary working and coordinated care pathways

Staff of different kinds did not always work effectively together as a team.

Community teams consisted of district nursing teams and therapy teams of physiotherapists and occupational therapists. Safety huddles included therapists and nurses. However, some staff we spoke with told us that they still felt they worked as individual teams rather than as an integrated team. The team at Pocklington were all based in the same office, which helped with communication and team working.

Specialist nurses were based in different locality teams. For example, a bladder and bowel practitioner worked at Pocklington and Whitby, a heart failure nurse specialist was based at

Scarborough and Whitby and a stroke service nurse was based at Scarborough. Dieticians were based at each locality and health trainers covered a wide area.

Some of the nursing staff we spoke with told us that despite having an electronic patient record and working closely with the therapies team, they still had to complete paper referrals to the service, rather than an online referral. Staff we spoke with told us there were no referral pathways in to services such as the tissue viability service, which would assist teams to make an appropriate referral.

The Pocklington locality team were based in a GP practice. Staff told us they worked closely with the practice staff. The practice nurse had been involved in the recruitment of a long-term conditions nurse for the community services.

During our inspection, we saw physiotherapists and occupational therapists carrying out joint visits. This reduced the need for separate visits and enabled staff to work together to provide holistic care.

There was limited engagement between the separate community teams. Staff we spoke with told us there was no cross team working.

Health promotion

The health trainers service supported individuals to live a healthy lifestyle. Health trainers supported people with healthy eating, losing weight, physical activity, addictions and mental wellbeing. A weight management programme offered patients weekly group sessions centred around exercise and diet.

We observed a dietician's clinic and saw that the practitioner offered support to patient's with managing their own health and diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The trust had an up to date consent policy and Mental Capacity Act (MCA) and best interest's decision-making policy, which set out the responsibilities of staff when considering consent and mental capacity.

Staff completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training.

Mental capacity was considered as part of the initial assessment that was completed on a first visit to a patient. If there were concerns about a patient's capacity then a further assessment was completed. We saw completed capacity assessments

Consent to share information was obtained from patients on the first visit.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 September 2017 to 31 August 2018.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

During our inspection, we observed staff in clinics and patient's homes providing care and treatment with a kind and caring approach. We saw that staff maintained patient's privacy and dignity.

We observed staff taking time to interact with patients and their families in a respectful and considerate way.

Patients we spoke with described the staff as helpful and caring.

Friends and family test (FFT) responses were consistently positive. In December 2018, 100% of patients would recommend the service to friends or family.

Emotional support

Staff provided emotional support to patients to minimise their distress.

The health trainers service supported patients with emotional wellbeing. They had a social prescribing team that worked from GP practices. Social prescribing involves helping patients to improve their health, wellbeing and social welfare by connecting them to community services.

We observed staff enquiring about patients' wellbeing during home visits.

The bladder and bowel nurse specialist undertook a full assessment of patients referred to them, which included psychological wellbeing.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff taking the time to explain things clearly to patients and their families, they did not rush visits and took time to ensure their patients had understood everything.

We observed staff in clinics discussing plans of care and patient goals. Patients were given the chance to ask questions.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people.

Community services worked with commissioners to deliver services. The community services were commissioned by three different clinical commissioning groups (CCGs). Services in Scarborough and Ryedale had only been commissioned since May 2018. Three hubs were created around GP practices and the aim was for integrated working between the community nursing and therapies teams. This was still work that was ongoing as the decision as to which staff would be aligned with which hub had only been finalised in December 2018. The service was in the process of consultation with therapists to move to seven-day working.

The community nursing team in Whitby provided a 24-hour service. Other community nursing teams provided a 24-hour service over the weekend. During the week, out of hours nursing cover was provided by a different provider.

A customer access team was the central point of contact for referrals in to community services. Referrals were received via email, electronically or by phone.

Specialist services were available for those patients with more complex needs such as a stroke, cardiac care, tissue viability, musculoskeletal, and bowel and bladder services. Clinics were held in various locations.

Staff told us they could access an interpreting service if needed. This was mainly provided via telephone but face to face contacts could be arranged. Staff in the health trainer service told us they had used a sign language interpreter during their group sessions for a patient that was deaf.

The health trainers service was delivered in various locations throughout North Yorkshire. Regular meetings were held with the commissioners to develop the service.

Meeting the needs of people in vulnerable circumstances

The service was meeting the accessible information standards. Routine questions were asked on initial assessment to identify any communication needs. These were recorded and flagged on the electronic patient record.

Staff told us how they worked with carers to meet the needs of patients with learning disabilities. The health trainers team allowed carers to attend group sessions. Health trainers staff told us they did extra assessments for wheelchair users to ensure the course was suitable and the venues accessible.

Staff told us there was no formal assessment or plan for patients with challenging behaviour.

Access to the right care at the right time

Referrals went to a central access team, where they were looked at daily. This was a seven-day service that worked from 8am to 6pm. The central access team were a team of administrators that looked at the referrals and would assign them to the correct team. For any urgent cases they rang or sent an electronic task to the relevant team.

Community response teams, consisting of district nurses and therapists, provided a rapid response to see patients the same day to help people stay in their own home or return to their home environment.

The musculoskeletal physiotherapy waiting list for Scarborough and Ryedale held 1200 patients during our inspection. This was due to staffing issues and lack of administrative support due to the administrative role being moved to the central access team when the service moved over from another provider. This resulted in no administrative support to address short notice appointments. Staff told us that in December 2018, this loss accounted for 77 hours of missed opportunity which would have dealt with over 100 patients on the waiting list. At the time of our inspection, the administrative support had been reintroduced and new staff had been appointed. All referrals were being reviewed to see whether any were suitable for the community rehabilitation team, as this would ensure patients were seen sooner. Any referrals deemed urgent were seen within two weeks. There was written information on triaging and what should be considered as urgent or routine. All band 6 staff triaged on a weekly basis to ensure it was completed.

The service sent letters to patients asking if they still required an appointment. Physiotherapist diaries were being forward planned so that any follow up slots that had not been filled would be used for new patients.

There were no waits over 18 weeks for any other therapy services.

Patients we spoke with who were attending clinics, for example dieticians at Scarborough and musculoskeletal physiotherapy at Pocklington, told us they had been offered appointments quickly.

Accessibility

The largest ethnic minority group within the trust catchment area is Other White with 2.5% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	Other White	2.5%

Second largest	Asian/Asian British	1.5%
Third largest	Mixed/multiple ethnic groups	0.9%
Fourth largest	Black/African/Caribbean/Black British	0.4%

Referrals

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

The trust met the referral to assessment target in one of the targets listed.

The trust did not provide any targets for assessment to treatment.

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	Systmone Continence Management-Humber FT Scarborough & Ryedale Community Services	Scarborough & Ryedale Community Services	14	15	N/A		Contract commenced on 1/5/18
Willerby Hill	Systmone Dietetics-Humber FT Scarborough & Ryedale Community Services	Scarborough & Ryedale Community Services	14	43	N/A		Contract commenced on 1/5/18
Willerby Hill	Systmone MSK Level 1 Outpatients Out of Area-Humber FT Musculoskeletal Services	Vale of York Community	126	22	N/A		Referral to First Contact Only

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Complaints

Community services for adults received 11 complaints between 1 September 2017 and 31 August 2018. The main complaints themes were patient care (5) and values and behaviour (3).

Total Complaints	Fully upheld	Partially upheld	Not upheld	Referred to Ombudsman	Upheld by Ombudsman
11	2	3	5	0	N/A

Staff we spoke with were aware of the complaints procedure. Leaflets were available for them to give to patients. Any complaints made would be raised with managers in the first instance and information would be given to the patient about the patient liaison and advice service (PALS).

Feedback from complaints was shared at team meetings. Although staff we spoke with told us they had very few complaints.

Compliments

The trust received 442 compliments during the last 12 months from 1 September 2017 to 31 August 2018. Sixteen of these related to community services for adults, which accounted for 4% of all compliments received by the trust.

Is the service well-led?

Add headings, text, graphs and diagrams

Leadership

There had been changes in the service since our last inspection in September 2017, with the addition of community services for the Scarborough and Ryedale locality. Several of the service managers, team leaders and clinical leads were relatively new in post. Feedback from staff was mixed, some felt that their leaders did not have the experience to lead effectively.

Community services for adults belonged to the primary care, community services, learning disabilities and children's services care group. The care group had a care group director, clinical care director and an associate medical director. There was an assistant care group director specifically for community services and two locality matrons.

There was a band eight service/hub manager for Whitby and Pocklington, one for Scarborough North and one for Scarborough South and Ryedale. Each team had a band seven team leader and a band seven clinical lead, apart from Pocklington which had a combined team lead and clinical lead role. Several of these senior staff were relatively new in post. The Scarborough and Ryedale teams had moved over from another provider in May 2018 and there had been recent changes in the service leads and team leads, with some only in their current post for one month. The team leader at Whitby had been in post since October 2018.

We received mixed feedback from staff about their leaders. Staff in Pocklington spoke positively about their local leaders and told us they were visible and supportive. In Whitby, staff told us that there had been positive changes since the team leader had come in to post in October 2018. However, there were also some concerns as there had been lack of support from one of the senior team members. In Scarborough and Ryedale, some of the staff we spoke with thought there was good support from local leaders. However, other staff told us they did not feel well supported, there was poor communication and concerns were not responded to. Some of the staff we spoke with felt that their local leaders were not effective. Most of the staff we spoke with across all localities told us they did not see senior managers regularly.

Staff in the central access team in Scarborough told us that since the move from another provider they were unsure who their line manager was. They told us there had been poor communication about the change to a new role and they did not know who they should raise concerns to above the band four co-ordinator. When we spoke with the assistant care group director, they told us they were repeating the consultation process with the central access team, as there had been concerns raised by staff that there had been insufficient consultation.

Although leaders told us they held ongoing engagement events with staff, some staff felt there had been poor communication from senior management and lack of engagement.

Vision and strategy

The service had a vision for what it wanted to achieve, with significant transformation work underway.

The community services had an operational plan for 2018/2019, this had been developed with the trust strategy as a key driver. The key priorities for the period were aligned with the trust's strategic goals. Key priorities included developing the central access service, integrating community hubs, support to care homes and workforce planning.

Staff we spoke with had a limited understanding of the vision and strategy, there had been significant changes in the community services with extra services been delivered by the trust.

Managers told us that significant transformation work was underway and a large degree of change was still required to deliver on the community services vision.

We saw trust vision and values displayed in areas we visited.

Culture

The culture did not always make staff feel supported and valued.

Staff were focused on the care of their patients and there was a focus on helping people to continue in their own homes.

Staff we spoke with told us they all worked well together in their individual teams, but there was little communication between localities, no cross team working or training. There were three different commissioners involved in the commissioning of services, and each area appeared to work in isolation, with no consistency across the localities. Staff did not see themselves as part of a wider team.

Staff felt slightly disconnected from the main trust as a lot of the services and training was provided in Hull. However, managers told us they were arranging for more training to take place locally.

Morale amongst staff was variable and, in some areas, was particularly low. Some staff felt that changes had been made or was planned but there had been poor communication about the changes and the impact this would have on staff.

At the time of our inspection, there were no effective lone working practices in place. Some of the staff we spoke with told us there were no checks in place to ensure staff safety. At Whitby, the team leader told us they had introduced a buddy system, where staff would check up on each other through the day. They were looking at introducing a lone working device.

Governance

Governance systems and processes were in place.

Care group business meetings took place monthly which included representatives from finance, human resources and performance. Locality business meetings also took place monthly. These followed a standard agenda and included quality and governance, workforce, finance and performance, and the risk register. Issues from these meetings could be escalated to the care group business meetings, which could in turn escalate issues to trust governance meetings.

Community services clinical network meetings, which covered all localities, took place regularly. These meetings had a clinical focus and looked at standards, training, documentation, National Institute for Health and Care Excellence (NICE) guidance, incidents and complaints.

Team meetings took place monthly. We reviewed team meeting minutes and found that although there were appropriate discussions taking place, they did not seem to follow a standard agenda across the different teams.

Management of risk, issues and performance

The service had effective systems in place for identifying risks, planning to eliminate or reduce them, although team leaders from Scarborough told us they had only used the Humber risk register for two weeks prior to our inspection.

Although we saw evidence in meeting minutes of discussion of risk and senior leaders told us risk registers for Scarborough and Ryedale had been maintained from the implementation of the mobilisation board, the risk register that we reviewed from October 2018, did not contain any risks for Scarborough and Ryedale. During our inspection, team leaders at Scarborough and Ryedale told us that they had only utilised the Humber community services risk register for two weeks prior to our inspection.

Prior to our inspection, we reviewed the community services risk register form October 2018, and saw that it contained risks related to Whitby and Pocklington. These included capacity and capability issues, low percentage of holistic assessments completed and risks to the overnight service in Pocklington. There were no risks identified on the risk register for Scarborough and Ryedale localities. However, during our inspection staff we spoke with, in the Scarborough and Ryedale localities, told us risks had been added to the register in the two weeks prior to our inspection.

It was noted at our last inspection in September 2017 that providing full holistic assessments was on the risk register. At that time, staff told us they had an action plan and were upskilling staff and providing training. However, the risk remained on the register and when we spoke with the assistant care director they told us the top three risks related to staff skills set, holistic assessments and documentation.

Regular audits of the service were not carried out to assess, monitor and improve the quality and safety of the service.

Information management

The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.

Monthly performance reports were completed for each locality. These contained details such as staffing, compliance with mandatory training and appraisals, friends and family test (FFT) results, complaints and expenditure information.

Information technology systems were used to process referrals and manage waiting lists. Different services could access the electronic patient record. Some GP's used the same system as the community nursing teams which allowed for sharing of information.

Engagement

The service engaged with patients, but there was limited evidence of change following engagement. Engagement with staff was variable.

Services collected FFT data from patients. We saw FFT comment cards available in clinics we attended and observed staff asking patients to complete them. We did not see any evidence of changes in practice due to patient feedback.

There were mixed opinions from staff when asked about engagement and communication. Some of the therapy staff at Ryedale and the central access team at Scarborough, that had moved from an alternative provider in May 2018, felt that there had not been enough engagement and communication with staff about proposed changes to their services. However, other staff we spoke with told us they felt communication was good and things were progressing well.

Although staff felt isolated from the trust geographically, they told us they received weekly updates on events, policy updates and things that were happening in the trust. Staff told us the chief executive had attended away days, was present at their induction and had visited services.

Learning, continuous improvement and innovation

The community services for Scarborough and Ryedale had been taken over by the trust in May 2018. A transition plan was in place.

Accreditations

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.

No services within community services for adults have been awarded an accreditation.

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. Patients are admitted informally or detained under the Mental Health Act 1983.

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

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

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

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

At this inspection, we visited all five wards.

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Miranda House	Avondale Assessment Unit	14	Mixed
Miranda House	Psychiatric Intensive Care (PICU)	10	Mixed
Newbridges	Newbridges Inpatient Unit	18	Male
Westlands	Westlands Inpatient Unit	18	Female
Mill View	Mill View Court	15	Mixed

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 environment

Safety of the ward layout

Same sex accommodation breaches[1] (Remove before publication)

Avondale assessment ward, the psychiatric intensive care ward at Miranda House and Mill View Court provided mixed sex accommodation to patients. There were designated male and female sleeping areas on the wards and patients access to separate male and female toilets and bathrooms. Female patients had access to female only lounge areas. The female patients we spoke with told us they felt safe on wards that admitted male patients.

Over the 12-month period from 1 September 2017 to 31 August 2018 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was the same as the zero reported at the time of the last inspection.

[1] Mixed Sex Breaches

There were ligature risks on five wards within this service. All wards had a ligature risk assessment in the last 12 months.

Ward/unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Mill View Court	Doors soap dispensers and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.
Newbridges	Doors soap dispensers, notice boards and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment - notice boards are sealed around the edges to reduce the risk of exposed edges
Westlands	Doors soap dispensers and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.
Avondale	Doors and soap dispensers are in situ which introduces a ligature risk but are necessary for the safety of the unit	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.
PICU	Doors soap dispensers and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.

Staff carried out supportive engagement with patients depending on their assessed risk. Staff engaged with and observed patients more frequently during temporary periods of distress when they were at risk of harm to themselves or others. Staff also carried out environmental checks of the ward area regularly throughout the day to identify potential risks to patients and staff.

The layout of wards did not allow staff to observe all parts of the ward but convex mirrors were used to improve observation of these 'blind spots'. Wards also had closed circuit television to observe off-ward areas such as visitors' rooms.

All staff carried personal alarms that were regularly checked to ensure they worked properly. Patients did not have access to nurse call systems except at Mill View Court. Staff on other wards provided patients with a personal alarm if they requested but some staff carried out assessments with patients to decide this. None of the patients we saw at inspection had requested a personal alarm and all the patients we spoke with told us they felt safe on the wards. Staff checked the ward regularly so they knew where patients were and that they were safe.

Maintenance, cleanliness and infection control

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 supports privacy and dignity, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), three of the locations scored higher than similar trusts for cleanliness and two scored higher than similar trusts for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Miranda House	MH – Acute wards for adults of working age and psychiatric intensive care units	100%	95.5%
Newbridges	MH – Acute wards for adults of working age and psychiatric intensive care units	92.9%	93.1%
Westlands	MH – Acute wards for adults of working age and psychiatric intensive care units	99.0%	92.3%

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Mill View	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Wards for older people with mental health problems	99.7%	96.7%
Trust overall		**99.2%**	**95.1%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

Except for Newbridges, where one communal bathroom was not visibly clean, all acute and psychiatric intensive care ward environments were clean and well maintained, which patients and carers confirmed. Domestic staff carried out and recorded daily cleaning tasks. Also, some furnishings in the psychiatric intensive care ward were scuffed and showed signs of heavy wear and tear. Staff told us the trust planned to replace the sofas and curtains in those communal areas. We saw that some furnishings had already been replaced on this ward and on other wards such as Westlands. At the time of our inspection, a patient had caused significant damage to some of the wards furnishings and staff were waiting for replacements.

There were hand gel dispensers at the entrances to all wards and both staff and patients had access to guidance about hand hygiene.

Seclusion room (if present)

Except for Mill View Court, all wards had a seclusion room. We reviewed all the seclusion facilities except those on the psychiatric intensive care ward as one patient formally secluded. Seclusion rooms allowed for two-way communication via a hatch and had clocks which patients could see. They had access to natural light and the temperature could be controlled from outside the area by staff. Seclusion rooms were not en-suite but patients were escorted to adjacent toilet facilities when required. Where patients could not use the toilet facilities due to risks, staff provided them with urine bottles and bowls through the door. Staff told us this was an extremely rare event

because they always had enough staff trained in the management of violence to enable them to escort patients safely.

Clinic room and equipment

All wards had well equipped clinic rooms with examination couches and equipment for physical health examinations. Emergency drugs and resuscitation equipment were accessible and except for some issues identified at Mill Court View and on the psychiatric intensive care unit, staff checked them regularly. On Mill View Court, the resuscitation equipment had not been checked or signatures were not recorded on two consecutive days in January 2019. Staff had highlighted problems with this previously and had raised this in their team meeting in September 2018. Also, the cleaning schedule for the equipment had some gaps in the days preceding our inspection but otherwise, staff kept equipment clean. During the inspection, we observed that nurses were often interrupted to attend to other matters when checking equipment, which could have impacted on how thoroughly these tasks were completed and accurately recorded. On the psychiatric intensive care unit, the portable appliance testing was overdue for the blood pressure monitor and on Avondale ward, the blood pressure monitor had a sticker to say the monitor should have been re-calibrated in June 2018. When we pointed this out to staff, they took immediate action to remove the devise to have it re-calibrated.

Staff checked room and fridge temperatures consistently and took appropriate action when temperatures were out of range.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 18% as of 31 August 2018.

This core service reported an overall vacancy rate of 28% for registered nurses at 31 August 2018.

This core service reported an overall vacancy rate of 32% for nursing assistants.

(CAVEAT: The trust changed their financial reporting system part way through the 12 month reporting period and therefore vacancy data is inconclusive).

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Miranda House	Avondale Assessment Unit	2.0	15	13%	9.9	18.7	53%	9.9	36.2	27%
Westlands	Westlands Inpatient Unit	12.4	32.5	38%	13.3	53.3	25%	24.5	107.1	23%
Miranda House	Miranda House	6.0	16.4	37%	4.6	17.6	26%	6.6	39.4	17%
Mill View	Mill View Court	3.0	14.8	20%	5.0	16	31%	5.5	39.4	14%
Newbridges	Newbridges Inpatient Unit	4.0	17.8	22%	8.4	24.4	34%	2.8	50.8	6%
Core service total		**27.4**	**96.5**	**28%**	**41.2**	**130.0**	**32%**	**49.3**	**272.9**	**18%**
Trust total		**149.1**	**1082.7**	**14%**	**126.9**	**646.8**	**20%**	**397.2**	**3685.1**	**11%**

NB: All figures displayed are whole-time equivalents

Between 1 September 2017 and 31 August 2018, of the 124,317 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were vacancies, absence, and high patient acuity.

In the same period, agency staff covered <1% of available hours for qualified nurses and 5% of available hours were unable to be filled by either bank or agency staff.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Avondale - Wards	23217	97	0%	24	0%	861	4%
Mill View Court Adult	24222	103	0%	28	0%	220	1%
Miranda House - PICU	24475	134	1%	83	0%	2655	11%

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Miranda House ECT	2991	5	0%	0	0%	44	1%
Newbridges Residential Unit	25683	88	0%	141	1%	750	3%
Westlands Unit Nursing	23729	281	1%	172	1%	1715	7%
Core service total	**124317**	**708**	**1%**	**448**	**0%**	**6244**	**5%**
Trust Total	**958417**	**2753**	**0%**	**934**	**0%**	**18576**	**2%**

Between 1 September 2017 and 31 August 2018, of the 203,245 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards/teams were vacancies, absence, and high patient acuity.

In the same period, agency staff covered <1% of available hours and 4% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Avondale - Wards	29726	437	1%	18	0%	1496	5%
Mill View Court Adult	29623	160	1%	19	0%	585	2%
Miranda House - PICU	47765	521	1%	129	0%	3908	8%
Newbridges Residential Unit	47543	276	1%	9	0%	751	2%
Westlands Unit Nursing	45032	411	1%	65	0%	1446	3%
Core service total	**199689**	**1803**	**1%**	**240**	**0%**	**8186**	**4%**
Trust Total	**908881**	**7895**	**1%**	**377**	**0%**	**34624**	**4%**

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing **reporting, to that provided in the RPIR. The previous relates to that received in the RPIR).**

Overall, the service had enough staff to safely care for patients. During day time hours, Monday to Friday, other staff apart from nurses and healthcare assistants could provide care for patients on

the ward. These staff included modern matrons, consultants, junior doctors, charge nurses, occupational therapists, psychologists and activity workers. However, this core service reported a higher vacancy rate than the trust average. Most of the staff we spoke with told us their ward was often short of staff, especially qualified nurses. Some staff told us recruitment procedures for healthcare assistants were not always responsive and could lead to delays in getting them onto the wards.

Ward managers could adjust daily staffing levels to take account of patient need. They did this by using bank and agency staff but they also used staff from other wards to provide cover. Ward managers who were experienced nurses could be counted into the minimum staffing levels when needed. Due to low staffing levels and high levels of patient acuity, managers on the psychiatric intensive care unit had restricted the number of patients who could be admitted to 10 at any one time. On the day of our inspection visit, they had seven patients on the ward and the manager had increased staffing levels by two healthcare assistants because of patient need.

Staff told us their staffing sometimes fell below minimum safe staffing levels but modern matrons carried out regular safer staffing monitoring and reporting. A formal review of safer staffing levels was being considered by the trust following a report carried out by the deputy director of nursing. This review on staffing levels across the acute in-patient wards and the psychiatric intensive care unit was carried out from April to September 2018. It identified minimal staffing concerns on Avondale and Mill View Court and moderate staffing concerns on Westlands, Newbridges and the psychiatric intensive care unit. The review highlighted that across these wards, there were a total of 16 safer staffing incidents in the period April to September 2018 but none had resulted in any patient harm. The report also highlighted good levels of care hours per patient per day despite staff shortages. Overall, in the context of higher than average rates of admissions per head of population, the findings from the report reflected an improvement in the staffing position compared to 2016 - 2017 data.

All bank and agency staff received an induction to the wards and many of the bank staff we spoke with carried out regular shifts on the wards. Managers tried to request staff already familiar with the ward but this was not always possible.

Staff were visible on the wards and a qualified nurse, though not always present in communal areas, was available on shifts. Patients had two named staff allocated including a named nurse and a healthcare assistant. Patient care records confirmed that staffing levels allowed patients to have regular one to one time with their named nurse and care worker. Patients told us that mostly, they could find staff to engage with but sometimes activities could be cancelled if there were a lot of patients on the ward that required higher levels of staff engagement. However, none of the patients we spoke with on the inspection had experienced their leave being cancelled because of staff shortages. Staff told us they would prioritise patients who had escorted leave and that they

were required to submit an incident report if a patient's leave was cancelled. The trust provided data to show that in the three months from October 2018 to December 2018, there was one instance of cancelled leave on Westlands. The trust could not provide any information about any cancelled activities because they did not monitor this.

There were enough staff to carry out physical interventions safely and we found additional multidisciplinary team staff such as occupational therapists and psychologists had received training in intermediate life support and managing actual and potential aggression which meant they could assist with patients where needed.

This core service had 19.8 (12%) staff leavers between 1 September 2017 and 31 August 2018. This higher than the 11% reported at the last inspection (from 1 June 2016 to 31 May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Mill View	Mill View Court Adult (Team)	30.8	5.4	17%
Newbridges	Newbridges Residential Unit (Team)	42.6	6.0	15%
Miranda House	Avondale - Wards (Team)	26.3	3.0	11%
Westlands	Westlands Unit Nursing Team	33.6	4.4	11%
Miranda House	Miranda House - PICU (Team)	30.8	1.0	3%
Core service total		**164.1**	**19.8**	**12%**
Trust Total		**2091.3**	**255.3**	**11%**

The sickness rate for this core service was 6.5% between 1 September 2017 and 31 August 2018. The yearly average was higher than the sickness rate of 5% reported at the last inspection (from 1 June 2016 to 31 May 2017).

The managers we spoke with on inspection could not identify any particular reason why this core service had higher levels of sickness than the rest of the trust. Some of the staff we spoke with

told us they felt stressed when they thought they were going to be moved at short notice to provide cover for other wards and that this had impacted on their general well-being.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Westlands	Westlands Unit Nursing (Team)	2.9%	10.9%
Mill View	Mill View Court Adult (Team)	0.8%	7.5%
Miranda House	Night Switchboard Service (Team)	12.9%	6.3%
Newbridges	Newbridges Residential Unit (Team)	8.3%	6.3%
Miranda House	Miranda House - PICU (Team)	3.4%	5.1%
Miranda House	Avondale - Wards (Team)	2.9%	1.4%
Core service total		**4.1%**	**6.5%**
Trust Total		**3.9%**	**4.7%**

The below table covers staff fill rates for registered nurses and care staff during April 2018, May 2018 and July 2018. Staff fill rates for June 2018 were not available.

Westlands ward had below 90% of the planned registered nurses for day shifts in two of the months reported and for night shifts in all months reported. PICU ward had below 90% of the planned registered nurses for day shifts and above 125% of the planned care staff for day shifts, in all months reported. PICU ward also had above 125% of the planned care staff for night shifts in all months reported. Avondale ward also had below 90% of the planned registered nurses and care staff for day shifts in two of the months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	April 2018				**May 2018**				**July 2018**			
Avondale	97%	90%	97%	134%	89%	88%	98%	116%	85%	87%	91%	121%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	April 2018				May 2018				July 2018			
New Bridges	92%	99%	99%	100%	94%	97%	92%	103%	91%	98%	98%	106%
Westlands	93%	104%	**78%**	117%	83%	97%	82%	112%	62%	95%	74%	107%
Mill View Court	95%	103%	**87%**	102%	96%	99%	99%	102%	95%	93%	95%	95%
PICU	77%	141%	95%	161%	76%	167%	92%	186%	69%	151%	82%	152%

Medical staff

Between 1 September 2017 and 31 August 2018, of the 7128 total working hours available, 0% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reasons for bank and agency usage for the wards/teams were vacancies and support for consultant.

In the same period, agency staff covered 47% of available hours and 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Newbridges – General Adult -S.D	1840	0	0%	1104	60%	0	0%
Westlands – General Adult -S.D	1320	0	0%	1192	90%	0	0%
Newbridges – General Adult - Cons	1840	0	0%	152	8%	0	0%
Westlands – General Adult - Cons	1840	0	0%	840	46%	0	0%
Mill View – General Adult – S.D	288	0	0%	56	19%	0	0%
Core service total	**7128**	**0**	**0%**	**3344**	**47%**	**0**	**0%**
Trust Total	**36104**	**0**	**0%**	**12181**	**34%**	**0**	**0%**

All wards had adequate medical cover during the day and each ward had a consultant psychiatrist with junior doctors to support. The psychiatric intensive care unit also had a speciality doctor. At night, there was one junior doctor providing on-call cover for all the wards. Staff reported they had no difficulty contacting the on-call doctor who could provide advice where they were not able to attend. Last time we inspected this core service, some patients and carers had complained they could not see the doctor enough but at this inspection, patients told us they saw their doctor regularly and they had no complaints. At night, staff contacted the emergency services where

necessary after seeking advice from the on-call doctor. We heard evidence from staff and patients. that emergency services had been summoned quickly by staff when needed.

In the period 1 September 2017 to 31 August 2018, there were seven occasions at night where medical reviews for secluded patients did not take place every four hours on Newbridges, Westlands, and the psychiatric intensive care unit. The audits the trust carried out could not identify the specific reasons for this and whether it was due to a lack of on-call doctor availability. The trust told us they intended to review their audit process to enable the auditor to add comments to explain the context of the non-compliance. The trust told us staff would escalate concerns where necessary.

Mandatory training

The compliance for mandatory and statutory training courses at 31 August 2018 was 91%. Of the training courses listed three failed to achieve the trust target and of those, one failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training, and a target of 95% for Information Governance training. Training completion is reported on a rolling month on month basis.

The training compliance reported for this core service during this inspection was the same as the 91% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✖

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Adults - Level 2	57	57	100%	✓
Mental Capacity Act - Level 1	12	12	100%	✓
Infection Prevention - Level 1	12	12	100%	✓
Safeguarding Adults - Level 1	12	12	100%	✓
Safeguarding Children - Level 1	7	7	100%	✓
Fire Safety - 2 Years	5	5	100%	✓
Prevent Awareness	103	102	99%	✓
Infection Prevention - Level 2	154	151	98%	✓
Safeguarding Children - Level 2	60	58	97%	✓
Prevent – WRAP	63	61	97%	✓
Equality and Diversity	166	159	96%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
COSHH Awareness	166	160	96%	✓
Health and Safety	166	160	96%	✓
Display Screen Equipment	162	154	95%	✓
Mental Capacity Act - Level 2	154	145	94%	✓
Information Governance	166	156	94%	✗
Fire Safety - 1 Year	161	146	91%	✓
Moving and Handling - Level 1	20	18	90%	✓
Safeguarding Children - Level 3	99	87	88%	✓
Moving and Handling - Level 2	146	123	84%	✗
Safeguarding Adults - Level 3	98	18	18%	✗
Total	**1989**	**1803**	**91%**	✓

Following our last comprehensive inspection in September 2017, we told the trust that they must ensure that staff received the full range of mandatory training including immediate life support training. At this inspection, data supplied by the trust showed that overall compliance rates for immediate life support and the management of actual and potential aggression was 85% across all the different wards.

All the staff we spoke with told us they were up-to-date with their mandatory training and that this had improved since the previous inspection. The only mandatory training course which had a compliance rate of below 75% was safeguarding adults level 3. This was because the course was only introduced June 2018 following national guidance. The trust provided us with a detailed plan to show that 68% of all staff who required the training would have received it by the end of March 2019 and the remainder by August 2019. At inspection, we found staff to be knowledgeable about safeguarding adult issues and they had access to specialist staff within the trust where they could go to for advice if needed. All staff had completed adult safeguarding training at levels one and two.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed a total of 19 patient care records across all five wards. Staff used a recognised risk assessment tool called the functional analysis of care environments or FACE which they completed when patients were admitted and updated regularly in response to incidents and changing risk levels. Where wards accepted patients under the age of 18 years, staff used a different version of the risk assessment tool tailored to the needs of young people. All the care records we looked at contained comprehensive risk assessments and some patients had specific risk assessments where staff had particular concerns. For example, we saw a patient with a falls

risk assessment in place. Staff followed a standardised comprehensive risk assessment prior to patients going on leave from the ward.

Management of patient risk

Patients had safety plans in place which identified staff engagement levels and strategies to manage patient risk. We saw examples where staff did not lone work with particular patients because of the risks involved. In another record, we saw harm minimisation advice which staff provided for a patient with substance use issues. Staff held multidisciplinary meetings frequently, in some cases every day, where they discussed patient risk assessments and management plans.

The trust had a patient engagement policy as oppose to an observation policy. Staff told us observing patients could increase the risks to them and instead they engaged with patients more frequently when their risk behaviours escalated. They used the engagement policy as appropriate to the risks involved, including to minimise risks from potential ligature points. Staff had developed a toolkit so they could help patients develop their own self-harm risk management strategies. All wards had ligature cutters which were clearly marked and easily accessible to staff.

Staff conducted patient searches only in response to identified risks based on individual assessment, in line with the trust's search policy. For example, where they suspected a patient had brought a cigarette lighter back onto the ward. Staff sought permission from the patient but if the patient did not consent, staff increased engagement levels to mitigate the risk. Staff encouraged patients to handover items and only completed searches as a last resort.

Staff had a number of blanket restrictions in place on some wards. For example, patients were not allowed to be unsupervised in some rooms, for example, kitchens and laundry rooms where there were sharps and things which patients could use as weapons. Staff participated in the trust's reducing restrictive interventions programme and were identifying ways of allowing patients access to more rooms. For example, on Westlands, staff told us they were waiting for an anti-barricade door to be fitted and other adjustments before allowing patients unsupervised access. Since our previous inspection in September 2017, patients were allowed their own mobile phones and lap tops including on the psychiatric intensive care unit. In in the focus groups prior to our inspection, patients told us staff on some wards turned the communal televisions off at midnight but when we raised this with ward managers, they told us this issue had been addressed with individual staff and was no longer a concern. None of the patients we spoke with at our inspection reported any blanket restrictions on their freedom apart from the restriction on smoking which was new.

The trust had just implemented a smoke free policy on all wards in November 2018. Whilst staff offered patients access to nicotine replacement therapy, some patients continued to smoke in the

outside garden areas on some wards. Staff told us they were required to incident report these occurrences but there were too many instances on some wards and staff were unclear how they should respond when patients continued to smoke. On some wards, staff did not tolerate patients smoking in the outside garden areas of the ward and some patients expressed dissatisfaction with this. Following the inspection, we requested a copy of the smoke free policy, which did not contain any references to nicotine replacement therapy and did not provide staff with any guidance about how to respond if patients continued to smoke on trust premises.

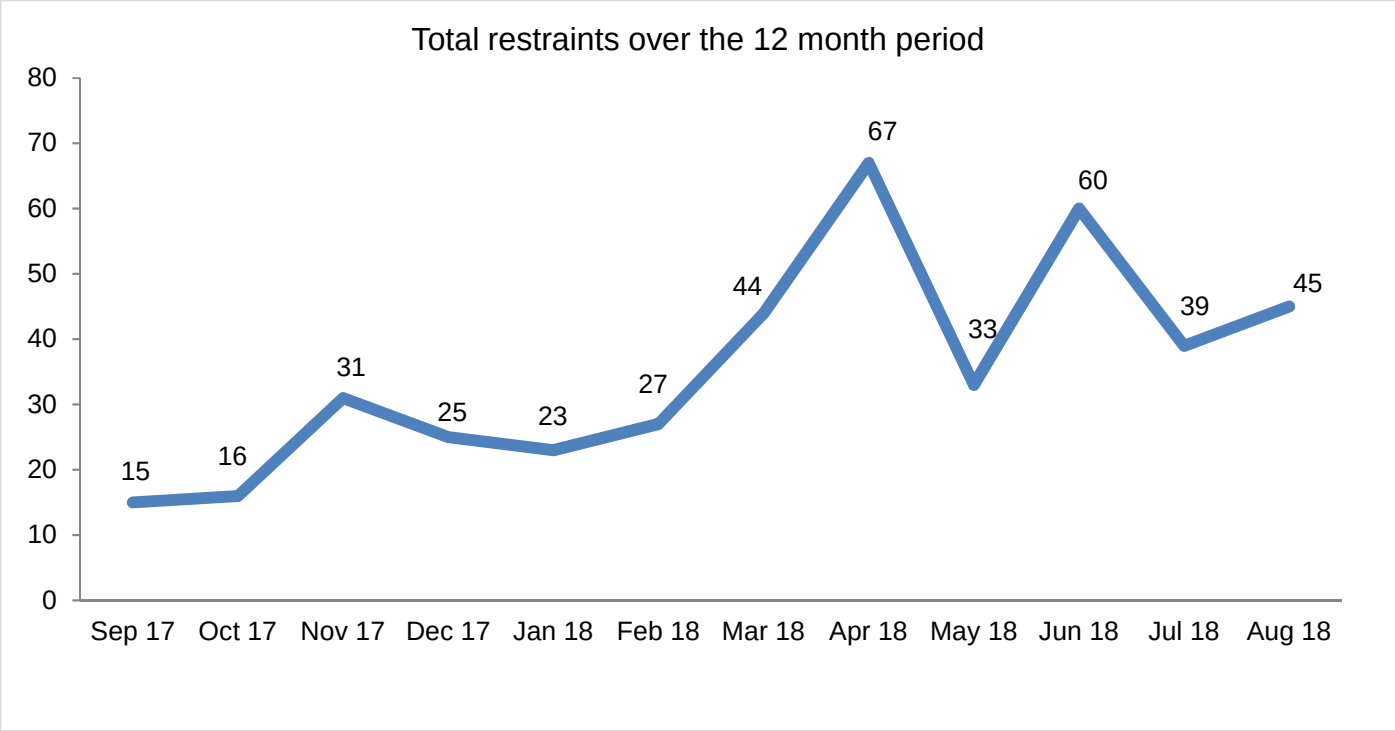
At our last inspection in September 2017, we struggled to find notices informing informal patients of their rights to leave the wards. At this inspection, we found all wards had clear notices at the entrance to the wards informing non-detained patients of their right to leave and to ask a member of staff to open the doors.

Use of restrictive interventions

This service had 425 incidences of restraint (161 different service users) and 117 incidences of seclusion between 1 September 2017 and 31 August 2018.

The below table focuses on the last 12 months' worth of data: 1 September 2017 to 31 August 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Psychiatric Intensive Care Unit – Miranda House	69	187	50	9 (5%)	26 (14%)
Avondale Unit	25	77	47	14 (18%)	20 (26%)
Westlands	6	69	18	0 (0%)	26 (38%)
Newbridges	17	50	27	3 (6%)	9 (18%)
Mill View Court	0	42	19	1 (2%)	14 (33%)
Core service total	**117**	**425**	**161**	**27 (6%)**	**95 (22%)**



There were 27 incidences of prone restraint, which accounted for 6% of the restraint incidents. Over the 12 months, incidences of prone restraint ranged from zero to eight per month. The number of incidences (27) was the same as the previous 12-month period (27). Following the inspection, the trust told us that since March 2018, they had collated data on the reason for prone restraint, including whether it was instigated by staff; instigated by the patient or for the administration of medication. The data highlighted that prone restraint was rarely instigated by staff, with the main reason for restraint resulting in the prone position being due to the patient taking themselves in that direction. All prone restraints were reviewed by the trust's positive engagement trainers team Lead to ensure consistency with trust policy'

There were 95 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from two to 16 over September 2017 to August 2018. The number of incidences (95) had decreased from the previous 12-month period (175).

There have been zero instances of mechanical restraint over the reporting period.

The number of restraint incidences reported during this inspection (425) was higher than the 305 reported at the time of the last inspection.

All the staff we spoke with during the inspection told us they used restraint as a last resort and tried to manage incidents with verbal de-escalation techniques and increased engagement with patients. We saw evidence of staff using verbal de-escalation and positive engagement strategies effectively with patients. Staff felt confident to use restraint and received service specific training delivered by the trust's positive engagement team.

The number of reported restraints had increased from the previous year despite the efforts of staff to reduce restrictive practice. When we asked the trust about this they told us the increases were due to the clinical presentation of a small number of patients within the psychiatric intensive care unit. Better reporting and monitoring of restraint incidents were also considered to account for some of the increase.

There have been 117 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from one to 17 per month.
The number of seclusion incidences reported during this inspection was higher than the 116 reported at the time of the last inspection.

All the wards except Mill View Court had seclusion facilities and, at the time of our inspection, there was one patient secluded on the psychiatric intensive care unit. We saw that staff were making every effort to end seclusion by gradually introducing the patient back to the ward environment when they thought it was safe to do so. Modern matrons carried out seclusion audits and escalated concerns to higher managers as appropriate.

Staff on some wards, for example, Westlands and the psychiatric intensive care unit, had identified a separate room on the ward where they intended to provide patients with quiet space where they could go if they felt they would benefit from this. The rooms had not been completely refurbished but staff hoped they would provide an alternative to seclusion where patients were agitated or upset. Staff told us this would be less restrictive than seclusion because patients would be free to leave the room at any time.

There have been no instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) was the same as the previous 12-month period (zero).

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.

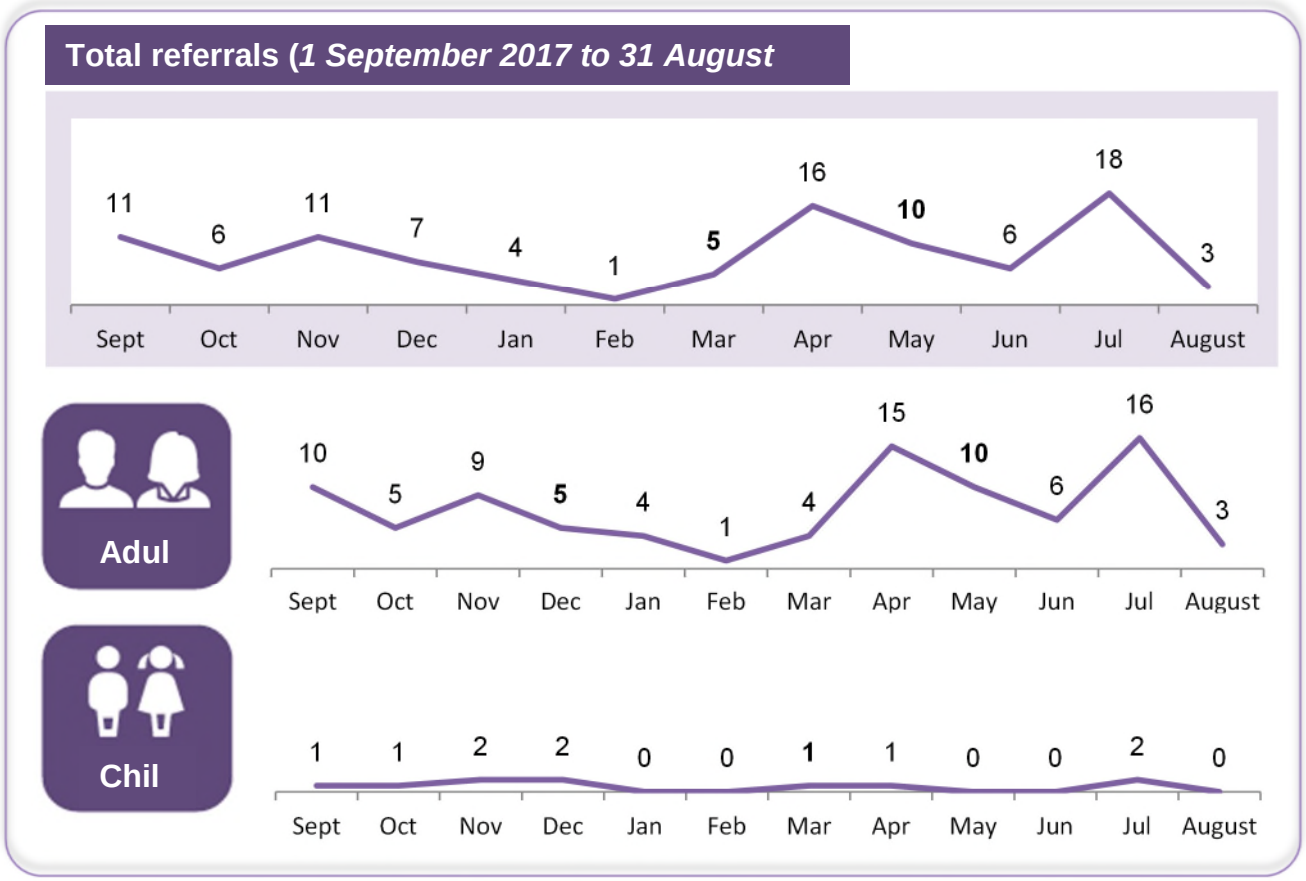
This core service made 98 safeguarding referrals between 1 September 2017 and 31 August 2018, of which 88 concerned adults and 10 children.

The number of safeguarding referrals reported during this inspection is not comparable to the safeguarding referrals reported at the last inspection as core services were not previously assigned.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
Acute wards for adults of working age and psychiatric intensive care units	88	10	98

The number of adult safeguarding referrals in each month ranged from one to 16 (as shown below).

The number of child safeguarding referrals ranged from zero to two (as shown below).



Staff participated in safeguarding training, which included both adults and children. The staff we spoke with demonstrated a good understanding of what constituted abuse and how to recognise it. Healthcare assistants sought support from nursing staff where necessary and staff had access to a trust safeguarding team who could provide specialist advice and support.

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

demonstrated a good knowledge of the procedures in place to keep child visitors safe and some wards had closed circuit television to monitor activity in visitor areas.

Staff described using Prevent, a UK wide government counter-terrorism strategy, to safeguard patients and to protect and divert people away from terrorist activity. All staff participated in mandatory Prevent training and we saw examples where staff were actively working with outside organisations to safeguard patients from radicalisation.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 September 2017 and 31 August 2018) that relate to this service.

Staff access to essential information

Staff used electronic patient records to store most of the patient care they delivered. Patient medication records and Mental Health Act documentation were kept in paper records in clinic rooms or staff offices. We reviewed 19 care records and found that staff had varying degrees of knowledge about where information was recorded on the system and there were inconsistencies between teams about where information was recorded. This is what we found when we last inspected the service in September 2017.

At this inspection we found, for example, that some teams recorded risk management actions in the care plan section of the record and others recorded them in the safety plan section of the record or a mixture of the two. Staff reported the system could be slow and could freeze a lot making it difficult to access patient information quickly. Most teams had developed a paper summary record for each patient which they used in addition to the electronic record. Teams were experimenting with different formats but there was no standard agreement about the format of the paper records.

Staff from other parts of the trust including community teams could input into a single shared patient record. This enabled staff to see relevant information, for example, where patients had previous contact with mental health teams or other acute services. Staff thought this was useful to providing continuity of care but it was not easy for staff to identify the professional who had inputted into the record or which service they were from.

Temporary staff such as agency staff were given access to the electronic care record system but substantive staff told us that sometimes this took too long and it was sometimes easier if they completed care record entries on behalf of agency staff.

Medicines management

We checked medicines management practices across all wards including a sample of patient prescription charts. Overall, we found that staff followed good practice in relation to the storage

and administration of medicines. Wards had access to a pharmacist and a pharmacy technician who visited the wards several times each week and carried out regular 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. Staff gave patients and their carers a range of medicines information leaflets.

Staff reviewed the effects of medication on patients' physical health regularly and in line with appropriate guidance. Records showed appropriate monitoring of patients prescribed high dose antipsychotics.

Track record on safety

Between 1 September 2017 and 31 August 2018 there were six serious incidents reported by this core service. Of the total number of incidents reported, the two most common types of incident were 'Apparent/actual/suspected self-harm meeting SI criteria' and treatment given without valid consent' with two incidences of each. One of the two unexpected deaths was an instance of Apparent/actual/suspected self-harm meeting SI criteria.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with six reported.

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

The number of serious incidents reported during this inspection was higher than the three reported at the last inspection.

Type of incident reported (SIRI)	Operation/treatment given without consent	Environmental Incident meeting SI criteria	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Unauthorised absence meeting SI criteria	Sub-optimal care of the deteriorating patient meeting SI criteria	Total
Newbridges	1	1	0	0	1	3
Westlands	0	1	0	1	0	2
Avondale	0	1	0	0	0	1
Total	**1**	**3**	**1**	**1**	**1**	**6**

Reporting incidents and learning from when things go wrong

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.

Data obtained from the Coroner's website (www.judiciary.uk) indicated there had been one prevention of future deaths report relating to a patient of the trust in the last two years. The prevention of future deaths report was sent to NHS Improvements

Date of report: 6th October 2016

A patient died after hanging herself using the taps in a bathroom at the Westlands Mental Health Unit, Hull. The conclusion of the inquest was accidental death.

The Coroner's concerns were:

- Evidence was heard that NHS England is undertaking an ongoing programme of work to eliminate ligature points in in-patient and other psychiatric facilities. It was established that a 'traffic light' system is in operation which prioritises the work once a ligature point has been identified. Red equates to extreme risk and mandates urgent elimination of the risk; amber nevertheless represents a high risk. This classification is based on height of ligature point from the ground. If the ligature point is one metre or less it is categorised as amber, over one metre above the ground is categorised as red.

Expert evidence was adduced from expert witnesses and Consultant Psychiatrists that at least 50% of deaths due to hanging in inpatient psychiatric facilities occur from ligature points which are one metre or less in height above the ground. Patients lean forward and tighten the ligature around their neck under their body weight and they collapse into unconsciousness within ten to twenty seconds and death can occur in as little as two to three minutes. The evidence was backed up by peer reviewed literature which was also read out during the inquest.

The principle concern is that there is an obvious incongruity in the classification system as effectively all ligature points, no matter what their height, should be regarded as representing extreme risks.

The following learning / recommendations were given: (include where applicable)

- Action should be taken to prevent future deaths. All ligature points, no matter what their height, should be regarded as representing extreme risks. Evidence was heard that the risk is independent of height and consideration needs to be given to classifying all ligature points once identified as red and their elimination tackled on an urgent basis.

The trust told us that the recommendation from the coroner was not directed at Humber Teaching NHS Foundation Trust. It was a regulation 28 that was sent to NHS improvement as it was about national policy requirements.

All staff had access to an electronic incident reporting system and were encouraged to report different types of incidents including near misses. All incidents were reviewed by modern matrons and service managers at a patient safety review meeting every weekday. The meeting was supported by members of the trust's patient safety team. From that meeting, staff then identified incidents for further discussion and investigation at the weekly in-patient safety huddle attended by ward managers and service managers. Managers cascaded incident feedback down to teams for discussion in team meetings. However, when we reviewed minutes from team meetings, we did not see evidence that all teams discussed incidents routinely at team meetings. For example, Newbridges did not follow the same team meeting structure as other wards and we could not see they had discussed incidents in any of the team meetings notes we reviewed from April to December 2018. Some teams, for example, Westlands and Avondale had safety huddles each day where they discussed the incidents that had occurred on their ward. We did not see evidence that staff discussed lessons learned in ward safety huddles team meetings from incidents which had occurred in the wider trust. However, we did see that all wards had implemented learning from an incident several years ago where a patient took their own life whilst away from the ward on leave. As a result, staff followed a standardised comprehensive risk assessment prior to any patient leaving the ward.

Serious untoward incidents were investigated by two managers including one from outside the patient area where the incident had occurred. Serious incidents were categorised by the trust's clinical risk management group but some managers told us they didn't always understand the way the trust categorized the most serious incidents. Some managers told us they did not always receive timely feedback from serious incident investigations and they were not always sure who had been assigned to coordinate the investigation. The trust told us that incidents and feedback were discussed by managers at regular charge nurse meetings and acute care forum meetings.

Staff including bank staff had access to weekly reflective supervision facilitated by a psychologist. The staff we spoke with at the inspection told us they valued this and had received support and debrief from local managers after incidents, for example, involving patient aggression on the ward.

A duty of candour prompt was incorporated into the incident reporting system which was then reviewed by higher managers who took action where necessary. The duty of candour is a legal duty on hospitals to inform and provide a written apology to patients if there have been mistakes in their care that have led to significant harm. Staff knew about their responsibility under the duty of candour to share information with relevant parties.

Is the service effective?

Assessment of needs and planning of care

We examined 19 patient care records across all five wards. We found that all patients had a timely comprehensive mental health assessment including an assessment of their physical health on admission. Patients were offered health improvement profiles, and where patients declined staff recorded it in nursing notes and the communication boards in the staff offices.

In seven of the records we looked at, we did not find evidence that care plans were personalised holistic or recovery oriented. For one patient on Newbridges, we could not find evidence of any structured care plan for a patient who had been admitted in November 2018. Some wards had made improvements, for example on the psychiatric intensive care unit, staff had personalised care plans by incorporating patients' own words and statements but this was not the case in many of the care plans we looked at on other wards. Not all the care plans we look at reflected the care that was being delivered and staff said they sometimes struggled to update care plans in a timely manner due to pressure of work and the slowness of the electronic records system. Some of the care plans we looked at on Mill View Court were focussed mainly on physical health needs and did not reflect the patient's other needs. For example, we looked at one record where the patient had sexuality issues but staff had not addressed these specifically in the care plan. Following the inspection, we looked at the latest care records audits from each ward but we could not identify from these audits how many records staff had looked at or how they had arrived at their scores. Records audit reports did not look consistent across the wards and we did not see any action plans attached to any of the audits we looked at.

We did however, see some examples of good practice in care planning particularly in relation to patients with substance use issues. We saw evidence across the wards of tailored care planned interventions aimed at patients with mental health and drug and alcohol issues.

Best practice in treatment and care

This service participated in seven clinical audits as part of their clinical audit programme 1 September 2017 – 31 August 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Audit of MDT standards	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	27/09/2018	To include a heading on the individual patients' MDT record to reflect consideration and documentation of capacity and risks, if relevant. To include a risk assessment column in the new referral table. To update the MDT sheets to include a 'completed by:' heading.
Driving risk assessment amongst	Inpatient adult	MH - Acute wards for	Clinical	27/02/2018	Posters around all adult psychiatric inpatient units. Patient information leaflets with useful

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
inpatients with psychiatric disorders (Newbridges)	mental health unit	adults of working age and psychiatric intensive care units			contact information (DVLA). Driving assessment tool. Re-audit on regular basis. Raise awareness of responsibility of healthcare professionals. GMC guidance and DVLA rules and regulation.
Audit of General Liaison MDT sheets	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	30/09/2017	To update the MDT sheets to include a 'completed by:' heading. To include a risk assessment column in the new referral table. • To include a heading on the individual patients' MDT record to reflect consideration and documentation of capacity and risk, if relevant.
NICE CG16 Self-harm in over 8s - short term management	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	27/12/2017	It was identified following the audit that 1 staff member will receive family inclusive training and knowledge of sharing of information with Humberside Police. (to be actioned within supervision) Further qualitative notes audit to be completed on 2 staff members to ascertain decision making is sound when referrals are deemed as inappropriate. 1 staff member will be offered additional shadowing/training in relation to the assessment of patients under 18 years of age. Clear guidance around documentation to be issued to the staff team following care group review of assessment documentation.
NICE CG178, CG133, CG185, CG90, CG120	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	26/10/2017	
Weight Monitoring in Psychiatric Inpatients (Westlands	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric	Clinical	05/05/2018	The key actions following the results of this audit are to implement the recommendations outlined above. Following the implementation of these changes there will need to be a re-audit in three months' time to ensure an improvement has been made. It appears the main focus is to

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		intensive care units			improve access to the weight monitoring forms; to encourage staff to complete them, but also to educate the team on the importance of physical health and the impact that being over- or underweight can have on the body.
NICE CG90 Depression in Adults	Inpatient adult mental health units	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	31/08/2018	Review of psychology strategy underway. CBT provision to be reviewed for Hull and East Riding CMHTs. Service to agree what OT provision should be available to support rehabilitation approach / vocational interventions. OT provision to be reviewed throughout Hull and East Riding CMHTs.

Staff provided a range of care and treatment interventions including medication and psychological therapies in line with guidance produced by the National Institute of Clinical Excellence. Staff also provided occupational therapy and, where appropriate taught patients daily living skills such as cooking.

Patients had access to physical healthcare monitoring from ward staff. Staff 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.

Staff used the National Early Warning Score to assess and score vital signs for patients. Where appropriate, staff used the Malnutrition Universal Screening Tool, and Waterlow risk assessments. We saw evidence of staff using the Glasgow ant-psychotic side effects scale, the clinical outcomes and routine evaluation tool, an alcohol screening tool and the brief psychiatric rating scale.

Wards had tablet computers to enable staff to use the perfect wards app to audit and review nursing processes and systems.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 85%. At the end of last year (31 March 2018) the overall appraisal rate for non-medical staff within this service was 78%. This year so far, the overall appraisal rates was 87% (as at 31 August 2018). The wards with the lowest appraisal rate at 31 August 2018 were Newbridges Residential Unit with an appraisal rate of 75%, Miranda House – PICU Team with an appraisal rate of 83%, and Westlands Unit Nursing Team with an appraisal rate of 89%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 77% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (previous year – 1 April 2017 to 31 March 2018)
Mill View Court Adult (Team)	31	30	97%	84%
Avondale – Wards (Team)	26	25	96%	78%
Westlands Unit Nursing (Team)	36	32	89%	64%
Miranda House – PICU (Team)	30	25	83%	81%
Newbridges Residential Unit (Team)	44	33	75%	81%
Core service total	**167**	**145**	**87%**	**78%**
Trust wide	**2585**	**2001**	**77%**	**79%**

The trust's target rate for appraisal compliance is 85%. The trust was unable to provide appraisal data for permanent medical staff.

The trust's target of clinical supervision for staff is 80% of the sessions required. The trust stated that they are only able to provide this information at team level not by ESR staff group, therefore data includes both medical and non-medical staff. Between 1 September 2017 and 31 August 2018, the average rate across all six teams in this service was 65%.

The rate of clinical supervision reported during this inspection was lower than the 70% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Newbridges Residential Unit Team	450	362	80%
Miranda House PICU Team	316	231	73%
Mill View Court Adult Team	335	222	66%
Miranda House ECT Team	48	31	65%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Avondale Wards Team	269	143	53%
Westlands Unit Nursing Team	401	194	48%
Core service total	**1819**	**1183**	**65%**
Trust Total	**11648**	**8989**	**77%**

All the staff we spoke with at inspection, except bank staff, told us they had access to one-to-one line management and clinical supervision and that this occurred regularly. Following our inspection, the trust provided us with updated clinical supervision figures for December 2018. The clinical supervision rates for the psychiatric intensive care unit, Newbridges and Westlands were all above the trust's target at 80%, 89% and 82% respectively. The two wards that were slightly below the trust target were Avondale at 76% and Mill view at 71%.

Staff told us they were well supported by their immediate line managers and had received an appraisal within the previous 12 months where they required one. All staff including bank staff had access to weekly reflective supervision facilitated by a psychologist from the team. Some bank staff were undertaking a considerable number of shifts but not all managers knew whether they were able to provide one-to-one supervision for them. Some managers had provided one-to-one supervision for bank staff but told us it was up to individual staff to request this. Following the inspection, we asked the trust to clarify for staff the position regarding bank staff and access to one-to-one-supervision.

Teams had access to doctors, nurses, occupational therapists, clinical psychologists, pharmacists, healthcare workers and activity workers to meet the needs of patients. Each ward also had access to a social worker who could assist patients and staff with discharge planning, housing and benefits advice.

Staff had access to further training and development and some staff had received specialist training to enable them to perform specific functions, such as phlebotomy and electrocardiogram testing. Each ward had access to a staff member trained delivering interventions with patients with mental health and substance use issues. Some managers had developed a suicide and self-harm toolkit to enable staff in providing appropriate interventions with patients who were at risk. They were in the process of rolling out the training to staff on all the acute wards. All the staff we spoke with at inspection thought the specialist training on offer by the trust was useful and had led them to feeling more confident in their roles.

Managers dealt with poor staff performance effectively and had access to monthly clinics with trust human resource personnel. They received specialist advice and guidance concerning issues such as discipline, grievance and sickness absence processes.

Multidisciplinary and interagency team work

Staff held regular multidisciplinary meetings and most wards met several times per week to discuss patients. Some teams, for example, Newbridges met as a multidisciplinary team every day, but on some wards, for example, Westlands, healthcare assistants were not part of the meeting. As part of our inspection, we observed two multidisciplinary meetings on two separate wards and one handover meeting. We saw how staff shared information with each other about patients' needs and risks and used team meetings to discuss ways of improving communication and ensuring meetings were as effective as possible. The staff we spoke with told us their teams worked well together to meet patient need. The social workers and pharmacists described feeling fully integrated with teams despite not being based with them all the time.

Staff had effective working relationships with other relevant teams such as drug and alcohol services, social care organisations and voluntary organisations such as MIND.

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

As of 31 August 2018, 92% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 90% reported at the last inspection.

Staff were knowledgeable in the application of the Mental Health Act and knew how to access the Mental Health Act policies and Code of Practice. They had access to good support from staff within the trust's Mental Health Act legislation team. However, On Westlands, we found gaps in a number of records where staff had not recorded patients' capacity to consent to treatment. An audit carried out by staff in January 2019 identified this and highlighted that it was a repeat issue from a previous audit on some wards, despite this being raised in team meetings. Patients had access to mental health advocacy which was well embedded across all wards. For detained patients, independent mental health advocates visited the wards regularly and staff knew how to refer and support patients to engage with the advocacy services. We saw posters displayed in patient areas about advocacy services including those for informal patients. The patients we spoke with on inspection confirmed staff had explained their rights to them in a way they could understand. However, an audit carried out by staff in January 2019 highlighted that on Westlands

two patients had not had their rights explained to them. On Mill View Court, a recent audit highlighted that in one record out of three, there was no evidence that staff had made a referral to an independent mental health advocate for a patient who lacked capacity to consent to treatment. The audit did not contain an explanation of how these deficits would be addressed.

Staff ensured that patients were able to take Section 17 leave when this had been granted but an audit carried out in December 2018 highlighted that there was no evidence that three out of three carers on Mill View Court were offered a copy of the patient's Section 17 leave form. This might mean carers were not clear about any expectations or instructions concerning the leave.

All wards had a clearly displayed poster to tell informal patients that they could leave and to ask a member of staff to open the exit doors.

Good practice in applying the Mental Capacity Act

As of 31 August 2018, 100% of the workforce in this service had received training in the Mental Capacity Act – Level 1. As of date, 94% of the workforce in this service had received training in the Mental Capacity Act – Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The Mental Capacity Act training compliance reported during this inspection is not comparable to the training compliance reported at the last inspection.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 31 September 2017 to 31 August 2018.
CQC received no direct notifications from the trust, in relation to this service, between 1 October 2017 to 31 August 2018 [2]. This matches with the zero as submitted in the PIR.
The number of DoLS applications made during this inspection was not comparable to the last inspection.

Overall, staff had a good knowledge about the principles of the Mental Capacity Act but we found variable levels of staff knowledge about best interest decision-making and documentation was not always evident in care records.

In the care records we looked at, we found that where there were issues of capacity identified, we could not always find evidence of an assessment of capacity. For example, in one record, staff described a patient as having fluctuating capacity but we did not see evidence of a written capacity assessment in the care record as required by the Mental Capacity Act code of practice. In another record, we could not see written reviews of capacity for a patient who lacked capacity to manage their finances. We spoke with two clinicians about best interest decision-making but found they

[2] CRM

had difficulty identifying the process they would follow if the patient who lacked capacity to consent but required treatment for a physical health condition. We spoke with a carer who told us staff did not always allow their relative the right to eat the food they wanted because they thought it would be bad for their health condition. This is against guidance set out in the Mental Capacity Act code of practice, which says that people have the right to make decisions that others might regard as unwise or eccentric.

Following the inspection, we asked the trust for any audits they had carried out on the acute wards in relation to the Mental Capacity Act. They told us a review process was in place and they intended to carry out reviews across all the acute wards and the psychiatric intensive care unit starting with Westlands inpatient unit on 1 April 2019 and ending with Mill View Court on 4 December 2019.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at four locations including Miranda House (88.3%), Mill View (87.5%), Newbridges (83.1%), and Westlands (81.1%) scored lower when compared to other similar trusts for privacy, dignity and wellbeing.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Miranda House	MH – Acute wards for adults of working age and psychiatric intensive care units	88.3%
Newbridges	MH – Acute wards for adults of working age and psychiatric intensive care units	83.1%
Westlands	MH – Acute wards for adults of working age and psychiatric intensive care units	81.1%
Mill View	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Wards for older people with mental health problems	87.5%
Trust overall		**87.0%**
England average (mental health and learning disabilities)		**91%**

Involvement in care

All the patients we spoke with during the inspection told us staff behaved respectfully towards them and that staff were always on hand to provide emotional support and advice. Following the inspection visit, we received 12 comments written on comment cards. Eight comments were positive and specifically mentioned how staff had helped and responded to patients appropriately when they needed it. However, one patient on Mill View Court told us none of the staff had spoken to them during the day when they were first admitted and they had found this daunting. Mostly, we observed staff interacting frequently with patients on the wards and saw they treated patients with kindness and care. Patients told us staff treated them well and behaved appropriately towards them. Staff were respectful of patients' privacy and would knock on patients' doors before entering their room.

Staff supported patients to understand and manage their treatment and provided them with appropriate information including medication information leaflets. Patients told us staff understood their personal, cultural and religious needs. For example, several patients told us it was important to them to have only female staff working closely with them and staff facilitated this whenever they could. Patients also told us staff respected their religious needs and supported them to carry out daily religious observance on the ward. Staff said they could and would raise any concerns they had about disrespectful attitudes or abusive behaviour towards patients without fear of retribution.

Staff completed information sharing agreements with patients to protect their confidential information. The patients we spoke with confirmed that staff checked with patients when they shared information with, for example, their carers and relatives. Staff had systems in place to protect confidential patient information, however, on Westlands, we observed that two patients entered the office area to speak with staff on the day of our visit. We did not see any privacy screens on computers nor did staff have time to cover patient details on the large wipe board in the office. Staff ensured the patients were escorted out of the office quickly and told us it was rare for patients to cross the door threshold. Most patients did not or had no need to enter the office when they needed to speak with staff. On Newbridges, patient information contained on the large wipe board in the staff office could be seen from the car park when it was dark outside and the lights were on in the office but we did not directly observe this at inspection. The trust told us they had installed privacy film on the windows but staff told us this was not always effective especially at night. Staff could cover patient names on the wipe boards and did so when they did not need them to be visible. None of the patients we spoke with at Westlands or Newbridges expressed concerns about any shortfalls in the confidentiality of their personal information. On some wards, we found the viewing hatches on some patient bedrooms could only be closed from the outside which could have compromised patient privacy. The trust told us they had commenced a review across all the acute wards with a view to replacing viewing hatches where appropriate.

Involvement of patients

Patients told us when they arrived on the ward and they were well enough, staff showed them round to orient them to the ward. Staff offered patients choices and information about treatment options. When we spoke with patients, the majority of them told us they felt involved in the treatment but we did not always find this was reflected in the care records. Some wards, for example, the psychiatric intensive care unit, had begun incorporating the patient's own words into care plans so they were more personalised but on other wards, we found a lack of evidence of the patient voice in care plans. However, patients took part in multidisciplinary reviews and the meetings we observed demonstrated that staff actively encouraged patients to participate in the development of their care plans. Most patients told us they had been offered a copy of their care plan and some patients had signed them. We saw copies of some signed care plans in paper files. There was an area on the electronic record where staff could tick a box to identify whether the patient had been offered a copy of their care plan or had signed it. Not all staff completed this on every occasion so it was difficult to tell whether patients had been offered a copy of their care plans on some of the wards we visited. Overall, staff involved patients in safety plans by incorporating patient views but when we looked at care records, not all patients on all wards had written safety plans in place.

On the inspection, we did not speak with any patients who had been involved in decisions about the service, for example, staff recruitment, but managers told us that each ward had a patient and carer experience champion. The trust also had a patient experience manager who had developed a patient group to allow the trust to consult patients about trust policies.

Patients had access to regular community meetings and each month, they were asked for feedback about whether they would recommend the service to a family member if they needed support. Each month, staff also asked patients about what staff had done well and what they could have done better. Wards had 'you said, we did' boards where staff posted information in response to patient suggestions.

Staff ensured patients had access to advocacy and we saw information about advocacy services available for informal patients.

Involvement of families and carers

Overall, patients told us staff involved families and carers in the patients' treatment plans and we saw evidence of this when we looked at care records. For example, we saw families and carers had been involved in care reviews. Staff held reception meetings with families and these were sometimes attended by psychology staff who provided families with appropriate support. Most of the carers we spoke with told us staff kept them informed of treatment plans where the appropriate consents had been obtained. Carers told us staff provided them with appropriate information and encouraged them to ask questions and get involved with their loved ones' care. However, three

carers we spoke with on Mill View Court and Newbridges and one patient on the psychiatric intensive care unit told us they thought that communication by staff could be improved.

The trust's website enabled carers to give feedback, contact the patient advice and liaison service and complete the friends and family test anonymously on line.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for five wards in this service between 1 September 2017 to 31 August 2018.

Four of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 September 2017 – 31 August 2018) (current inspection)
Avondale Unit	49% - 83%
Mill View Court	92% - 107%
Newbridges	90% - 113%
PICU Unit	73% - 97%
Westlands Unit	74% - 101%

Unlike at our previous inspection in September 2017, ward managers told us they were able to refuse admission when the beds were full and the trust had stopped the practice of admitting patients to leave beds. Managers told us there were no instances of patients sleeping on sofas and mattresses on the floor and there was always a bed available for patients when they returned from leave. Staff on Mill View Court told us patients from Mill View lodge could be admitted to their ward if Mill View lodge was full but that their admissions criteria allowed for older patients to be admitted where appropriate.

The trust provided information for average length of stay for the period 1 September 2017 to 31 August 2018.

Ward name	Average length of stay range (1 September 2017 – 31 August 2018) (current inspection)
Avondale Unit	3 - 5
Mill View Court	12 - 33
Newbridges	14 - 50
PICU Unit	12 - 174
Westlands Unit	16 - 64

This service reported six out area placements between 1 September 2017 to 31 August 2018. As of 31 August 2018, this service had one ongoing out of area placements. There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 87 days.

Two out of the six out of area placements were where a patient was placed with another provider due to this better suiting their care or personal needs, and four were where a patient was placed with another provider due to capacity issues.

The number of out of area placements reported during this inspection was not comparable to the last inspection.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
6	2	4	5 – 87 days	1

This service reported 97 readmissions within 28 days between 1 September 2017 to 31 August 2018. Sixty-one (63%) of readmissions were readmissions to the same ward as discharge. The average of days between discharge and readmission was 11 days. There were five instances whereby patients were readmitted on the same day as being discharged and there were seven where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 May 2016 to 30 April 2017, there were a total of 132 readmissions within 28 days. Of these, 72 (55%) were readmissions to the same ward and the average days between discharge and readmission was 11 days.

Therefore, the number of readmissions within 28 days has decreased between the two periods and the average time between discharge and readmission has remained static.

Ward name	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
Avondale Unit	58	44	76%	<1 – 28	10
Mill View Court	15	5	33%	1 -23	13
Newbridges Unit	16	8	50%	<1 – 28	15
PICU Unit	1	1	100%	7	7
Westlands Unit	7	3	43%	1 - 16	9

Discharge and transfers of care

Between 1 September 2017 to 31 August 2018 there were 1068 discharges within this service. This amounts to 61% of the total discharges from the trust overall (1763). Of the 1068 discharges, 37 (3%) were delayed.
Delayed discharges across the 12-month period ranged from zero to seven.
The proportion of delayed discharges reported during this inspection is not comparable to the delayed discharges reported at time of the last inspection.

We saw evidence in patient care records that staff planned for patients' discharge and where appropriate, patients had written plans in place. Discharges were sometimes delayed because staff could not identify an appropriate placement for a patient or because an appropriate placement did not have a bed immediately available. We saw that staff supported patients when they were transferred between the services for example from New Mill Court to acute medical services.

The trust had access to step-down beds which they managed in partnership with a local voluntary organisation. This provided additional capacity to enable staff to transfer appropriate patients when they were ready for discharge.

Facilities that promote comfort, dignity and privacy

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts. There were no locations that scored worse when compared to other similar trusts for ward food.

Site name	Core service(s) provided	Ward food
Miranda House	MH – Acute wards for adults of working age and psychiatric intensive care units	100.0%
Newbridges	MH – Acute wards for adults of working age and psychiatric intensive care units	100.0%
Westlands	MH – Acute wards for adults of working age and psychiatric intensive care units	94.3%
Mill View	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Wards for older people with mental health problems	99.0%
Trust overall		**99.0%**

Site name	Core service(s) provided	Ward food
England average (mental health and learning disabilities)		**92.2%**

All patients had single bedrooms, which they could personalise if they wanted. Each room had a lockable safe for storing valuables and patients could keep larger items in a secured cupboard on the wards. Mill View Court was the only ward where all bedrooms had en-suite facilities but all wards had communal bathrooms, with shower and bathing facilities. Patients had an electronic fob which they used to access their own bedrooms.

The range of facilities varied across the wards but all patients had access to a clinic room, private rooms where they could meet with visitors and access to a phone to make phone calls in private. On the day of our inspection, patients on Westlands and Newbridges did not have access to a patient phone because it was out of order. Staff told us it would be repaired but in the meantime, staff plugged a phone into the room when patients wanted to make a call in private. Patients had access to activity rooms except on Avondale ward where activities took place in the main lounge area. On some wards, for example, the psychiatric intensive care unit, patients had access to a small gym on the ward. Patients had access to games stations, reading material, pool tables, televisions, music stations, table tennis and other activities on the wards such as arts and crafts and musical instruments.

Patients had access to drinks and snacks on the wards 24 hours a day and access to a fully equipped kitchen where staff taught them how to prepare and cook meals. Patients confirmed the food was of good quality with enough variety. However, we also received one comment that said the food was not great and another saying it was difficult to obtain fresh fruit for breakfast on one occasion. Where patients were in seclusion, they were still offered a choice of hot or cold food from a separate menu.

There were quiet areas on the wards where patients could relax and all mixed wards had separate lounges for female patients. The staff on some of the wards were creating specific relaxation rooms with comfort boxes to help patients lower their levels of agitation. Patients had access to secure outside space with seating areas.

Patients' engagement with the wider community

Patients had access to a recovery college with education, support and well-being opportunities. Staff supported patients to maintain contact with their families and carers and each ward had a carer's champion. Occupational therapy assistants and activity workers had access to information

technology to research community resources so patients could maintain engagement with the wider community. Where appropriate, staff supported patients to maintain contact with their friends and other people who were important to them.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the locations scored lower than similar trusts for the environment being dementia friendly and scored lower than similar trusts for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
Miranda House	MH – Acute wards for adults of working age and psychiatric intensive care units	N/A	70.4%
Newbridges	MH – Acute wards for adults of working age and psychiatric intensive care units	N/A	77.9%
Westlands	MH – Acute wards for adults of working age and psychiatric intensive care units	N/A	74.7%
Mill View	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Wards for older people with mental health problems	78.5%	86.0%
Trust overall		**69.8%**	**79.7%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

Wards had arrangements in place to support patients and visitors with mobility needs. For example, lifts were available in all locations where patient rooms including activity rooms were not located on ground floors. Some wards, for example, Westlands had some dementia friendly fittings installed to help patients with those needs. Patients had access to occupational therapists who could assist with providing mobility equipment where needed. Staff ensured patients had access to information which they could understand. In patient records we saw how some patients who needed it had communication support, for example, easy read materials.

The patients we spoke with told us staff had provided them with information about their rights and about how to complain. On wards, we saw posters about how to complain and how patients could contact the Care Quality Commission. Information leaflets were available in languages spoken by patients and staff confirmed these could be obtained from the trust intranet where required. Staff made information available in easy-read format where necessary and we saw examples of this on the psychiatric intensive care unit. Staff ensured patients had easy access to interpreters as there were many patients whose first language was not English. The trust had made available an on-line translation service which could be accessed by patients and staff.

Staff were respectful of people's cultural and spiritual needs. They supported patients to visit places of worship and arranged for the chaplain or different faith representatives to visit patients on the ward where necessary.

Staff ensured that food appropriate to meet patients' religious preferences and dietary requirements was available on the wards. On menus, we saw staff provided a range of vegetarian, vegan kosher and halal meals, as well as specific meals for patients with food sensitivities.

We did not see that staff provided information on wards for patients with lesbian, gay, bisexual and transgender needs, (LGBT). We did not see evidence that staff had links with local LGBT organisations but on the trust website, we saw that staff were involved with the Hull Pride campaign in 2018 and staff and patients from across the trust attended the event.

Listening to and learning from concerns and complaints

This service received 26 complaints between 1 September 2017 to 31 August 2018. Five of these were upheld, eight were partially upheld and 13 were not upheld. One was referred to the Ombudsman. The most common complaint themes were patient care (7) and communications (6).

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Avondale Unit	6	1	2	3	0	1	0	0
Mill View Court	4	1	0	3	0	0	0	0
Newbridges	7	2	2	3	0	0	0	1
Westlands	9	1	4	4	0	0	0	0

This service received 50 compliments during the last 12 months from 1 September 2017 to 31 August 2018 which accounted for 11% of all compliments received by the trust.

The patients we spoke with during the inspection told us they had been informed of how to raise concerns and make complaints. We saw information displayed on ward areas about how to complain and staff made information available in patient welcome packs. Staff knew how to respond to patient complaints and we saw examples where staff responded to patients on the ward when they complained. Team meeting notes contained examples where staff had taken action to resolve patient complaints on their ward.

Staff responded to patients' formal complaints by carrying out appropriate investigations and providing written feedback to patients where they had complained. The trust had a complaints and patient advice liaison service to respond to complaints from both patients and carers. The trust provided examples of where they had made ward changes in response to complaints from patients. At inspection, we saw that patients had sent thank you cards and other compliments to ward staff.

Is the service well-led?

Leadership

Ward managers were experienced and had the skills and knowledge to perform their roles. They were supported by two modern matrons that worked to improve patient care across the acute wards and the psychiatric intensive care units. Ward managers, modern matrons and service managers had an in-depth understanding of the services they managed.
Managers and modern matrons were visible in the service. Staff knew them and could approach them for advice and support. Senior leaders, however, were not visible and ward level staff did not always know who they were.

Vision and strategy

Most staff we spoke with could describe in general terms the trust's vision and values though they had not been involved in developing them. The trust's vision and values were posted in ward areas which were visible to patients and staff. When we observed staff working with patients and with colleagues, we could see that they demonstrated the trust's values, for example, caring and learning. Each member of staff has been issued with a pocket strategy booklet that incorporated an overview of the trust's strategy, including the mission, vision, values and goals. This was updated in 2018.

Staff at ward level could not tell us how they contributed to strategy discussions about the service but managers had a voice through a care forum dedicated to acute services. Some staff told us the trust sent emails asking for their opinion about service developments.

Staff described working to deliver high quality care to patients and families by working together as a team, supporting and learning from each other.

Culture

The trust carried out regular staff surveys but not at the level of this core service. The staff we spoke with at inspection felt valued and supported by their immediate managers up to the level of service manager. They felt positive about working in their own teams and proud of the care they provided for patients. Managers felt proud of their staff teams and how hard they worked. However, most of the staff and managers we spoke with said they did not feel valued by senior leaders. They told us they did not feel listened to or supported especially when things went wrong. Some staff thought senior leaders did not understand how moving staff around to cover wards which were short staffed had affected staff morale. Some staff told us this had led to higher levels of stress within the workforce and an increase in sickness absence.

The staff we spoke with felt able to raise concerns without fear of retribution and could tell us about the whistle-blowing process. Posters were displayed on the ward about speaking up and staff could tell us about the role of the freedom to speak up guardian.

Managers dealt with poor staff performance when needed and had access to specialist advice and support from the trust's human resources department.

Teams worked well together and supported each other. Staff spoke with mangers about career progression and gave us examples of how they had been supported to develop their knowledge and skills. We saw examples where staff had been promoted to managerial roles and, in the past, some had been supported by the trust to undertake nurse training.

The trust promoted equality and diversity in providing opportunities for career progression. For example, apprenticeship schemes were available to all staff across the trust and had been widely advertised and promoted. Staff had access to secondment opportunities both within and external to the trust.

The sickness rate for this core service was higher than the average for the trust as a whole. Staff had access to the trust's independent occupational health service as well as a range of other health and well-being initiatives including a cycle to work scheme and discounted membership at council run gyms in Hull.

The trust invited staff to nominate colleagues and teams for an annual awards scheme aimed at celebrating innovative and inspiring work to improve the lives of patients.

Governance

Since the last inspection in September 2017, the trust had made improvements to staff training, appraisal, medicines management and bed management. Managers had systems in place to monitor staffing levels, cleanliness, and adherence with the Mental Health Act. The trust's positive engagement team ensured staffs' use of restraint and seclusion were reported through the incident system and trends monitored. They provided staff with training which emphasised least restrictive practice and staff were skilled in the use of verbal de-escalation. Staff were using new technology to carry out audits and this meant they could be more efficient with their resources. Staff and managers met with each other regularly to discuss and improve the quality of care on the wards. Some staff had implemented safe wards strategies on their wards but this was more embedded on some wards than others. For example, not all teams were holding safety huddles consistently.

However, staff thought the senior leadership team did not consult them about changes to the service or listen to their concerns. For example, staff had been told they could not work on the bank rota during any of their annual leave. They worried how services were going to be staffed because of these changes. The trust did not provide effective guidance around the implementation of the smoke free policy so some patients continued to smoke in the outside areas on some wards and staff were unsure what action to take. Some staff and managers thought staff recruitment and retention needed to be further improved and that the recruitment procedures for healthcare staff were not responsive enough and left wards short of staff for longer than they needed to be. The trust had not reviewed their minimum staffing levels, nor had they begun to audit compliance with the Mental Capacity Act in any of the acute services. Some staff we found had a lack of knowledge around unwise decisions and best interest processes. Patients on most of the wards did not have access to a nurse alarm call system but the trust did not ensure staff always carried out assessments with patients to determine if they needed one. Some of the measures the trust had taken to protect patient confidentiality, such as privacy film on external windows was not always effective.

We did not see a consistent framework for what should have been discussed at team meetings. Teams had a different standard agenda and we did not see evidence that learning from trust-wide incidents and complaints had been discussed or shared in the records of the team meetings we looked at. We did not see evidence that staff shared lessons learned with each other on the acute wards. In total, we looked at a sample of notes from nineteen team meetings from across all the wards from June 2018 to January 2019.

Staff participated in ward audits and flagged up when repeat issues had been identified or resolved. However, this was not consistent across all audit reports. Some of the audit reports we looked at, for example seclusions and care records did not clearly identify all the problems and did not contain actions needed to address any concerns.

Staff worked with other teams within the trust and we saw good examples of joint work with the trust's substance misuse teams and with local emergency departments. Higher managers were in the process of changing management structures to provide better integrated pathways between community mental health teams and the acute mental health in-patient services.

Management of risk, issues and performance

Unlike at our previous inspection on September 2017, each ward had a local risk register and staff could give us examples of the kinds of issues which would be recorded. Where appropriate, staff could escalate risks through their service manager to the trust-wise risk register.

The service had business continuity plans in place which they had used recently in relation to a serious incident causing disruption to one of the acute wards. Some patients had to be moved temporarily to other wards.

Information management

The service had a well-embedded incident system in place and staff reported all incidents to the trust and made notifications to external bodies such as safeguarding authorities when required. However, staff felt overburdened because they had been told to complete a separate incident report every time a patient attempted to smoke. They felt this was impractical as patients on busy wards were smoking frequently.

Overall, staff felt they had access to the equipment and information technology they needed to carry out their work. However, most staff we spoke with described the electronic patient recording system as slow. Teams had developed paper based summary files for patients because they could access this more quickly than the electronic system. Staff did not always know where on the patient record information was stored, for example, mental capacity assessments.

Staff received training and were knowledgeable about information governance systems including confidentiality.

Ward managers had access to regular ward performance reports including staffing data such as compliance with mandatory training. However, staff did not always understand some of the reports produced. For example, the safer staffing report did not clearly identify whether the ward had met

safer staffing levels. We found some of the audits staff carried out, for example, care records audits, did not identify what further actions were required to improve.

Engagement

Staff had access to information on the trust intranet and patients could access the trust internet. When we looked at the trust's website, we found some information was out-of-date. For example, recruitment events were still listed when they had happened three months previously. Information about how patients could nominate staff for a patient choice award was still posted despite the closing date being November 2017. Staff on some wards put data about staff sickness and other ward performance related outcomes on the wards but we did not see a consistent approach to this.

Patients and carers had opportunities to give feedback through community meetings, suggestion boxes and through monthly friends and family questionnaires. They could also provide feedback via the trust's website but we did not see evidence that patients or carers were involved in decision-making about changes to the service. The trust showed us a poster which invited patients to get involved in the recruitment of staff and other activities aimed at improving and developing services within the trust generally.

Learning, continuous improvement and innovation

Staff had opportunities to contribute to service improvement through care group meetings and through supportive relationships with line managers who could give protected time for professional development. Staff on Westlands had developed a toolkit for use with patients at risk of suicide and self-harm. They were in the process of providing training for staff on other wards. Some managers had applied for funding to create a low-stimulus room on their ward to benefit patients with high levels of agitation.

Staff had access to regular development days which they used to learn and share good practice with staff from across their care group. We spoke with some staff who had attended these and they had found them useful.

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 service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
Accreditation for Inpatient Mental Health Services (AIMS) - PICU	MH – Acute wards for adults of working age and psychiatric intensive care units	PICU (September 2016)	Newbridges, Westlands, and Mill Vew Court have not been re-accredited.
Accreditation for Inpatient Mental Health Services (AIMS) – Assessment and triage wards	MH – Acute wards for adults of working age and psychiatric intensive care units	Avondale (February 2016)	Newbridges, Westlands, and Mill View Court have not been re-accredited.

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	Ullswater Ward (Medium Secure)	12	Male
Willerby Hill	Swale Ward (Medium Secure)	15	Male
Willerby Hill	Southwest Lodge (Low Secure)	4	Male
Willerby Hill	Ouse Ward (Medium Secure	14	Male
Willerby Hill	Derwent Ward (Medium Secure)	10	Male
Willerby Hill	Darley Ward (Low Secure)	8	Male
	Greentrees Lodge – Temporarily closed in July 2018 for refurbishment		

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 environment

Wards were generally safe, clean, well equipped, well furnished, well maintained and fit for purpose. There were blind spots on the wards.

Safety of the ward layout

Staff completed regular risk assessments of the care environment. Staff followed trust procedures in the safe management of keys and security on the wards. New staff received a five-day security induction which was refreshed annually. Staff undertook daily checks of the environment to ensure security standards were maintained.

The wards complied with guidance on eliminating mixed-sex accommodation, as all wards were male only.

Not all ward layouts allowed staff to observe all parts of the ward. There were ligature risks on all wards. Each ward had an up to date ligature risk assessment. Staff were aware of ligature anchor

points and completed individual patient risk assessments and used supportive engagement to observe and engage with patients who might try to harm themselves.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Darley	Kitchen, doors, soap dispensers smoke alarms identified as residual risks in the environment. Radiators height.	Yes	Radiators subject to remedial work
Ouse	Doors and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit. Bedroom and shower room fitments	No	Local risk management regime and patient risk assessment used to manage identified risk
Derwent	Doors and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit. Bedroom and shower/bath room fitments	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.
Swale	Doors and smoke detectors are in situ which introduces a ligature risk but are necessary for the safety of the unit.	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.
Ullswater	Doors and smoke detectors are identified as residual risks	Yes	Environmental Risk Assessment in place with local risk management based on individual need and risk assessment.

Staff had easy access to alarms and patients had easy access to nurse call systems. Nursing observations were completed in line with prescribed levels

Maintenance, cleanliness and infection control

Wards were clean, had good furnishings and were generally well-maintained. There was offensive graffiti etched on a window on Derwent ward. Staff said this had been there for a number of months. There was a ‘defects log book’ in the reception area. We reviewed this and found that the graffiti had not been logged in the book. Staff were unsure if this had been reported for repair/replacement. We raised a concern about this issue and managers said they would look into this urgently. All issues recorded in the ‘defects log book’ were reported to the estates department by reception staff. There were a number of issues recorded in the log book that were not marked as completed. Staff said this did not mean the work had not been carried out, but that the log book may not have been updated.

On Ouse ward, showers were out of commission due to positive legionella tests. One of the laundry rooms in the service was out of use, awaiting repair. Staff and patients said that these had been out of use since November 2018. Staff did not know when the showers and laundry facilities were due for repair.

Prior to the inspection, there had been a legionella outbreak on Ouse ward. We looked a number of water running records and it was clear that regular running was taking place. There were a small number of records that did not contain location details so it was difficult to identify which area of the hospital these related to. Some of the recording forms provided referred to checking just showers, some showers and taps and some showers taps and toilets, there was an inconsistent approach across the hospital in how these checks were carried out. An external contractor carried out legionella inspections and regular thermostatic mixing valve temperature checks. These checks raised a number of maintenance issues relating to water appliances and there was no record that these had been followed up.

Throughout the Humber centre a new system for portable appliance testing had been put in place. The traditional test and date stamp system had been replaced by a barcode system that would indicate upon scanning when the item had last been tested and if it had passed or not. It was not possible to see if appliances had been tested and passed during the inspection. Data sheets provided after the inspection confirmed that portable appliances had been checked.

Certificates confirmed that fire safety equipment and electrical installations were checked regularly.

Cleaning records were up to date and demonstrated that ward areas were cleaned regularly. For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the location scored higher than similar trusts for cleanliness and scored higher than similar trusts for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Humber Centre Forensic Unit	MH – Secure wards/Forensic inpatient	99.7%	98.8%
Trust overall		**99.2%**	**95.1%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

Staff adhered to infection control principles, including handwashing.

Seclusion room (if present)

There were four seclusion rooms across the five wards. At the time of the inspection, all seclusion rooms were being used so we were unable to enter these. At our last inspection, and in unannounced Mental Health Act monitoring visits, the seclusion rooms were found to allow clear observation and two-way communication and had toilet facilities and a clock.

Clinic room and equipment

There were clinic rooms on Swale and Ullswater wards. Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff carried out daily checks of medicines in line with trust policy.

Staff maintained equipment well and kept it clean.

Safe staffing

The service did not always have enough nursing staff on the wards. This impacted on the delivery of therapeutic interventions and patient leave.

Staff and patients were concerned about staffing levels within the service. At ward level, there were no defined staffing establishment numbers.

The service had implemented a centralised system for the deployment of bank staff in November 2018. This meant that staff working bank shifts could be deployed on any of the wards within the service. Staff were unhappy about the centralised bank system, feeling that it negatively impacted upon therapeutic relationships between staff and patients.

Patients told us that planned leave was regularly cancelled because there were not enough staff to support this. Patients also said they felt uncomfortable when staff were on the wards that they did not know, and that this happened regularly.

Staffing levels did not always allow patients to have regular one-to-one time with their named nurse. Patients said their named nurse was often changed as staff were moved onto other wards to meet staffing shortfalls. Carers felt that bank staff did not demonstrate a good understanding about the needs of individual patients.

Nursing staff

This core service reported a vacancy rate for all staff of 15% as of 31 August 2018.

This core service reported an overall vacancy rate of 30% for registered nurses at 31 August 2018.

This core service reported an overall vacancy rate of 5% for nursing assistants at 31 August 2018.

(CAVEAT: The trust changed their financial reporting system part way through the 12-month reporting period and therefore vacancy data is inconclusive).

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Humber Centre	Humber Centre Forensics/Offender Health	29.4	98.4	30%	3.9	76.5	5%	35.9	232.3	15%
Core service total		**29.4**	**98.4**	**30%**	**3.9**	**76.5**	**5%**	**35.9**	**232.3**	**15%**
Trust total		**149.1**	**1082.7**	**14%**	**126.9**	**646.8**	**20%**	**397.2**	**3685.1**	**11%**

NB: All figures displayed are whole-time equivalents

No breakdown of establishment levels by ward. Ward managers were unable to share what their staffing establishment levels were.

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing reporting, to that provided in the RPIR. The following relates to that received in the RPIR.)

Between 1 September 2017 and 31 August 2018, of the 110248 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were safety and vacancies.

In the same period, agency staff covered 0% of available hours for qualified nurses and 4% of available hours were unable to be filled by either bank or agency staff.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Humber Centre - Bridges Ward	44976	214	0%	26	0%	1599	4%

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Humber Centre - Darley Ward	18126	118	1%	0	0%	626	3%
Humber Centre - Swale	24079	68	0%	31	0%	477	2%
Humber Centre - Ullswater	23068	165	1%	0	0%	1427	6%
Core service total	**110248**	**565**	**1%**	**57**	**0%**	**4130**	**4%**
Trust Total	**958417**	**2753**	**0%**	**934**	**0%**	**18576**	**2%**

Between 1 September 2017 and 31 August 2018, of the 203319 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards/teams were safety and vacancies.

In the same period, agency staff covered 0% of available hours and 7% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Humber Centre - Bridges Ward	80163	947	1%	0	0%	5984	7%
Humber Centre - Darley Ward	29651	269	1%	0	0%	1449	5%
Humber Centre - Swale	44054	695	2%	0	0%	3695	8%
Humber Centre - Ullswater	49451	670	1%	0	0%	2253	5%
Core service total	**203319**	**2582**	**1%**	**0**	**0%**	**13381**	**7%**
Trust Total	**908881**	**7895**	**1%**	**377**	**0%**	**34624**	**4%**

We reviewed the number of bank shifts for all wards not filled for band 5 and band 3 staff between August and December 2018. This information showed an increase in the proportion of bank shifts that were unfilled since the introduction of the centralised e-rostering system for bank staff. This is detailed in the table below.

	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total

Total shifts	798	796	903	896	1161	4554
Filled	635	654	752	590	574	3205
Unfilled	163	142	151	306	587	1349
Fill rate	80%	82%	83%	66%	49%	70%

There was a frequent reliance upon occupational therapy staff to maintain safer staffing levels. Between October to December 2018, a total of 446 occupational therapy staff hours were used to support staffing levels on the wards. This meant that the delivery of therapeutic activities on the wards was adversely affected.

Between July to December 2018 there had been 81 reported incidents linked to staffing numbers. Twenty-two incidents were reported as not affecting patients directly. Fifteen incidents resulted in an inability to provide adequate care and nine incidents resulted in planned activities being reduced. There had been 35 occasions where patients' planned Section 17 leave did not take place due to staffing levels.

Senior staff on the wards felt that they sometimes struggled to keep up to date with their duties as they were often required to work into staffing numbers. We reviewed e-roster reports for the four-week period from 5 November 2018 to 2 December 2018 and found the number of shifts where band 6 and band 7 nurses had deployed across the wards to support safer staffing levels:

Ouse ward – B7 – 1 shift / B6 – 7 shifts

Derwent ward – B6 – 6 shifts

Ullswater – B6 – 16 shifts

Darley 0 B7 – 1 shift / B6 – 17 shifts

Swale – B7 – 2 shifts

This core service had 17.6 (8%) staff leavers between 1 September 2017 and 31 August 2018. This was lower than the 11% reported at the last inspection (from 1 June 2016 to 31 May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Humber Centre	Secure Services	5.4	3.0	42%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
	Psychology (Team)			
Greentrees Lodge (Temporarily closed in July 2018 for refusrbishment)	Admin (Team)	17.9	4.6	26%
Humber Centre	Medical Staff (Team)	5.6	1.0	18%
Humber Centre	Ullswater (Team)	28.6	3.0	11%
Humber Centre	Bridges Ward (Team)	51.5	4.0	8%
Humber Centre	Darley House (Team)	22.6	1.0	5%
Humber Centre	Swale (Team)	27.4	1	4%
Baker Street Treatment Centre	Secure Services Therapies (Team)	17.8	0	0%
Greentrees Lodge	Greentrees (Team)	0	0	0%
Humber Centre	Involvement (Team)	1.4	0	0%
Humber Centre	Secure Services Social Work (Team)	5.0	0	0%
Humber Centre	Specialist Services	9.4	0	0%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
	Management (Team)			
Core service total		**192.5**	**17.6**	**8%**
Trust Total		**2091.3**	**255.3**	**11%**

The sickness rate for this core service was 7.1% between 1 September 2017 and 31 August 2018. The most recent month's data (31 August 2018) showed a sickness rate of 5.6%. This was lower than the sickness rate of 8% reported at the last inspection between 1 June 2016 and 31 May 2017.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Humber Centre	Secure Services Social Work (Team)	11.6%	15.0%
Humber Centre	Bridges Ward (Team)	9.1%	9.3%
Greentrees Lodge	Greentrees (Team)	N/A	8.4%
Humber Centre	Darley House (Team)	3.1%	7.7%
Baker Street Treatment Centre	Secure Services Therapies (Team)	7.8%	6.6%
Humber Centre	Specialist Services Management (Team)	4.1%	6.2%
Humber Centre	Swale (Team)	2.8%	6.1%
Humber Centre	Ullswater (Team)	3.0%	6.0%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Greentrees Lodge	Admin (Team)	5.7%	5.8%
Humber Centre	Involvement (Team)	16.6%	4.0%
Humber Centre	Secure Services Psychology (Team)	0.0%	1.4%
Humber Centre	Medical Staff (Team)	1.0%	1.1%
Core service total		**5.6%**	**7.1%**
Trust Total		**3.9%**	**4.7%**

The below table covers staff fill rates for registered nurses and care staff during April 2018, May 2018 and July 2018. Staff fill rates for June 2018 were not available.

Darley ward had below 90% of the planned care staff for day shifts. Swale ward had above 125% of the planned care staff for night shifts during two of the months (May 2018 and July 2018). Ullswater ward had below 90% of the planned registered nurses for day shifts across two months (May 2018 and July 2018).

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	April 2018				**May 2018**				**July 2018**			
Darley	113%	65%	98%	115%	98%	63%	100%	106%	73%	67%	103%	127%
Swale	116%	104%	113%	119%	135%	131%	110%	159%	81%	109%	100%	130%
Ullswater	104%	130%	94%	167%	70%	91%	107%	88%	59%	104%	101%	93%

We reviewed staff fill rates for October to December 2018 during the inspection and found that all wards were operating at fill rates well below 90% during the day for qualified nurses every month.

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	October 2018				November 2018				December 2018			
Darley	53%	66%	98%	98%	43%	68%	100%	92%	32%	78%	87%	100%
Swale	72%	111%	117%	193%	77%	96%	100%	162%	83%	92%	107%	155%
Ullswater	67%	118%	106%	105%	60%	140%	102%	114%	51%	128%	110%	94%
The Bridges	57%	81%	102%	101%	59%	73%	100%	109%	70%	86%	96%	101%

Medical staff

There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency. A team of five consultants provided medical input across the wards. Out of hours medical cover was provided by junior doctors with consultants as second on call.

Between 1 September 2017 and 31 August 2018, of the 1840 total working hours available, no hours were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reasons for bank and agency usage for the wards/teams were vacancies.

In the same period, agency staff covered 40% of available hours and 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Humber Centre – Forensic	1840	0	0%	736	40%	0	0%
Core service total	**1840**	**0**	**0%**	**736**	**40%**	**0**	**0%**
Trust Total	**36104**	**0**	**0%**	**12181**	**34%**	**0**	**0%**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The trust set a target of 85% for completion of mandatory and statutory training. Training completion was reported on a rolling month on month basis.

Staff were sufficiently trained to meet the needs of the patient group. Compliance with mandatory training had improved since the previous inspection. Some staff had not been able to complete

training due to sickness absence. Managers were aware of this and had plans to address this once staff returned to work.

The compliance for mandatory and statutory training courses at 31 August 2018 was 93%. Of the training courses listed three failed to achieve the trust target and of those, one failed to score above 75%. Basic life support training was being introduced into the annual security training refresh.

The training compliance reported for this core service during this inspection was higher than the 92% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Fire Safety - 2 Years	6	6	100%	✓
Moving and Handling - Level 3	2	2	100%	✓
Safeguarding Adults - Level 2	135	133	99%	✓
Information Governance	198	195	98%	✓
Prevent Awareness	119	117	98%	✓
Safeguarding Children - Level 3	39	38	97%	✓
Display Screen Equipment	197	191	97%	✓
Infection Prevention - Level 2	173	167	97%	✓
Prevent - WRAP	79	77	97%	✓
Infection Prevention - Level 1	25	24	96%	✓
Safeguarding Adults - Level 1	24	23	96%	✓
COSHH Awareness	198	191	96%	✓
Moving and Handling - Level 1	50	48	96%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Children - Level 1	21	20	95%	✓
Mental Capacity Act - Level 2	173	163	94%	✓
Equality and Diversity	198	187	94%	✓
Mental Health Act	67	63	94%	✓
Health and Safety	198	183	92%	✓
Safeguarding Children - Level 2	138	127	92%	✓
Mental Capacity Act - Level 1	25	23	92%	✓
MAPA - Inpatient	153	138	90%	✓
Fire Safety - 1 Year	192	171	89%	✓
Immediate Life Support	64	56	88%	✓
Personal and Team Safety (PATS)	43	37	86%	✓
Moving and Handling - Level 2	146	123	84%	✗
Adult Basic Life Support	109	89	82%	✗
Safeguarding Adults - Level 3	39	19	49%	✗
Total	**2811**	**2611**	**93%**	

Assessing and managing risk to patients and staff

Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. They minimised the use of restrictive interventions and followed best practice when restricting a patient.

Assessment of patient risk

Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident. Staff had completed a comprehensive risk assessment and safety plan in all six records we reviewed. Staff used recognised risk assessment tools to identify and

manage patient risks. These were the Short-Term Assessment of Risk and Treatability tool and the Historical Clinical Risk Management-20 tool.

Staff were aware of individual patient risks and these were discussed in the daily morning meeting. Risk assessments and safety plans were routinely reviewed in monthly multi-disciplinary team meetings.

Management of patient risk

Staff identified and responded to changing risks to or posed by patients.

Patients had comprehensive safety plans in place which outlined risks, triggers, behaviours, agreed ways of working to respond to risk, protective factors and management strategies. Patients were involved in the development of their safety plans.

Staff followed trust policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Staff understood the supportive engagement policy and used this to manage individual patients' risks. Patient records and observations of the morning meeting evidenced staff discussing risk and increasing or decreasing observation levels as risks changed. Staff carried out random bedroom searches on medium secure wards. Patients were only subject to personal searches in response to specific information or risks.

Restrictive practices for patients were robustly reviewed. Any restrictions were based on individual assessment of risk and were reviewed monthly. We saw that individual restrictions were removed as risk decreased. There was a blanket restriction across the service in relation to the observation of visits. The visitor policy for the ward stated that all visits would be observed by staff. Family members and patients had mixed views about the observation of visits. Some did not have any issues with this, whilst others had challenged this but nothing had been done as a result.

The trust had become a smoke free site in September 2016. Staff offered smoking cessation support to patients and nicotine replacement therapies were available. Patients were unhappy that the trust had consulted upon the use of electronic cigarettes but had decided not the allow these to be used. Patients felt the reasons for this decision had not been communicated to them.

Use of restrictive interventions

Staff used restraint only after de-escalation had failed and used correct techniques. We reviewed six incident records which outlined actions taken prior to physical restraint being used.

This service had 90 incidences of restraint (21 different service users) and 55 incidences of seclusion between 1 September 2017 and 31 August 2018.

The below table focuses on 12 months' worth of data: 1 September 2017 to 31 August 2018.

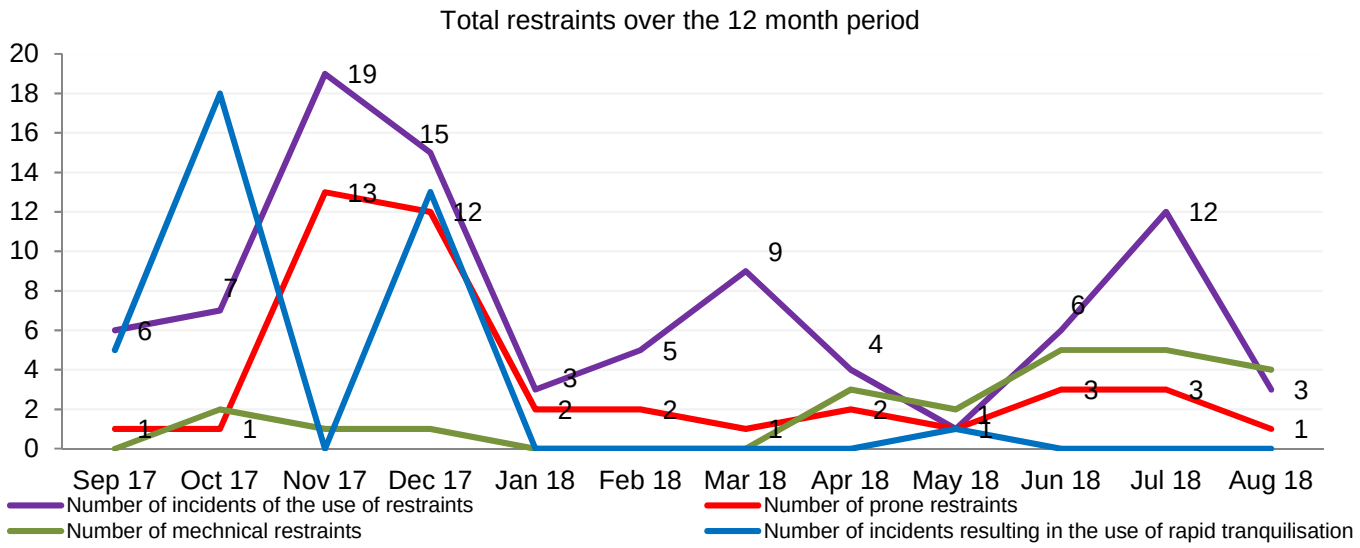
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Derwent Ward	24	51	9	37 (73%)	32 (63%)
Ullswater House	12	28	6	3 (11%)	4 (14%)
Swale Unit	14	7	4	0 (0%)	1 (14%)
Darley House	3	3	1	2 (67%)	0 (0%)
Ouse Ward	0	1	1	0 (0%)	0 (0%)
Greentrees	0	0	0	N/A	N/A
Humber Centre	2	0	0	N/A	N/A
Core service total	**55**	**90**	**21**	**42 (47%)**	**37 (41%)**

There were 42 incidences of prone restraint, which accounted for 47% of the restraint incidents. Over the 12 months, incidences of prone restraint ranged from one to 13 per month. The number of incidences (42) had increased from the previous 12-month period (13).

There were 37 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to 18 per month over 1 September 2017 to 31 August 2018. The number of incidences (37) had increased from the previous 12-month period (10). We reviewed the rapid tranquilisation data and found that 29 incidents related to one patient who had refused to take anti-psychotic medication orally, so was administered via injection. Where rapid tranquilisation had taken place, monitoring of patients took place in line with national guidance.

There were 23 instances of mechanical restraint involving nine patients over the reporting period. The number of incidences (23) had increased from number of incidences from the previous 12-month period (zero). Handcuffs were only used with patients outside the Humber Centre, never within the secure perimeter. The main uses were with restricted patients, particularly those transferred from prison who did not otherwise have authorised leave.

The number of restraint incidences reported during this inspection (90) was higher than the 34 reported at the time of the last inspection.



Staff used seclusion appropriately. We reviewed records of five episodes of seclusion. We found good documentation of the reason for seclusion and seclusion care plans which detailed the steps needed to bring the seclusion episode to an end. In one of the five records there was incomplete entries of required 15-minute observations and no documented information about the discussions that had taken place prior to seclusion coming to an end. Staff said this information had been handwritten due to problems with accessing the electronic system but were unable to locate the handwritten notes. In three of the records, medical reviews had taken not taken place every four hours. We saw entries in the records which indicated that during the night, doctors had contacted the ward by telephone but had not visited to review the patient in seclusion.

There was a generic emergency evacuation plan in place for patients in seclusion, but these were not personalised to reflect the individual needs of different patients using the seclusion rooms. This had been identified at our previous inspection and remained an issue.

There were 55 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from one to ten per month. The number of incidences (55) had decreased from the previous 12-month period (95).

The number of seclusion incidences reported during this inspection was lower than the 72 reported at the time of the last inspection.

Staff adhered to the Mental Health Act Code of Practice and trust policy in their use of 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’. There were 17 instances of long-term segregation over the 12-month reporting period. The number of incidences (17) had increased from the previous 12-month period (zero).

The number of segregation incidences reported during this inspection was higher than the six reported at the time of the last inspection.

Data reviewed on site during the inspection showed that during the reporting period the actual number of incidences of long-term segregation was nine, involving five patients.

At the time of our inspection, there were three patients in long-term segregation. We reviewed care records for these patients and found a clear rationale for long-term segregation taking place. Staff had developed care plans that included what was required for long-term segregation to end. Patients in long-term segregation had plans that included periods out of segregation and continued to have treatment and interventions delivered, including by the occupational therapy and psychology teams. Care was reviewed daily by the responsible clinician, weekly by the multi-disciplinary team and was reviewed by external agencies. For example, another NHS trust had been involved in the review of care delivered to one patient in long-term segregation. External reviews took place every three months. Two of the patients in long-term segregation required specialist placements for autistic spectrum disorder. Staff were working closely with other stakeholders including commissioners of specialist services to identify appropriate placements.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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.

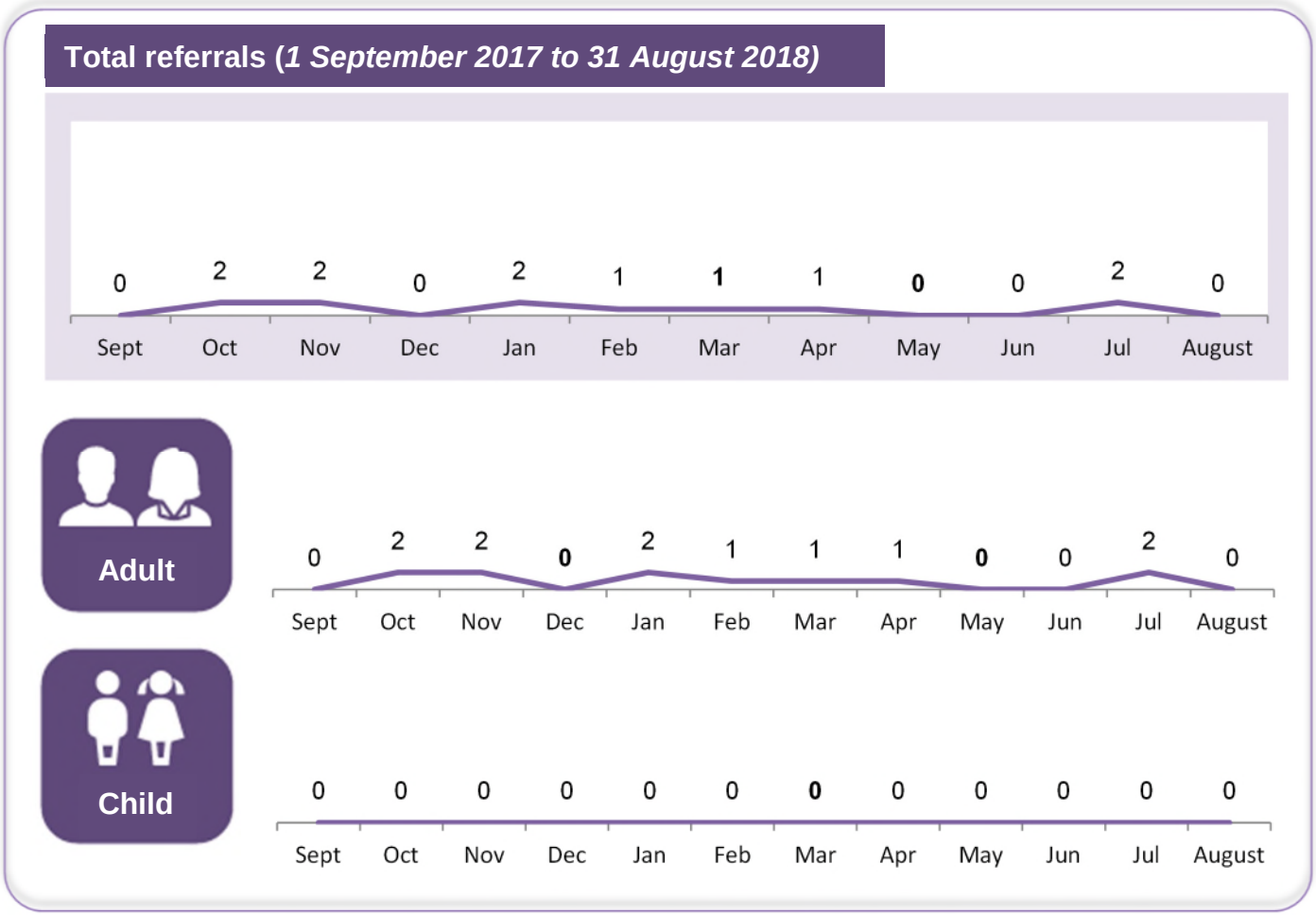
This core service made 11 safeguarding referrals between 1 September 2017 and 31 August 2018, of which 11 concerned adults and zero concerned children. The number of safeguarding

referrals reported during this inspection was not comparable to the last inspection due to core services not previously being allocated to referrals.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Secure wards/Forensic inpatient	11	0	11

The number of adult safeguarding referrals in month ranged from zero to two (as shown below).

The number of child safeguarding referrals was none (as shown below).



There were good relationships with the internal trust safeguarding team and staff sought advice on safeguarding issues when needed.

Staff followed safe procedures for children visiting the service.

The trust submitted details of no serious case reviews commenced or published in the last 12 months (1 September 2017 and 31 August 2018) that relate to this service.

Staff access to essential information

Staff kept detailed records of patients care and treatment. Most records were clear, up-to-date and easily available to all staff providing care. Information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Care records were maintained on an electronic care records system. During the inspection we reviewed care records and found that the electronic system was very slow. Staff told us the system was frequently slow and sometimes 'crashed' and that it could be difficult to navigate.

Staff in the healthcare hub used the electronic care records system as well as SystmOne, a primary care clinical record system. This meant that patient information was stored in two places. The electronic care record system did not have a facility to book or record health care appointments. These were recorded in a paper diary, but this meant automatic review appointments and annual physical health checks could not be generated.

Medicines management

Staff generally followed best practice when storing, dispensing and recording medication. Staff regularly reviewed the effects of medications on each patient's physical health.

Staff prescribed medicines in accordance with the provisions of the Mental Health Act. Medicines were stored securely in clinic rooms with access restricted to authorised staff in line with trust policy. Only Ouse and Swale wards had clinic rooms. In the clinic rooms, fridge temperatures were checked daily. On other wards, some medications were stored in cupboards in the nursing station.

There were gaps in processes for receiving medication on the wards. Staff were not signing to indicate they had taken medication deliveries from the reception area onto individual wards.

There were only two controlled drugs cabinets and controlled drug registers for five wards. This raised concerns about the effectiveness of the management and oversight of controlled drugs.

A pharmacist visited the wards regularly and carried out regular audits.

Track record on safety

Between 1 September 2017 and 31 August 2018 there were two serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Sub-optimal care of the deteriorating patient meeting SI criteria' and 'Substance misuse whilst inpatient meeting SI criteria' with one incident each. One of the unexpected deaths was an instance of 'Substance misuse whilst inpatient meeting SI criteria.'

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with two reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

	Number of incidents reported					
Ward Name	**Unauthorised absence meeting SI criteria**	**Confidential Information**	**Disruptive/ aggressive/ violent behaviour meeting SI criteria**	**Substance misuse whilst inpatient meeting SI criteria**	**Sub-optimal care of the deteriorating patient meeting SI criteria**	**Total**
Derwent Ward	0	0	0	1	0	1
Darley House	0	0	0	0	1	1
Total	**0**	**0**	**0**	**1**	**1**	**2**

Reporting incidents and learning from when things go wrong

The service did not have a robust system of sharing learning from incidents. Staff recognised incidents and reported them appropriately. Whilst incidents were investigated, staff were not informed of investigation outcomes and there was a lack of learning from incidents.

Staff knew what incidents to report and how to report them. We reviewed incident records and found that a number of incidents had not been 'signed off'. There were 74 incidents flagged as being overdue for sign off. Some of these incidents were very old, dating back to 2017. Managers were unclear what the timescales were for signing off incidents on the system. There were no systems in place to assess the quality of incident reviews or whether these had been signed off within required timescales.

There was a monthly forensic clinical network meeting. We reviewed agendas and minutes for the December 2018 and January 2019 meetings. Learning from incidents was a standing agenda item

at this meeting. The minutes of the January 2019 meeting reflected that there was no evidence to show compliance for the significant event analysis and serious incidents dating back to 2016.

The trust used a tracker system for significant event analysis and serious incidents to monitor progress against any identified actions. We reviewed trackers which highlighted that most actions had not been completed within required timescales.

Staff said they did not receive feedback on the outcome of the review of incidents or investigations. Staff could not provide examples of things that had changed as a result of learning from incidents.

Staff said that de-brief following incidents was variable, with some staff reporting no or delayed de-brief following serious incidents.

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.

Data obtained from the Coroner's website (www.judiciary.uk) indicated there had been one prevention of future deaths report relating to a patient of the trust in the last two years. The prevention of future deaths report was sent to NHS Improvement. This report did not relate to this service.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.

Staff had completed a comprehensive assessment of each patient in all six of the care records we reviewed, including a review of their physical health needs. Each patient had an individualised care plan which reflected the needs of the patients as outlined in the comprehensive assessment.

Patients worked with staff to complete recovery stars, which were regularly reviewed. The recovery star is a tool that measures changes and supports recovery by providing a map of the patient's journey to recovery.

Each patient had a positive behaviour support plan, which was personalised and written in the patient voice.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives.

Patients had good access to physical healthcare, including access to specialists when needed. The healthcare hub was a shared resource for all wards in the Humber Centre, staffed by two registered general nurses, an associate nurse practitioner and a GP who delivered two sessions each week. Patients had physical health plans in place including those who had long term conditions such as diabetes and asthma. Patients with diabetes attended a special clinic, with access to a podiatrist, dietician and diabetes specialist nurse. Staff in the healthcare hub reported a much improved relationship with ward staff. Ward champions for physical healthcare were in place and had completed training in physical health. Patients had an annual health check. Staff used the Health Improvement Profile, which is specifically designed to support physical health care of people with severe mental illness.

Staff supported patients to live healthier lives including smoking cessation programmes, weight management and healthy eating advice.

Patients had good access to psychological interventions which were delivered through group sessions and one to one interventions. Psychology staff lead formulation workshops.

All patients had individualised activity plans in place. There was a well-resourced occupational therapy team comprised of 15 staff. Each ward had an assigned occupational therapist and associate practitioner. Patients had access to a wide range of therapeutic activities. Due to staffing pressures on the wards,

There was a frequent reliance upon occupational therapy staff to maintain safer staffing levels. Between October to December 2018, a total of 446 occupational therapy staff hours were used to support staffing levels on the wards. This meant that the delivery of therapeutic activities on the wards was adversely affected.

A small social work team worked across the service, comprising of two qualified social workers and an associate practitioner. The associate practitioner supported patients to develop independent living skills and maintain links with friends and families.

Staff used recognised rating scales to assess patients and monitor their progress and outcomes. Psychology staff used 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 baseline assessment of patients' needs and occupational functioning. Staff used the Health of the Nation Outcome Scale to monitor the health and social functioning of patients.

This service participated in one clinical audit as part of their clinical audit programme 1 September 2017 – 31 August 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Completion of Discharge	Inpatient Forensic Service	MH - Secure wards/Forensic inpatient	Clinical	08/11/2017	Highlight the concerns and recommendations from the re-audit of completion of discharge letters to all relevant staff members. Devise a checklist of discharge pack: checklist to be included in the full discharge summary template.

Skilled staff to deliver care

Managers could not always ensure there were sufficient staff with the required range of skills needed to provide high quality care. Managers supported staff with appraisals and supervision. There were some opportunities for staff to further develop their skills.

The team included or had access to the full range of specialists required to meet the needs of patients. In addition to qualified nurses and health care assistants, there was a multi-disciplinary team which included consultant psychiatrists, psychologists, occupational therapists, art therapists, speech and language therapists, social workers, a GP and registered general nurses. Due to staffing pressures, safer staffing levels were not always maintained and there was a heavy reliance on occupational therapy staff to try to meet safer staffing levels.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff had access to training to support the delivery of effective care. For example, staff working on the personality disorder wards could complete the Knowledge Understanding Framework for Personality Disorder awareness training. In total, fifteen staff had completed or were undertaking this training. Some staff were supported to study for relevant national vocational qualifications, foundation degrees and master's degrees. However, some staff told us that staffing pressures meant they were not always able to complete training.

New staff, including bank and agency staff, completed a five-day induction programme which included the Quality Network of Forensic Mental Health Services standards for medium secure services.

The trust's target rate for appraisal compliance was 85%. For the period 1 April 2017 to 31 March 2018, the overall appraisal rate for non-medical staff within this service was 94%. Appraisal rates as of 31 August 2018 was 91%. The teams with the lowest appraisal rate at 31 August 2018 were Secure Services Psychology with an appraisal rate of 80%, Darley House with an appraisal rate of 83%, and Ullswater with an appraisal rate of 86%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 94% reported at the last inspection.

Ward name	**Total number of permanent non-medical staff requiring an appraisal**	**Total number of permanent non-medical staff who have had an appraisal**	**% appraisals (as at 31 August 2018)**	**% appraisals (previous year 1 April 2017 – 31 March 2018)**
Humber Centre - Involvement (Team)	2	2	100%	100%
Secure Services Social Work (Team)	5	5	100%	80%
Humber Centre - Bridges Ward (Team)	57	55	96%	94%
Secure Services Therapies (Team)	18	17	94%	100%
Humber Centre - Swale (Team)	27	25	93%	96%
Specialist Services Management (Team)	11	10	91%	100%
Humber Centre - Admin (Team)	19	17	89%	84%
Humber Centre - Ullswater (Team)	29	25	86%	96%
Humber Centre - Darley House (Team)	23	19	83%	92%
Secure Services Psychology (Team)	5	4	80%	100%
Core service total	**196**	**179**	**91%**	**94%**
Trust wide	**2585**	**2001**	**77%**	**79%**

The trust's target rate for appraisal compliance was 85% for permanent medical staff. The trust was unable to provide appraisal data for permanent medical staff.

Managers provided staff with supervision and appraisal of their work performance. Psychologists facilitated reflective practice sessions on the wards which staff found beneficial.

The trust's target of clinical supervision for staff was 80% of the sessions required. The trust stated that they are only able to provide this information at team level not by ESR staff group, therefore data includes both medical and non-medical staff. Between 1 September 2017 and 31 August 2018, the average rate across all eight teams in this service was 73%.

The rate of clinical supervision reported during this inspection was not comparable to the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Secure Services Psychology (Team)	79	74	94%
Humber Centre - Ullswater (Team)	292	248	85%
Humber Centre - Darley House (Team)	267	212	79%
Secure Services Social Work (Team)	59	43	73%
Secure Services Therapies (Team)	212	155	73%
Humber Centre - Swale (Team)	317	222	70%
Humber Centre - Bridges Ward (Team)	612	392	64%
Community Forensic MH (Team)	36	21	58%
Core service total	**1874**	**1367**	**73%**
Trust Total	**11648**	**8989**	**77%**

Staff had regular team meetings. However, there was no standard agenda and there were wide variations in what was discussed and the quality of minutes of the meetings. There were plans to implement ward governance meetings. Managers had developed terms of reference and standard agendas for the meetings which were due to start in February 2019.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to try to ensure patients had no gaps in their care.

Multi-disciplinary meetings took place weekly, reviewing each patient at least once a month. We observed a multi-disciplinary meeting and found that staff knew patients well and supported patients to raise concerns and ask questions. Staff ensured patients understood what had been discussed and involved them in reviewing their risk assessment and treatment plan. There was a shared professional respect amongst staff from different disciplines.

Staff attended handovers twice each day. This enabled staff to share relevant information at the beginning of each shift. Staff from all wards attended a daily morning meeting where staffing levels were reviewed and patient activity and engagement levels were discussed. Staff were deployed across the wards to make up any staffing shortfalls. This frequently resulted in staff from the occupational therapy team being deployed to wards to maintain safer staffing levels. Consideration to the impact on therapeutic activities was not considered.

Staff worked closely with external agencies, including commissioners, to plan patients' discharge or transfer to other hospital settings.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.

As of 31 August 2018, 94% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training was non-mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 90% (YTD) reported at the last inspection.

The trust had a Mental Health Act policy which staff were aware off and knew how to access. Patients had easy read information leaflets which explained the Mental Health Act. There was information on the wards about independent mental health advocates and patients told us they were aware of the advocates.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice.

We reviewed Mental Health Act documentation in six patient records. All records showed staff had regularly explained to patients their rights under the Mental Health Act and recorded this had been done. Patients had signed to confirm this.

Section 17 leave forms were present in all records we reviewed and old leave forms had been removed. Due to staffing issues, there were occasions when patients' Section 17 leave had to be

cancelled. Detention paperwork was present including reports from approved mental health professionals.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

As of 31 August 2018, 92% of the workforce in this service had received training in the Mental Capacity Act – Level 1. As of 31 August 2018, 94% of the workforce in this service had received training in the Mental Capacity Act – Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 98% reported at the last inspection.

The trust had a policy on the Mental Capacity Act. Staff were aware of this policy and how to access it.

Staff demonstrated a good knowledge of the Mental Capacity Act and gave examples of occasions where capacity had been assessed for individual issues such as finances and medication. Staff assumed capacity unless they had information to suggest otherwise, in line with the Act. Staff assessed and recorded capacity to consent appropriately on a decision-specific basis with regard to significant decisions.

The trust told us that no Deprivation of Liberty Safeguard applications were made to the Local Authority for this service between 31 September 2017 to 31 August 2018.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and supported their individual needs.

We observed staff and patient interactions on the wards. Staff knew patients well and spoke about patients in a way that was consistent with a culture of positive behaviour support.

During activity sessions, staff were relaxed and provided support and encouragement to patients during the sessions.

Staff were respectful and we saw staff knocking on bedroom doors before entering.

During the inspection we spoke with six patients. We contacted six carers whose relatives were using the service directly after the inspection. We also received feedback from eight patients and four carers in focus groups prior to the inspection.

Patients generally spoke very highly of the staff on the wards, but were critical of staffing levels. Patients reflected upon high levels of bank staff on the wards. Patients said they did not like having unfamiliar staff working onto the wards and said they were reluctant to engage with these staff.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one location Humber Centre Forensic Unit (89.6%), scored lower when compared to other similar trusts for privacy, dignity and wellbeing.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Humber Centre Forensic Unit	MH – Secure wards/Forensic inpatient	89.6%
Trust overall		**87.0%**
England average (mental health and learning disabilities)		**91.0%**

Involvement in care

Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.

Involvement of patients

Staff used the admission process to inform and orientate patients to the ward and to the service.

Staff involved patients in care planning and risk assessments. Care records showed that plans and assessments had been developed in partnership with patients. Patients had positive behaviour support plans that were written in the patients' own words. Patients told us they felt involved in decisions about their care and attended monthly multi-disciplinary meetings. Patients had copies of their care plans, unless they told staff they didn't wish to have a copy. Patients attended multi-disciplinary meetings to review their care and staff supported them to ensure their views were heard.

Staff communicated with patients in ways that meant they understood their care and treatment. On Ullswater ward, staff used visual aids including diagrams to support patients' understanding of information provided.

Patients spoke of good relationships with their named nurse, although were disappointed that they couldn't always meet on a one to one basis as often as they would like.

Staff enabled patients to give feedback on the service they received. Wards had community meetings which most patients spoke positively about. One patient said the community meetings didn't always take place. We reviewed minutes of community meetings and found these happened regularly on all wards. Notes of the meetings were taken, including any action points, which were reviewed at the next meeting. The psychology team had used the EssenCES scale to assess the atmosphere of the wards from a patient perspective. This is a validated tool in the form of a short questionnaire, designed for assessing forensic wards.

Therapeutic interventions were developed to meet specific needs of the patients within the service. Patients worked alongside the occupational therapy team to develop individualised activity plans.

Patient representatives from each ward attended a monthly patient council meeting. We reviewed minutes of these meetings and found that patient views and suggestions had been acted upon in most cases.

Patients and carers were invited to attend the monthly reducing restrictions group. We reviewed the last two meeting minutes and found only one patient had attended and no carers.

One patient told us they had been involved in recruitment processes for new staff.

The Humber Centre produced a quarterly magazine. Patients wrote articles for the magazine and submitted images of art work and creative writing and poetry pieces. A DVD was being produced about the Humber Centre, to provide information on life in the service for families, carers and new patients.

Patients were involved in 'The Road to Recovery Academy' within the Humber Centre. Patients sat on the board of the Academy and were involved in identifying new courses for delivery. All courses were signed off by patients through the validation panel and by service user attendance at the board.

The art therapy team had facilitated an arts project in 'The Street' within the Humber Centre. This was a shared area of the centre for all patients to use. Patients and their families and carers had been involved in the design and completion of the artwork. On Swale ward, patients were involved in the creation of a recovery wall.

Staff ensured that patients had access to advocacy service and information on the service was displayed on the wards. Patients were familiar with the service and accessed this as they needed.

Involvement of families and carers

Family members and carers were invited to attend the monthly reducing restrictions group. We reviewed minutes from the meetings in December and January and found no carers had attended.

Family members had mixed views about their level of involvement. Some attended carer meetings and family therapy sessions and found these beneficial. Others felt they would like to be more involved. Some family members had attended carers groups, but felt they were not particularly well attended so were less beneficial than then had been previously. Some family members felt that the focus on family involvement was not as strong as it could be.

Family members we spoke with were invited to Care Programme Approach meetings, although some felt they would benefit from more information in advance of the meeting so they could be better prepared.

Some family members felt that staff kept them up to date on key information about their loved ones. Others felt they were not informed when incidents occurred. For example, one patient had been taken to a local A&E department following an accident and the family had not been informed about this by staff.

Some family members were aware of planned changes on Ullswater and Swale wards in relation to the move to low secure units. There was concern about how this would impact upon patients and families did not feel that staff had fully communicated the impact of any changes with them. This caused some family members concern.

The majority of family members and carers spoke positively about staff but felt that the service was often short staffed. One carer was concerned about planned leave being changed or cancelled due to staffing levels. Some family members were unhappy about the high use of bank staff who were not familiar with patients on the ward. They felt this meant some staff didn't know how to support patients appropriately.

Through the Recovery Academy, a friends and family event had been held in September 2018. There were plans to run a second event early in 2019.

Is the service responsive?

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison.

There were plans to change Ullswater ward (learning disabilities) and Swale ward (personality disorder) from medium to low secure. Staff were working on transition plans for patients to move into alternative medium secure services. Timescales for this change to be fully implemented on Ullswater ward was April 2019. There was no clear timescale for this change on Swale ward.

All patients were detained under the Mental Health Act. For those referred to hospital for treatment under section 37/41, length of stay was depended upon 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 and had no time limit.

Bed management

The trust provided information regarding average bed occupancies for seven wards in this service between 1 September 2017 to 31 August 2018.
Six of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	**Average bed occupancy range (1 September 2017 – 31 August 2018) (current inspection)**
Darley House	50% - 100%
Derwent Unit	57% - 95%
Ouse Unit	79% - 100%
Southwest Lodge	25% - 97%
Swale Unit	79% - 96%
Ullswater House	50% - 100%

The trust provided information for average length of stay for the period 1 September 2017 to 31 August 2018.

Ward name	**Average length of stay range (1 September 2017 – 31 August 2018) (current inspection)**
Darley House	1460 - 1460
Derwent Unit	83 - 697
Ouse Unit	75 - 920
Southwest Lodge	387 - 588
Swale Unit	377 - 2134
Ullswater House	No discharges

This service reported no out area placements between 1 September 2017 to 31 August 2018.

The number of out of area placements reported during this inspection was the same as the zero reported at the time of the last inspection.

This service reported no readmissions within 28 days between 1 September 2017 to 31 August 2018.
At the time of the last inspection, for the period 1 May 2016 to 30 April 2017, there were no readmissions within 28 days. Therefore, the number of readmissions within 28 days has remained static between the two periods.

Discharge and transfers of care

Staff planned for patients' discharge in partnership with community teams. We saw evidence of discharge planning in care records. Staff worked with relevant agencies to support smooth and effective discharge pathways.

Between 1 September 2017 to 31 August 2018 there were 19 discharges within this service. This amounts to 1% of the total discharges from the trust overall (1763). Of the 19 discharges, two (11%) were delayed. At the time of our inspection, two of the patients in long-term segregation required specialist placements for autistic spectrum disorder. Staff were working closely with other stakeholders including commissioners of specialist services to identify appropriate placements. Delayed discharges across the 12-month period ranged from zero to one per month.
The proportion of delayed discharges reported during this inspection was not comparable to the last inspection.

Facilities that promote comfort, dignity and privacy

Staff supported patients' treatment, privacy and dignity.

Patients had access to a range of rooms and equipment to support their care and treatment. Wards within the Humber Centre had a number of shared facilities. 'The Street' was an area of the centre which included a patient shop, book and DVD library, bank and visitors room. Patients had access to the health hub, art therapy room, wood workshop, library, sports hall and two laundries. At the time of the inspection, one of the laundry rooms was out of use. This meant that patient access to laundry facilities was limited. Each ward had a patient kitchen, communal areas and outside courtyards. Patients could access kitchen areas with supervision from staff. Doors to the courtyard areas were open on all wards and patients could access these areas freely.

Patients had individual bedrooms and could personalise these. All rooms had secure storage facilities for patients to store their possessions. Patient bedrooms on Swale and Ullswater wards had ensuite facilities. All wards had communal bathrooms and shower rooms. At the time of our inspection the communal showers on Ouse ward were not in use and this had been the case for a

number of months. Patients who wanted to use a shower needed to use communal shower facilities on another ward. Patients told us that due to staffing pressures, it was not always possible to facilitate this.

Patients had access to outside space. There were paved courtyards accessible by patients on each of the wards. Patients on the assessment wing of Swale ward required assistance from staff to access the courtyard. Patients had access to an external garden, under the supervision of staff. Some patients told us they could not always use the garden due to staff shortages.

There were no visiting rooms on the wards. There was a large visits room in the main area of the Humber Centre. All visits between patients and their family and friends were supervised by staff. There was a two-way mirror in the room to allow staff to observe visits, but staff told us this was never used. Instead, staff were present in the room for the duration of the visit. Patients and family members had mixed views on the presence of staff in the visits with their loved ones.

There was a patient telephone on the wards. Some patients had personal mobile telephones, subject to individual risk assessment.

Patients had access to hot drinks and snacks. There were fridges in kitchens on the wards where patients could keep food items.

Patients said the food was poor. Menus were repetitive and hadn't changed for many years.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the Humber Centre Forensic Unit location scored higher than similar trusts. There were no locations that scored worse when compared to other similar trusts for ward food.

Site name	Core service(s) provided	Ward food
Humber Centre Forensic Unit	MH – Secure wards/Forensic inpatient	100%
Trust overall		**99.0%**
England average (mental health and learning disabilities)		**92.2%**

Patients' engagement with the wider community

Staff supported patients with activities outside the service and to remain in contact with their families through visits, leave, telephone contact and Skype.

There were strong links with the local community groups. Patients participated in an inclusion football league and attended football tournaments with other services in the region.

Patients spoke positively about the recovery college and the activities this gave them access to.

Staff ensured that patients had access to education and training opportunities. Staff had made good links with a local housing charity which provided volunteering opportunities for patients. Some patients attended a local adult learning centre, studying for formal qualifications.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.

There was accessible information on treatments, patient rights and how to complain. Information was provided in a form that was accessible to patients and their individual needs. On Ullswater ward, which was a learning disability ward, staff used the 'life star'. This was an adapted version of the recovery star, specifically for use with adults with a learning disability. Information was available in easy read format and visual aids were available.

Speech and language therapists worked across all wards to assess communication needs of patients. Staff were aware of the individual communication needs of patients and supported patients appropriately.

Staff were able to request interpreters and/or signers when required.

Patients had access to a multi-faith room and a chaplain visited the ward weekly.

The wards were accessible to people with physical disabilities, including wheelchair users.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the location Humber Centre Forensic Unit scored lower than similar trusts for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
Humber Centre Forensic Unit	MH – Secure wards/Forensic inpatient	N/A	85.9%
Trust overall		**69.8%**	**79.7%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

Listening to and learning from concerns and complaints

The service did not always share lessons learned from the results of concerns and complaints and did not routinely share these with all staff.

Staff did not always receive feedback on the outcome of investigation of complaints. Complaints were discussed within the monthly clinical network meeting. We reviewed minutes of the meeting and saw in the December 2018 minutes that there was a variation in how complaints were escalated. Actions were agreed to develop a more robust system for complaints.

Patients we spoke with knew how to complain. Information on how to make a complaint was displayed on the wards. Two patients said they had raised complaints. Staff had supported them to do so and they had received feedback from staff. Family members and carers said they were aware of how to complain, but were reluctant to do so as they were unsure if this would impact on their loved one.

This service received 13 complaints between 1 September 2017 to 31 August 2018. Two of these were upheld, four were partially upheld and seven were not upheld. Two were referred to the Ombudsman. The most common complaint themes were other (3) and communications (3).

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Swale Unit	6	1	1	4	0	0	0	1
Ullswater House	6	0	3	3	0	0	0	1
Darley House	1	1	0	0	0	0	0	0

This service received ten compliments during the last 12 months from 1 September 2017 to 31 August 2018 which accounted for 2% of all compliments received by the trust.

Is the service well-led?

Leadership

Leaders within the service had the skills, knowledge and experience to perform their roles and had a good understanding of the service they managed.

At a senior management level, the trust operated a triumvirate model, with each care group in the trust having a clinical care director, associate medical director and care group director. Forensic inpatient services were part of the specialist care group. At the time of the inspection, the clinical care director and care group director (specialist services) posts were vacant. An assistant care group director was in post. There were no immediate plans to appoint into the vacant director

posts, as the trust were consulting on a new operating model. The proposed structure comprised of two senior management posts, a secure services general manager and a secure services clinical lead. At the time of our inspection the service was being supported by an assistant director, who provided around one day per week of support.

Two modern matrons and a service manager provided service level leadership. These managers were held in high regard by staff and were well respected. Staff felt that service level leaders were not visible on the wards. Staff felt this was due to a lack of capacity rather than a lack of willingness. Some staff said that they were reluctant to escalate issues to the service level leadership team as they knew how busy they were and didn't want to add to their workload. Where staff did escalate issues, they felt appropriately supported.

Charge nurses and deputy charge nurses provided ward level leadership. Frequent staff shortages meant there were regular occasions when charge and deputy nurses were deployed across the wards to contribute to safer staffing levels. This negatively impacted upon the leadership and management capacity on the wards.

Vision and strategy

Most staff we spoke with could describe in general terms the trust vision and values. Staff had not been involved in the development of these. The trust vision and values were displayed in ward areas and were visible to staff. Staff demonstrated the trust value of caring in the delivery of patient care and through interactions with one another.
Generally, staff did not feel that they had opportunities to contribute to discussions about the strategy for their service. An external consultant was working with staff within the service on the development of a new clinical model.

Staff felt that they sometimes struggled to deliver high quality care due to staffing levels. This caused staff concern as they were trying to achieve high standard but had limited capacity.

Culture

Staff spoke positively about strong and supportive team working at ward level. Staff felt a strong sense of belonging within individual wards. Staff lacked a of sense of team working and ownership at a service level. Staff felt strongly about being deployed onto other wards to contribute to safer staffing levels. A new centralised e-roster had been implemented for the deployment of bank staff. Staff had not felt consulted about this and had negative views of the new system. Staff felt that their specific skills and therapeutic relationships with patients were not taken into account when they were deployed on other wards.

A new duty manger role had been introduced to develop a wider appreciation of the needs of the whole service. Charge nurses from each ward worked as duty manager on a rota.

Staffing levels were an ongoing issue for the service.

Staff were aware of the whistleblowing process and most felt able to raise concerns if needed. Staff were generally familiar with the Freedom to Speak up Guardian role.

Teams generally worked well together. There had been an improvement in relationships between ward staff and staff in the physical healthcare hub. Ward staff had been trained in physical health care and each ward had a physical healthcare champion. Multi-disciplinary meetings were effective and staff from different disciplines had mutual respect for one another.

Staff had annual appraisals. Staff views on access to career development opportunities was mixed. Some staff felt that the lack of opportunities contributed to poor staff retention rates within the service.

Staff sickness and absence levels were above trust average. Occupational health services were available across the trust.

Governance

There was not a systematic approach to continually improving the quality of the service and safeguarding high standards of care.

The service struggled to maintain safe staffing levels. This impacted upon the provision of safe and effective care.

Staff were accessing mandatory training and compliance rates had improved since our last inspection. Regular supervision and appraisals for staff took place.

At the time of the inspection, there was no clear framework of what should be discussed at ward team meetings. We reviewed minutes of ward meetings and found there was no standard agenda. The content of the meetings varied between wards. The quality of minutes and recording of action points was variable. Senior managers within the service had developed terms of reference and a standard agenda for ward clinical governance meetings. These were due to be introduced from February 2019.

There was a monthly clinical network meeting, attended by managers including charge nurses. Agenda items included learning from incidents and investigations, incident reporting, audit programme. However, we saw from minutes that assurance measures on these areas were not fully embedded. This resulted in a lack of oversight of incidents and sharing lessons learned within the service. We did not see evidence of trust-wide learning being shared.

There was a tracker system in place to monitor progress of actions resulting from serious incident and significant event analysis. However, we reviewed trackers and found these had not been updated and most actions had not been complete within identified timescales.

Incidents were reported and recorded appropriately by staff, but a number of incident reports had not been signed off. Some of these dated back to 2017. Managers were unclear of required timescales for incident sign off.

Staff did not feel confident that learning had been shared following investigation of serious incidents. This raised concern amongst staff that similar incidents could occur in the future.

Daily safety huddles took place at trust headquarters, where incidents were reviewed. It was unclear why issues relating to overdue actions from incident trackers and outstanding incident reports had not been identified at this meeting.

Staff understood the arrangements for working with other teams, both within the trust and externally, to meet the needs of patients. There were good examples of multi-disciplinary team working within the service and good links with external agencies.

Management of risk, issues and performance

There was a service level risk register which generally reflected the concerns of staff. Gaps in assurance systems, for example the ability to implement learning from incident investigations, were not identified as a risk.

There was an up to date business continuity plan in place for emergencies that had been developed in partnership with other agencies including the police.

Information management

Managers used an electronic system to monitor key performance indicators within the service. This provided performance reports on a range of areas including staff supervision rates, training compliance, medicines management audits, seclusion audits, physical health audits, Mental Health Act audit and infection prevention and control audit.

There were effective arrangements in place to ensure that notifications were submitted to external bodies.

Staff used an electronic system to maintain patient care records. Staff said, and we observed the system to be very slow. Staff sometimes found it difficult to locate information on the system. Staff in the physical healthcare hub used the electronic patient care record system as well as a primary care electronic recording system. This meant that patient information was stored over two different systems. Not all staff had access to primary care electronic system.

Staff had completed information governance training and were knowledgeable about governance systems including confidentiality.

Engagement

Staff had access to information on the trust intranet. Patients had supervised access to the internet which was individually risk assessed.

Patients had opportunities to provide feedback through attendance at weekly ward community meetings, monthly patient council meetings and monthly reducing restrictions meetings. Patients had been involved in recruitment processes for staff.

Families and carers could access carers meetings, although these were often poorly attended. Family members and carers did not feel that there were enough opportunities for their views to be heard.

Family members told us they did not feel there had been good communication about planned changes to services. This was particularly relevant for the wards that were changing from medium to low secure.

Learning, continuous improvement and innovation

Systems to review and implement learning from incidents were not working effectively within the service. Staff did not feel confident that findings from investigations were shared and acted upon.

Due to staffing pressures, there were limited opportunities for staff to be given time to support and consider areas for improvements in the service.

The service was a member of the Quality Network for Forensic Mental Health Services and participated in peer reviews. Action plans were in place to improve areas identified in the most recent review which had taken place in October 2018.

Staff strived to develop community links to extend the range of activities and learning opportunities for patients.

Daily reflective practice sessions took place, facilitated by the psychology team. Staff used these sessions to identify new approaches to work with patients to improve treatment outcomes.

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.

None of the wards within this service have been awarded an accreditation.

Mental health crisis services and health-based places of safety

Facts and data about this service

Add headings, text, graphs and diagrams

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Miranda House	Mental Health Response Service	Hull - Approx. 75 comprehensive assessment appointments and 12 pre-assessment appointments East Riding - Approx. 125 comprehensive assessment appointments and 16 pre-assessment appointments	Mixed

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

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

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

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

The mental health response service works 24 hours a day, seven days per week. They provide home based treatment mainly between 8am and 8.30pm seven days per week and outside of

these hours if required. The service aims to provide an alternative to an admission to hospital inpatient wards.

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

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

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

Is the service safe?

Safe and clean environment

Mental health crisis service

All areas were safe, clean well equipped, well furnished, well maintained and fit for purpose. The service completed regular environmental risk assessments including ligature audits of the care environments used by staff and patients.

All areas used by the mental health 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.

The mental health 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 three interview rooms and a police waiting room. These rooms were fitted with alarms and there was a system in place for staff to respond when an alarm was activated. Alarms were regularly checked and maintained.

The mental health response service did not have a dedicated clinic room. Staff used the clinic room of the electroconvulsive therapy department at Miranda House when needed. The service had equipment which staff took at the beginning of each shift for monitoring physical health out in the community. Staff told us there was not enough equipment for everyone to take a set out on visits at the same time and it was available on a 'first come' basis. This meant staff either

scheduled visits when equipment was available or that they couldn't always complete physical health monitoring.

There was a large monitor on the wall of the office where staff triaged calls. The monitor displayed information about call volume and how many calls were on hold at any moment in time. At the time of the inspection this monitor had not been working for two weeks due to requiring a 'password reset'. This had been reported and staff were waiting for the issue to be resolved.

Health Based Place of Safety

The place of safety was well-maintained and the furniture was in good condition. The suite was discreet, quiet and secure, designed to assist the assessment process and enable a disturbed person to be managed safely. There were anti-ligature fixtures and fittings and closed-circuit television to support observations with the exception of the toilet and shower area which did not have CCTV to maintain the privacy and dignity of people using the suite.

The place of safety had a clinical assessment area. This area had a blood pressure monitor and a defibrillator which were regularly checked and maintained.

Staff at the place of safety had access to mobile alarms and a mobile telephone. The mental health response service responded to provide assistance when required.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 12% as of 31 August 2018.

This core service reported an overall vacancy rate of 8% for registered nurses at 31 August 2018.

This core service reported an overall vacancy rate of 39% for nursing assistants.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Willerby Hill	Mental Health Response Service (MHRS)	3.6	44.3	8%	8.1	20.6	39%	11.8	96.4	12%

	Core service total	**3.6**	**44.3**	**8%**	**8.1**	**20.6**	**39%**	**11.8**	**96.4**	**12%**
	Trust total	**149.1**	**1082.7**	**14%**	**126.9**	**646.8**	**20%**	**397.2**	**3685.1**	**11%**

NB: All figures displayed are whole-time equivalents

(CAVEAT: The trust changed their financial reporting system part way through the 12 month reporting period and therefore vacancy data is inconclusive).

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

The mental health response service had determined a minimum staffing level. These were:

- days (8am – 8.30pm): ten staff comprising one clinical lead, four band six qualified staff, two band five qualified staff, four nursing assistants and an approved mental health practitioner. The home treatment team had eleven staff comprising one clinical lead, two band six and five band five qualified staff, and three nursing assistants.
- Nights (8pm – 8.30am): one clinical lead, two band six qualified staff, one band five qualified staff and one nursing assistant. One of either the band seven or band six posts was an approved mental health practitioner.

Qualified staff consisted of either nurses, social workers and occupational therapists.

Staff did not hold individual caseloads; the service had an allocated shift co-ordinator each shift who organised the assessments and visits required for the shift. On each shift a band six was allocated as a ‘136 co-ordinator’ for the place of safety, they were responsible for the running of the place of safety throughout the shift.

At the time of the inspection nursing assistant vacancies had reduced to 14.56% or three whole time equivalent staff. However, nursing vacancies had increased to 16.45% or 6.26 whole time equivalent staff. Managers told us they were recruiting to the vacancies although had difficulty filling the band 5 posts which equated to 3.85 whole time equivalent vacancies. To attract staff the service had recently advertised band five posts working across the mental health response team and the mental health acute ward on a rotational basis.

Between 1 September 2017 and 31 August 2018, of the 81816 total working hours available, <1% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the wards/teams was vacancies

In the same period, agency staff covered <1% of available hours for qualified nurses and 3% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Mental Health Response Team	81816	158	<1%	148	<1%	2550	3%
Core service total	**81816**	**158**	**<1%**	**148**	**<1%**	**2550**	**3%**
Trust Total	**958417**	**2753**	**<1%**	**934**	**<1%**	**18576**	**2%**

Between 1 September 2017 and 31 August 2018, of the 33881 total working hours available, <1% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank and agency usage for the wards/teams was vacancies.

In the same period, agency staff covered 0% of available hours and 1% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Mental Health Response Team	33881	109	<1%	0	0%	338	1%
Core service total	**33881**	**109**	**<1%**	**0**	**0%**	**338**	**1%**
Trust Total	**908881**	**7895**	**1%**	**377**	**<1%**	**34624**	**4%**

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing reporting, to that provided in the RPIR. The previous relates to that received in the RPIR.)

This core service had 5.6 (7%) staff leavers between 1 September 2017 and 31 August 2018. This was higher than the 2% reported at the last inspection (from 1 December 2016 to 31 May 2017).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Miranda House	mental health response service (Team)	83.0	5.6	7%
Miranda House	Miranda House - Admin (Team)	1.6	0.0	0%
Core service total		**84.6**	**5.6**	**7%**
Trust Total		**2091.3**	**255.3**	**11%**

The sickness rate for this core service was 7.0% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 9.3%. This was higher than the staff sickness rate of 4% reported at the last inspection in August 2017.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Miranda House	mental health response service (Team)	9.5%	7.0%
Miranda House	Miranda House - Admin (Team)	0.0%	4.9%
Trust Headquarters	Single Point of Access - Hull (Team)	N/A	4.9%
Core service total		**9.3%**	**7.0%**
Trust Total		**3.9%**	**4.7%**

Medical staff

The service employed one full time consultant psychiatrist and one full time speciality doctor. Between 6pm to 8am Monday to Friday and at weekends, the service accessed the doctor through

the out of hours on call system. 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 immediately available to see patients urgently.

Between 1 September 2017 and 31 August 2018, no hours were filled by bank or agency staff to cover sickness, absence or vacancy for medical staff. The trust reported no unfilled hours for medical staff.

Mandatory training

The compliance for mandatory and statutory training courses at 31 August 2018 was 89%. Of the training courses listed three failed to achieve the trust target and of those, one failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training, and a target of 95% for completion of Information Governance training. Training completion is reported on a rolling month by month basis.

The training compliance reported for this core service during this inspection was higher than the 88% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	LY Compliance (%)
Safeguarding Adults - Level 2	18	18	100%	✓	90%
Safeguarding Adults - Level 1	13	13	100%	✓	100%
Safeguarding Children - Level 1	11	11	100%	✓	100%
Fire Safety - 2 Years	11	11	100%	✓	75%
Moving and Handling - Level 3	1	1	100%	✓	100%
Mental Capacity Act - Level 2	75	73	97%	✓	81%
Prevent Awareness	31	30	97%	✓	97%
Infection Prevention - Level 2	75	72	96%	✓	90%

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	LY Compliance (%)
Prevent – WRAP	57	55	96%	✓	95%
Equality and Diversity	88	83	94%	✓	88%
COSHH Awareness	88	83	94%	✓	89%
Health and Safety	88	83	94%	✓	92%
Information Governance	88	82	93%	✗	97%
Safeguarding Children - Level 3	57	53	93%	✓	87%
Mental Capacity Act - Level 1	13	12	92%	✓	100%
Infection Prevention - Level 1	13	12	92%	✓	93%
Display Screen Equipment	88	81	92%	✓	86%
Moving and Handling - Level 1	87	79	91%	✓	87%
Safeguarding Children - Level 2	20	18	90%	✓	74%
Fire Safety - 1 Year	77	59	77%	✗	76%
Safeguarding Adults - Level 3	57	11	19%	✗	N/A
Total	**1056**	**940**	**89%**		**88%**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Managers had a system to monitor compliance which could identify both course and individual staff member compliance. The system refreshed daily and provided managers with live data.

At the time of the inspection the overall training compliance for the service was 88%. Compliance for safeguarding adults level 3 had risen from 19% to 73% although it remained below the care quality commission benchmark of 75%. Fire safety 1 year had increased to 81%. However, information governance had dropped from 93% to 85%. Fire safety 2 year and Mental Capacity Act level 2 had also fallen below the trust benchmark to 81% and 82% respectively. Managers informed us it could be difficult to access face to face training due to the availability of courses and staff would prioritise supporting patients over completing online courses. However, they were aware of which staff needed to complete specific courses and had plans in place to achieve this.

Adult basic life support and intermediate life support training were not classed as mandatory training for the core service. The compliance rate for the service for these courses was 78% and 76% respectively.

Assessing and managing risk to patients and staff

Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.

Mental health crisis service

We reviewed four patient records, all records had an initial assessment of risk at triage followed by a Functional Analysis of Care Environments risk assessment completed as part of the initial assessment. Plans contained a brief crisis plan in the form of contact details for the mental health response service which provided 24 hour support. Patients and carers we spoke with were aware of how to access the service to seek support.

Health based place of safety

Each shift a registered staff member was allocated the 136 co-ordinator role from the mental health 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. Following the initial risk assessment staff would complete a Functional Analysis of Care Environments risk assessment as part of the assessment process. Staff were able to safely manage disturbed behaviour without police support. However, if a patient presented a significant risk the police would remain at the place of safety.

Management of patient risk

Patients were triaged under three assessment categories, emergency, urgent and routine. Staff completed emergency assessments within four hours, urgent within 24 hours and routine 14 – 30 days.

The home treatment team utilised a rating system to categorise patients based on risk and need; higher risk patients would receive one or more visits a day with lower risk patients receiving less frequent interventions.

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. However, staff we spoke with described different systems for who they would inform following a visit. We raised this with the manager who informed us they would ensure staff were reminded of the correct system to maintain a consistent approach.

Health based place of safety

Staff completed a 136 observation plan for patients in the place of safety. This plan required staff to consider the level of risk and the level of observation needed to manage and the support the patient. 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 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.

There were dedicated staff responsible for the place of safety 24 hours a day to enable handover of a detained person from the police as soon as possible after arrival.

Staff at 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

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.

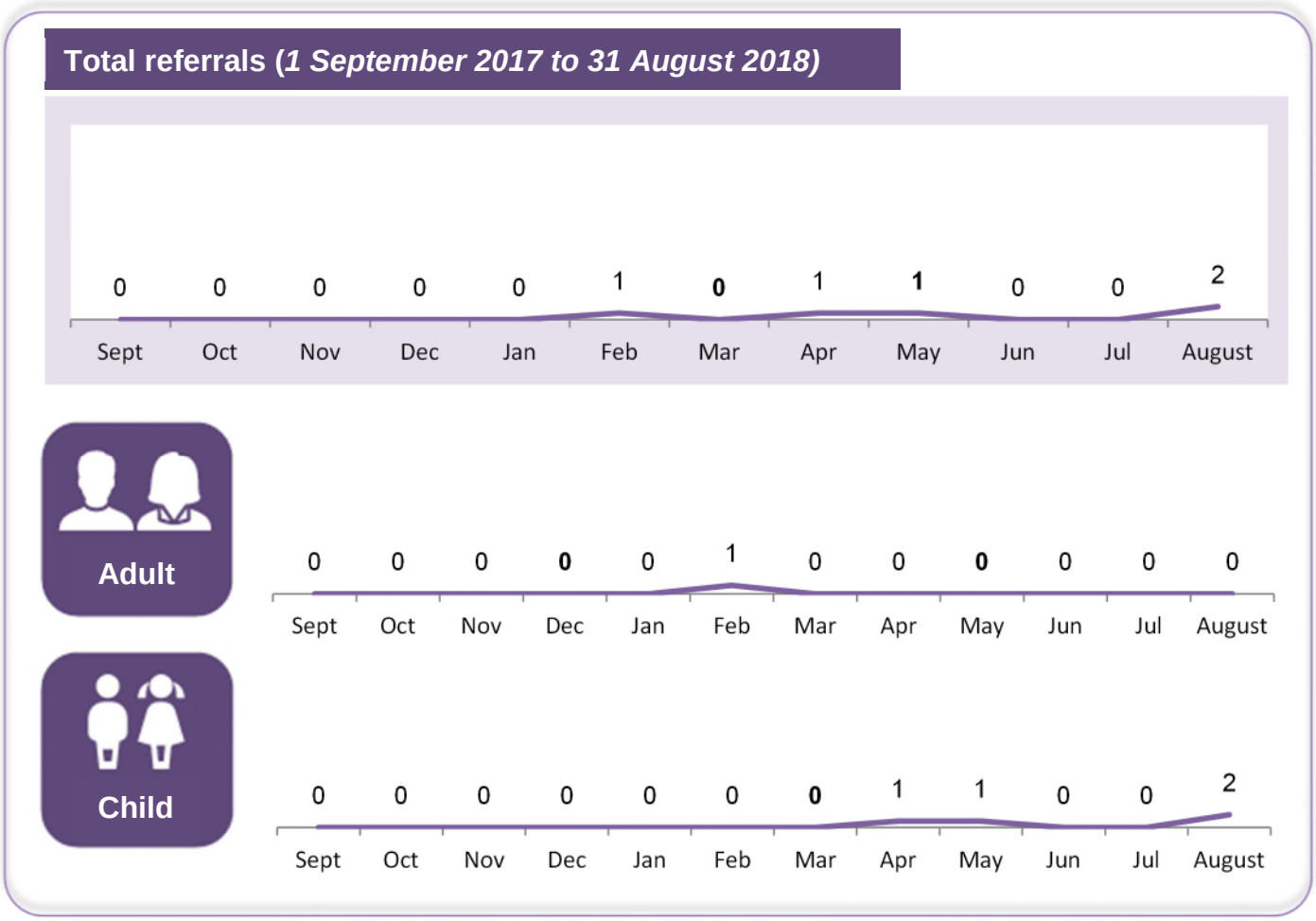
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine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

This core service made five safeguarding referrals between 1 September 2017 and 31 August 2018, of which one concerned adults and four referrals concerned children. The number of safeguarding referrals reported during this inspection was not comparable to those reported at the last inspection.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Mental health crisis services and health-based places of safety	1	4	5

The number of adult safeguarding referrals in month ranged from zero to one (as shown below).

The number of child safeguarding referrals ranged from zero to two (as shown below



The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 September 2017 and 31 August 2018) that relate to this service.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. A member of the team had recently completed training to provide safeguarding supervisions for the team. We observed safeguarding discussions as part of the multidisciplinary team meetings where staff discussed concerns and the most appropriate actions. Managers advised us that any safeguarding concerns were recorded under the safeguarding tab on the

trusts electronic recording system. However, none of the records we reviewed had anything recorded under this tab despite safeguarding concerns being apparent. Safeguarding information was available within other areas of the records including the daily notes, risk and care plan tabs. Although, this made it difficult to find. Where there were ongoing safeguarding concerns staff would use the 'flag' system on the electronic system to highlight this within patient records.
The trusts incident reporting system recorded safeguarding referrals and concerns, and managers also maintained a safeguarding consideration log to record staff concerns which had been discussed with the local safeguarding teams. The log demonstrated 88 concerns had been discussed with the local authority resulting in 27 safeguarding referrals between September 2017 and January 2019.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. 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. However, they could access the relevant information. At times staff recorded specific assessment information on paper records during community visits and would scan these into the electronic system after the visit. The trust had implemented a system to ensure services across the trust logged information in the same areas of the system to ensure staff could access relevant patient history in the patients' records. Staff told us this helped when assessing patients who accessed other parts of the trust. However, none of the records we reviewed contained safeguarding information in the correct section of the system. Although, staff were able to locate the information in other areas of the system.

Medicines management

The service did not routinely stock medication. The home treatment team would hold a patients' medication supply to manage risk as part of an agreed care plan. Procedures were in place to support the process. Staff followed best practice when storing, dispensing, and recording. Staff regularly reviewed the effects of medications on each patient's physical health.

When staff considered that patients might benefit from medication they would contact a doctor to organise a visit or appointment with the doctor for consultation. The service had a policy in place to cover the rare circumstances in which emergency medication was required, and had trained nursing staff who were able to administer and monitor the effect of any medication prescribed. The service employed non-medical prescribers and had developed patient group directives to support staff prescribing. However, at the time of the inspection trust procedures did not support this where medication was required out of hours. 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. Staff informed us despite the service level

agreement and patient directives been in place there continued to be difficulties in obtaining medication out of hours. Managers were aware of the issue and had included it on the service risk register.

Track record on safety

Between 1 September 2017 and 31 August 2018 there were four serious incidents reported by this service. All were incidents of 'Apparent/actual/suspected self-inflicted harm meeting SI criteria'. There were no unexpected deaths within this service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with four reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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. The trust had an up to date policy on the duty of candour and staff demonstrated an 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 to staff from the investigation of local incidents and incidents from across the trust 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 staff discussed incidents within meetings.

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.

Data obtained from the Coroner's website (www.judiciary.uk) indicated there had been one prevention of future deaths report relating to a patient of the trust in the last two years. The

prevention of future deaths report was sent to NHS Improvement. This report did not relate to this service.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed. 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.

Staff in the place of safety ensured an assessment of the person by a doctor and an approved mental health professional was completed at the earliest opportunity to ensure that arrangements for their ongoing care and treatment are appropriate. Documentation was in line with the Mental Health Act Code of Practice and included a record of a patients' time of arrival and assessment.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff offered interventions aimed at maintaining and improving patients' social networks, employment and education and provide support for people to continue to attend community resources. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff discussed patient's physical health and would refer patients back to their GP where there were ongoing concerns. The mental health response service completed mental health assessments and could offer immediate care and treatment interventions when required and referred patients on to community mental health teams for specific interventions for example, emotional regulation or for the trust's recovery college sessions. Patients who received home based treatment from the mental health 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 occupational therapists in line with guidance from the National Institute for Health and Care Excellence.

When patients arrived at the health based place of safety staff completed physical health observations and used these to calculate an early warning score for any underlying physical health conditions. Patients were detained under section 136 of the Mental Health Act for the shortest possible time and always for less than 72 hours.

This service participated in no trust wide clinical audits as part of their clinical audit programme 2017 – 2018. However, the service completed regular local clinical audits including triage and assessment documentation, case notes review, section 136 data and Mental Health Act assessment data. Managers collected data to monitor the service, including information about age, gender, ethnicity, mode of transport to the place of safety, type of place of safety used, transfers between places of safety, time taken to begin and complete assessment, time the police remained, outcome of assessment, total time person spent in a place of safety and instances where an individual was brought to the place of safety but was not accepted, and the reason for this. The service produced a quarterly audit report summarising data collected which was reviewed by the care group director.

Skilled staff to deliver care

Managers made sure they had staff with a range of skills need to provide high quality care including: doctors, nurses, approved mental health professionals, social workers, an occupational therapist, healthcare assistants and administrators. Staff were trained in risk assessment and management, observational skills, use of the Mental Health Act, use of physical intervention and resuscitation equipment. The team had access to a psychologist for one day a week who provided staff access to a reflective practice session. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. 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. We observed a team meeting to introduce the changes made in the updated 136 policy and staff roles and responsibilities.

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 87%. This year so far, the overall appraisal rate was 82% (as at 31 August 2018).

The rate of appraisal compliance for staff reported during this inspection was not comparable to the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (previous year 1 April 2017-31 March 2018)
Miranda House - Admin (Team)	2	2	100%	100%
mental health response service (Team)	86	70	81%	86%
Core service total	**88**	**72**	**82%**	**87%**
Trust wide	**2585**	**2001**	**77%**	**79%**

The trust's target rate for appraisal compliance is 85%. The trust was unable to provide appraisal data for permanent medical staff.

The trust's target of clinical supervision for staff is 80% of the sessions required. The trust stated that they are only able to provide this information at team level not by ESR staff group, therefore data includes both medical and non-medical staff. Between 1 September 2017 and 31 August 2018, the average rate of clinical supervision in this service was 65%.

The rate of clinical supervision reported during this inspection was not comparable to the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
mental health response service (Team)	667	434	65%
Core service total	**667**	**434**	**65%**
Trust Total	**11648**	**8989**	**77%**

Managers maintained a supervision log to record supervisions, the log demonstrated that all staff had received both managerial and clinical supervision. With staff receiving on average eight supervisions over the period of January 2018 to December 2018. Managers told us that staff would often forgo supervision to meet the operational need of the service and would prioritise completing an assessment. However, staff regularly accessed informal supervision through managers and peers which the service did not record. Managers had recently introduced a system of supervision passports which staff could carry to note when they had received ad hoc supervision. The staff we spoke with told us they felt supported by managers and were able to access supervision when required.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The mental health response service staff and the home based treatment staff each attended a shift handover twice daily. There was effective communication between the rapid response team and the home based treatment team to ensure relevant information about patients was shared between the teams. Staff told us they had effective relationships with external teams and agencies and shared 'need to know' information about the individual with relevant professionals. Managers told us there were good relationships with the emergency services. Previously the service had facilitated development opportunities for police officers to spend time with the team and gain an understanding of their work and mental health issues. The service was currently planning a similar programme for trainee paramedics to spend time shadowing staff. The service was an active member of the local crisis care concordat for the east riding of Yorkshire and Hull. The crisis care concordat included representation from local NHS trusts, commissioners, the police service, the ambulance service and third sector organisations. Managers regularly attended meetings with members of the concordat to discuss any issues within the agreed shared pathway to ensure effective care was available to people suffering with a mental health crisis.

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

As of 31 August 2018, 86% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 76% reported at the last inspection.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff documented consent for any treatment given. Staff explained

patients' rights to them, gave people appropriate information about their section 132 rights, and facilitates legal advice where requested

Good practice in applying the Mental Capacity Act

As of 31 August 2018, 92% of the workforce in this service had received training in the Mental Capacity Act – Level 1. As of 31 August 2018, 97% of the workforce in this service had received training in the Mental Capacity Act – Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was not comparable to the 96% reported at the last inspection due to the breakdown of levels.

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs staff could anticipate and respond to people's personal, cultural, social and religious needs. We observed staff interactions within telephone triage, initial assessment and following admission to the 136 suite. We saw staff demonstrating an understanding of peoples' needs and individual circumstances.

Patients we spoke with said staff were kind, caring and respectful. This was reflected in the patient survey where 97 percent of patients who completed the survey responded that staff were friendly and helpful.

Involvement in care

Involvement of patients

Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.

We saw evidence of patient involvement in care planning and risk assessment. Staff supported patients to set their own goals and targets. Patients, families and carers are provided with the tools needed to support ongoing care and recovery

Patients were asked to complete a patient survey following treatment. Those who did not wish to complete the full survey could complete a short survey consisting of one question 'would you recommend the Service.' Between April and December 2018, 95 percent of patients responded they would be likely/extremely likely or to recommend the service.

Similarly, 97 percent of patients who completed the full survey gave positive responses.

Involvement of families and carers

Carers we spoke with told us they felt involved in the care and treatment of their relative and we saw evidence of staff involving carers within the assessments we observed. Information, support and advice were provided to carers whilst making sure organisational confidentiality policies were upheld at all times.

Carers were asked to complete a carer survey. Between April and December 2018, all carers who responded to the survey provided positive feedback about the service they had received.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in two of the targets listed. The service met the referral to treatment target in two of the targets listed.

The number of days from referral to initial assessment and referral to treatment during this inspection was not comparable to the last inspection.

Name of hospital site or location	Name of Team	Please state service type.	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Miranda House	Mental Health Response Service	mental health response service	MH – Mental health crisis services and health-based places of safety	30	10.0	44	12.8
Miranda House	Mental Health Response Service Home Based Treatment	mental health response service	MH – Mental health crisis services and health-based places of safety	30	2.0	44	2.6

Mental health crisis service

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The mental health 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 emergency response (within four hours) urgent response (within 24 hours), routine assessment (within 14 – 30 days) or if none of these were appropriate, people were signposted to an external relevant organisation.

The service received an average of 515 calls a day, 56% of calls were received through the crisis line. Figures for the six months July 2018 to December 2018 indicated the service completed an average of 11 assessments a day.

Managers and staff told us due to the high volumes of calls there was inevitably a waiting time for calls to be answered. Managers regularly audited call patterns and had identified the peak days and times calls were received. Staffing patterns had been adapted around this. However, managers acknowledged that call patterns were unpredictable and had raised this as an issue on the services risk register with a view to reviewing staffing levels in the future.

Managers told us due to the demand on the service they had not always met the timeframe for routine assessments. However, they had secured funding for a pilot to utilise bank staff to focus on routine assessments and had implemented a regular multidisciplinary team meeting to review and prioritise routine referrals to ensure the service was now meeting these timescales.

The home based treatment team accepted direct referrals from patients that would otherwise necessitate hospital admission. They had an average of 710 open cases a month requiring an average of 28 visits per day across the Hull and East Riding geographical area. Staff told us this was difficult to complete at times when visits were towards the boundary of the services geographical footprint which could require over an hour travelling time. Staff provided all patients/carers with a direct contact number they can call for help and advice 24 hours a day.

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. 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, 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 did not exclude people on the basis that they had consumed alcohol or drugs, had a history of violence, had committed a criminal offence, or were exhibiting disturbed behaviour.

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. Figures provided by the trust indicated that between January and December 2018 patients were detained under section 136 for the shortest possible time and always for less than 72 hours. Staff carried out an initial screening of the individual as soon as possible following admission and ensured that assessment by the doctor and approved mental health professional began as soon as possible.

Between July and December 2018 there were an average of 41 admissions to the suite a month. Staff told us there were some days when the suite was not used. However, at other times there could be several people waiting for to be admitted to the suite. The trust had used feedback gained organisations involved in the operation of section 136 to inform the planning and delivery of the service and had plans to build an additional suite on site to relieve the pressure on the facilities.

The facilities promote comfort, dignity and privacy

Staff saw patients in the community either at their own homes or at local clinics in the community. Patients could see staff at Miranda House. Miranda House had three interview rooms, the rooms were appropriately furnished and sound proof. However, two of the rooms had doors with a glass panel down the length of the door. This meant people passing on the corridor could see patients during their assessments. We raised this to the manager who assured us this would be escalated with the estates department to have film fitted to the panels to provide patients with privacy during their assessments.

The health based place of safety was on the ground floor and was accessed by a dedicated entrance. This ensured the privacy and dignity of patients using the suite. somewhere for the person to lie down, a clock and appropriate toilet facilities. Patients could access a drink and staff would make arrangements for food to be available if a patient was detained for a length of time.

Patients' engagement with the wider community

The service offered interventions aimed at maintaining and improving patient's social networks, employment and education. The service provided information to patients and their carers about

other organisations and services in the wider community that they could access. 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

The service was accessible to all who needed it and took account of patients' individual needs. There was provision to meet the needs of specific groups, such as older people, and people with learning disabilities. Staff helped patients with communication, advocacy and cultural support. The service was starting to pilot an option to access the telephone interpreter service via a video call service to promote face to face interpretation.

This service received 25 complaints between 1 September 2017 to 31 August 2018. Five of these were upheld, eight were partially upheld and 12 were not upheld. One complaint was referred to the Ombudsman. The most common complaint themes were patient care (7) and communications (7).

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Mental Health Response Service	25	5	8	12	0	0	0	1

The service treated concerns and complaints seriously, patients and carers were given information on how to complain within the initial information pack. The service investigated complaints and learned lessons which were shared with staff through team meetings and email communications.

This service received nine compliments during the last 12 months from 1 September 2018 to 31 August 2018 which accounted for 2% of all compliments received by the trust.

Is the service well-led?

Leadership

Leaders had the skills knowledge and experience to perform their roles. Managers had a good understanding of the service and were aware of the development and improvement plans for the service.

Managers were compassionate and supportive. Staff told us that managers up to service manager were accessible and approachable. Staff said the service directors were also visible and visited the service though not frequently. Staff were less sure of senior managers and said they did not find them to be as visible and were unsure how well they understood the demand on the service.

Vision and strategy

The trust had the vision statement “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.” Supported by the values caring, learning and growing. Staff knew the vision and values and were seen to demonstrate these in the way they worked.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that they felt respected, supported and valued by their colleagues and managers up to the service manager level. Some staff felt less supported and valued by the trust as a whole.

Staff understood the whistleblowing process and were aware of who the freedom to speak up guardian was and how to contact them to raise concerns. However, some staff said they would be reluctant to raise a concern with them as they felt historically the trust had not been very supportive of staff following incidents and it had felt like there was a blame culture. Staff acknowledged that the current chief executive was trying to change this but they were unsure how much had improved.

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 and were able to progress within the trust.

The service had a vacancy rate of 12% which was in line with the overall trust vacancy rate of 11%. The core service reported a sickness rate of 9.3% in August 2018 which was considerably higher than the trust rate of 3.9% for the same period. At the time of the inspection this had reduced to 7.1%. Two members of the team were on long term absence and managers were working with the trusts human resources department to support these individuals. Managers told us much of the staff absence was due to short term sickness which managers monitored in line with trust policy to identify any themes or support needs.

Managers told us there were systems and processes in place to address performance issues including support from the trusts human resources team. Managers said issues would be addressed initially through supervision before progressing to formal processes if necessary.

Governance

Since the last inspection the service had made improvements including to the environment at Miranda House, staff use of the electronic patient record and the introduction of an audit schedule to monitor the service performance. The service used a systematic approach to continually improve the quality of the service and safeguard high standards of care. Although, managers had not identified staff were not using the correct section of the electronic record to record safeguarding concerns in patients notes.

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. Weekly clinical meetings and effective governance and communication structures were in place within the service. There was a programme of clinical audits in place which were supported by service specific audits to monitor call volume, type of call and outcome. Managers used this data to support development planning and improve the quality of the service provided. Managers had used the data on calls received to amend staffing rotas to ensure more staff were available to answer calls at peak times.

Staff compliance with clinical supervision was low due to staff prioritising patient needs. Managers were aware of this and were working to ensure staff received clinical supervision.

The service had good relationships with external agencies and had regular multi agency meetings to discuss the operation of section 136.

Policies, procedures and protocols were reviewed at least every 3 years and reviews included an equality impact assessment. However, there continued to be difficulty accessing medication out of hours as the service level agreement with the community pharmacy was not aligned to the operational needs of the service. Managers had tried to address this by training staff as non-medical prescribers and had developed patient group directives to support staff prescribing though remained restricted by the current service level agreement in place.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Specific risks including safeguarding concerns were flagged in patient records to ensure these were highlighted to staff.

Managers maintained a risk register for the service. Staff could raise concerns which could be added on to the risk register through team meetings. Risks could be escalated to the care group

risk register and in turn to the trust risk register. At the time of the inspection there were five issues on the service risk register including carparking, call waiting time and routine assessments.

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 three hours up to seven days, and longer.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.

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 assurance to the trust board.

Engagement

Staff told us that they received regular updates from the trust by email. They also had access to the trust intranet page.

Patients and carers were encouraged to provide feedback through the use of the patient and carer survey. For people who did not want to undertake the survey the service had developed a short survey consisting of two questions to encourage more responses.

Learning, continuous improvement and innovation

Staff could suggest ideas for improvement within team meetings. Staff told us they thought service managers listened and were open to ideas on how to improve the service. Ideas for improvement were discussed and agreed in team meetings.

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.

None of the services within this service have been awarded an accreditation.

Specialist community mental health services for children and young people

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Willerby Hill	Youth Justice Service	No set clinics - appointments are booked as required	Mixed
Willerby Hill	Primary Mental Health Worker Service	Contact with Patient booked when required	Mixed
Willerby Hill	Looked After Children's Team	Contact with Patient booked when required	Mixed
Willerby Hill	Hull Core CAMHS Team	Therapy and appointments booked as required	Mixed
Willerby Hill	Hull Core CAMHS Contact Point	Telephone triage only	Mixed
Willerby Hill	Forensic CAMHS	None - consultations, assessment and intervention as made as appointments when required	Mixed
Willerby Hill	East Riding Core CAMHS Team Contact Point	Telephone Triage Session every day	Mixed
Willerby Hill	East Riding Core CAMHS Team	Assessment clinics - 20 and follow up treatment booked as required contact with patients	Mixed
Willerby Hill	Children's LD Team - Hull	Therapy sessions and assessment appointment booked as required	Mixed
Willerby Hill	Children's LD Team - East Riding	Appointment booked as required	Mixed
Willerby Hill	Children's ASD Diagnosis service	Assessments with observations booked as required - no clinics	Mixed
Willerby Hill	CAMHS Eating Disorders Team	Assessment clinics - 4 and follow up treatment booked as required contact with patients	Mixed

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Willerby Hill	CAMHS Crisis Service	N/A	Mixed

Humber NHS Foundation Trust provide specialist community mental health services for children and young people up to the age of 18 for both East Riding of Yorkshire and Hull. The service is commissioned by two clinical commissioning care groups.
The provision provided by Humber Teaching NHS Foundation Trust is made up of the following:

Contact Point

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

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

Hull and East Riding have separate contacts points.

Core CAMHS

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

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

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

Hull team three: deliberate self-harm, trauma

Hull autism team: autism assessment and diagnosis

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

East Riding team two: conduct, Attention Deficit Hyperactivity Disorder

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

CAMHS Crisis Response Team

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

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

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

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

Is the service safe?

Safe and clean environment

Staff saw children and young people at various locations across Hull and East Riding. During this inspection, we visited the teams in Hessle, Hull. The building was clean and well maintained. Staff carried out appropriate health and safety requirements. We also visited teams in Beverley in East Riding. This building was owned and managed by the local authority who carried out the necessary health and safety requirements. There were good furnishings which were clean and well maintained.

Rooms did not have alarms. However, staff considered potential risks prior to appointments and if needed, would take appropriate actions.

The locations did not have specific clinic rooms. Clinicians used their consulting room to carry out any required monitoring interventions such as weight and blood pressure.

Safe staffing

The trust had established staffing levels to consider staff grades, caseloads and waiting lists. However, waiting lists were high for Hull. To reduce these, the service was recruiting staff for a specific autism team. This included a psychologist, an assistant psychologist, two speech and

language therapists, specialist nurses and administrative staff. Managers felt that on completion of this recruitment, staffing levels would meet the needs of the service.

The service did not use agency staff. There was minimal bank staff usage; this was covered by familiar registered nurses or nursing assistants.

Staff rarely cancelled appointments due to leave, sickness and vacancies. They ensured patient safety by reallocating appointments to another member of staff and considering risk and need.

There were psychiatrists available at the main locations during normal working hours. Outside of these hours, the service had access to the crisis psychiatrists when required.

This core service reported a vacancy rate for all staff of 8% as of 31 August 2018.
This core service reported an overall vacancy rate of 20% for registered nurses at 31 August 2018.

This core service reported an overall vacancy rate of 10% for nursing assistants.

(CAVEAT: The trust changed their financial reporting system part way through the 12-month reporting period and therefore vacancy data is inconclusive).

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Hull	CAMHS - Hull	9.6	43.4	22%	0.4	3.4	12%	11.7	87.2	13%
East Riding	CAMHS – East Riding	6.5	35.8	18%	0.4	4	10%	5.3	60.3	9%
Trust HQ	Hull & East Riding Children's Therapies	0	0	0%	0	0.6	0%	4.6	124.5	4%
	Core service total	**16.0**	**79.2**	**20%**	**0.8**	**8.0**	**10%**	**21.6**	**272.0**	**8%**
	Trust total	**149.1**	**1082.7**	**14%**	**126.9**	**646.8**	**20%**	**397.2**	**3685.1**	**11%**

NB: All figures displayed are whole-time equivalents

Between 1 September 2017 and 31 August 2018, of the 40251 total working hours available, 0% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were peak in work load, absence, and long term sickness.

In the same period, agency staff covered 0% of available hours for qualified nurses and 2% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CAMHS Crisis	18872	71	0%	0	0%	212	1%
Community Core – Rivendell	5686	25	0%	49	1%	392	7%
ER Contact Point & PMHW	10455	17	0%	17	0%	95	1%
Looked After Children	5238	4	0%	0	0%	8	0%
Core service total	**40251**	**116**	**0%**	**66**	**0%**	**706**	**2%**
Trust Total	**958417**	**2753**	**0%**	**934**	**0%**	**18576**	**2%**

Between 1 September 2017 and 31 August 2018, of the 2973 total working hours available, 2% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reasons for bank and agency usage for the wards/teams were absence and peak in workload.

In the same period, agency staff covered 0% of available hours and 6% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CAMHS Crisis	1897	72	4%	0	0%	172	9%
Community Core – Rivendell	1076	1	0%	0	0%	0	0%
ER Contact Point & PMHW	0	0	0%	0	0%	0	0%
Looked After Children	0	0	0%	0	0%	0	0%
Core service total	**2973**	**73**	**2%**	**0**	**0%**	**172**	**6%**
Trust Total	**908881**	**7895**	**1%**	**377**	**0%**	**34624**	**4%**

(CAVEAT: Since the RPM we have discovered conflicting bank use data in the trusts safer staffing reporting, to that provided in the RPIR. The previous relates to that received in the RPIR.)

This core service had 15.1 (9%) staff leavers between 1 September 2017 and 31 August 2018. This was not comparable to the rate reported at the last inspection (from 1 December 2014 to 30 November 2015).

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Children & Family Resource Centre	Rivendell House Children's Admin (Team)	3.6	2.0	40%
John Havelot House	Hull CAMHS Contact Point (Team)	11.4	2.0	20%
Beverley Health Centre	CYP IAPT (Team)	1.2	1.0	18%
Children & Family Resource Centre	East Riding CAMHS - Team 1 (Team)	9.4	1.6	16%
Townend Court	CAMHS Crisis (Team)	10.6	2.0	15%
Westend	Hull Community Core Team (Team)	4.0	1.0	14%
Hull Youth Justice Service	Hull CAMHS - Team 2 (Team)	13.6	1.5	11%
Beverley Health Centre	Eating Disorders Service (Team)	10.8	1.0	9%
Children & Family Resource Centre	ER Contact Point & PMHW (Team)	12.0	1.0	8%
Westend	Hull CAMHS - Team 1 (Team)	12.4	1.0	8%
Victoria House	Hull Children's Autism Service (Team)	5.1	0.4	7%
Westend	Hull CAMHS - Team 3 (Team)	15.7	0.6	4%
Beverley Health Centre	Community Core Team - Rivendell (Team)	3.6	0	0%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Beverley Health Centre	Hull Intensive Intervention (Team)	0	0	0%
Beverley Health Centre	Looked After Children (Team)	4.1	0	0%
Children & Family Resource Centre	Care Matters - ER (Team)	0	0	0%
Children & Family Resource Centre	East Riding CAMHS - Team 2 (Team)	10.4	0	0%
Council Offices, Skirlaugh	Youth Justice ER (Team)	1	0	0%
Hub School and Specialist Services	Children's LD - East Riding (Team)	3.8	0	0%
Hub School and Specialist Services	Children's Psychology (Team)	3.4	0	0%
Hull Youth Justice Service	Youth Justice Service - Hull (Team)	0	0	0%
Victoria House	Children's LD - Hull (Team)	0	0	0%
Westend	Children's Creative Therapies (Team)	0	0	0%
Westend	Children's Family Therapy (Team)	0	0	0%
Core service total		**136.1**	**15.1**	**9%**
Trust Total		**2091.3**	**255.3**	**11%**

The sickness rate for this core service was 4.4% between 1 September 2017 and 31 August 2018. The most recent month's data (31 August 2018) showed a sickness rate of 2.9%. This was not comparable to the sickness rate reported at the last inspection in April 2016.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Children & Family Resource Centre	Rivendell House Children's Admin (Team)	4.5%	28.1%
Children & Family Resource Centre	East Riding CAMHS - Team 2 (Team)	15.5%	14.8%
Beverley Health Centre	Community Core Team - Rivendell (Team)	0.5%	7.9%
John Havelot House	Hull CAMHS Contact Point (Team)	1.9%	8.0%
Children & Family Resource Centre	East Riding CAMHS - Team 1 (Team)	4.5%	7.1%
Hub School and Specialist Services	Children's Psychology (Team)	0.0%	5.6%
Children & Family Resource Centre	ER Contact Point & PMHW (Team)	8.3%	3.6%
Victoria House	Children's LD - Hull (Team)	N/A	4.4%
Beverley Health Centre	Hull Intensive Intervention (Team)	N/A	2.2%
Townend Court	CAMHS Crisis (Team)	0.0%	2.3%
Westend	Hull CAMHS - Team 1 (Team)	1.3%	2.5%
Beverley Health Centre	CYP IAPT (Team)	0.0%	0.7%
Beverley Health Centre	Eating Disorders Service (Team)	0.6%	1.3%
Council Offices, Skirlaugh	Youth Justice ER (Team)	0.0%	1.1%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Hull Youth Justice Service	Hull CAMHS - Team 2 (Team)	0.0%	0.9%
Westend	Hull Community Core Team (Team)	0.8%	1.0%
Beverley Health Centre	Looked After Children (Team)	0.0%	0.0%
Children & Family Resource Centre	Care Matters - ER (Team)	N/A	0%
Hub School and Specialist Services	Children's LD - East Riding (Team)	0.0%	0.2%
Hull Youth Justice Service	Youth Justice Service - Hull (Team)	N/A	0.0%
Victoria House	Hull Children's Autism Service (Team)	0.0%	0.1%
Westend	Children's Creative Therapies (Team)	N/A	0.0%
Westend	Children's Family Therapy (Team)	N/A	0.0%
Westend	Hull CAMHS - Team 3 (Team)	1.8%	0.3%
Core service total		**2.9%**	**4.4%**
Trust Total		**3.9%**	**4.7%**

Medical staff

Between 1 September 2017 and 31 August 2018, of the 1840 total working hours available, 0% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

The main reasons for bank and agency usage for the wards/teams were vacancies.

In the same period, agency staff covered 5% of available hours and 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CAMHS	1840	0	0%	88	5%	0	0%
Core service total	**1840**	**0**	**0%**	**88**	**5%**	**0**	**0%**
Trust Total	**36104**	**0**	**0%**	**12181**	**34%**	**0**	**0%**

Mandatory training

The compliance for mandatory and statutory training courses at 31 August 2018 was 88%. Of the training courses listed six failed to achieve the trust target and of those, two failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training. The trust reports training completion on a rolling month on month basis.

During our inspection, managers reported that with the exception of safeguarding training in East Riding, all mandatory units were within trust targets. There had been limited availability for staff to complete safeguarding training in East Riding. However, those staff out of date had been booked onto courses taking place in January 2019 and February 2019.

The training compliance reported for this core service during this inspection was higher than the 87% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✖

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Mental Capacity Act - Level 1	27	27	100%	✓
Moving and Handling - Level 2	3	3	100%	✓
Moving and Handling - Level 3	3	3	100%	✓
Prevent Awareness	36	35	97%	✓
Safeguarding Adults - Level 1	26	25	96%	✓
Infection Prevention - Level 1	34	32	94%	✓
Safeguarding Children - Level 3	110	103	94%	✓
Health and Safety	138	125	91%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
COSHH Awareness	138	124	90%	✓
Prevent - WRAP	102	92	90%	✓
Safeguarding Children - Level 1	9	8	89%	✓
Display Screen Equipment	138	123	89%	✓
Equality and Diversity	138	121	88%	✓
Infection Prevention - Level 2	104	92	88%	✓
Safeguarding Adults - Level 2	103	91	88%	✓
Fire Safety - 2 Years	136	117	86%	✓
Mental Capacity Act - Level 2	111	94	85%	✗
Moving and Handling - Level 1	132	111	84%	✗
Information Governance	138	113	82%	✗
Safeguarding Children - Level 2	19	15	79%	✗
Fire Safety - 1 Year	2	1	50%	✗
Safeguarding Adults - Level 3	10	0	0%	✗
Total	**1657**	**1455**	**88%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff carried out a risk assessment for children and young people referred to the service. They received initial information as part of the referral. Further risks were identified during triage. They used the recognised Functional Analysis of Care Environments risk assessment tool. We looked at 13 records for children and young people. Of these, 12 records had up to date risk assessments. A clinician was aware of the missing risk assessment and had actions to ensure the record was updated.

Management of patient risk

Of the 13 records we looked at, 12 had appropriate management plans in place to mitigate or decrease identified risks. Staff reviewed these at each appointment. Some patients had crisis plans where risks were higher.

Staff responded promptly to any sudden deterioration in the child or young person's health for those on the waiting lists or between appointments. Following referral, letters clearly informed parents and young people what actions to take if their concerns increased. Parents informed us that staff responded quickly and effectively when they contacted the service to inform them of

changes. Staff used urgent assessment appointments, re-triaged the patient, offered coping strategies or low-level interventions to respond to increased levels of risk.

The trust had a lone working policy. Staff mostly saw parents, children and young people in settings with other professionals around. Where they visited patients in their own homes, they could describe steps they took to ensure their safety.

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

Staff from both Hull and East Riding had good relationships with their local early help and safeguarding hubs. These hubs carried out single holistic assessments to consider wider needs and signpost accordingly. They used a multi-agency approach to ensure where needed, appropriate safeguarding referrals occurred.

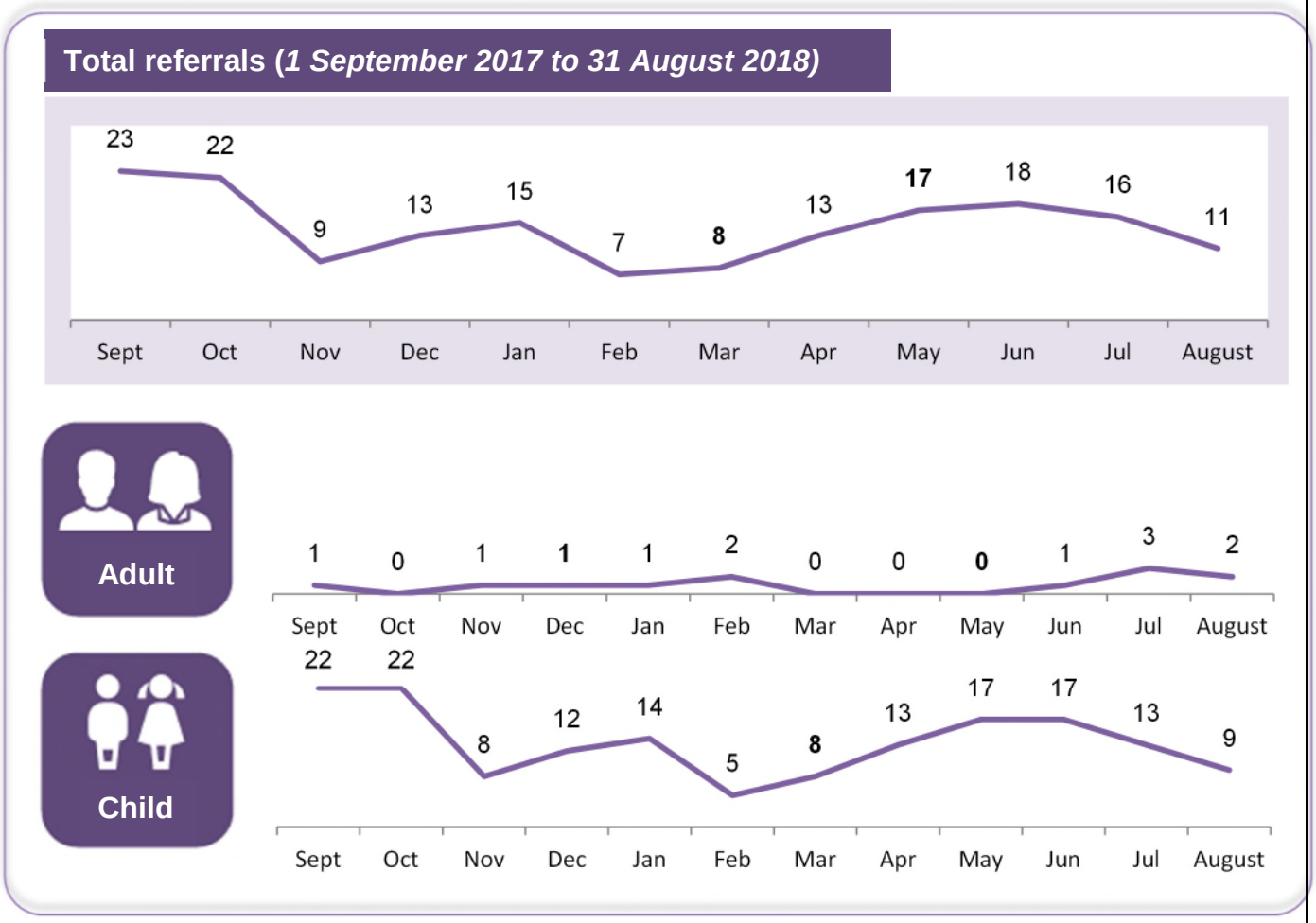
The trust had a safeguarding policy and there was a named safeguarding lead within the teams and the trust which staff were aware of to offer for advice when needed. They could explain how to recognise safeguarding concerns and describe the actions they would take. Staff had the availability of safeguarding supervision when necessary.

This core service made 172 safeguarding referrals between 1 September 2017 and 31 August 2018, of which 12 concerned adults and 160 children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
Specialist community mental health services for children and young people	12	160	172

The number of adult safeguarding referrals in month ranged from zero to three (as shown below).

The number of child safeguarding referrals ranged from five to 22 (as shown below).



Staff access to essential information

All patient information needed to deliver care was available to staff when needed. Most of the information was stored on the trust's electronic patient record system. However, there was some historical information still in paper format; this was accessible to staff if required.

Medicines management

Psychiatrists ensured that the effects of medication on physical health was regularly reviewed and in line with guidance from the National Institute for Health and Care Excellence. Some medications were prescribed, particularly for those children and young people on the Attention Deficit Hyperactivity Disorder pathway. The service had a shared care protocol with GPs to initiate and titrate children and young people on medications and then transfer to their GP once stable. General physical healthcare monitoring was managed by the patient's GP. Medications were not stored or administered from any of the service's locations

Track record on safety

Between 1 September 2017 and 31 August 2018 there were no serious incidents reported by this service and no unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with none reported.

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

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

Reporting incidents and learning from when things go wrong

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.

Data obtained from the Coroner's website (www.judiciary.uk) indicated there had been one prevention of future deaths report relating to a patient of the trust in the last two years. The prevention of future deaths report was sent to NHS Improvements. This report did not relate to this service.

Staff knew what incidents to report and how to report them. They could provide examples of incidents they reported and informed us that lessons learnt were shared in team business meetings and emails. They understood the duty of candour and felt supported following incidents.

Is the service effective?

Assessment of needs and planning of care

Staff completed a mental health assessment for each patient. The assessment considered the presenting problem, risks, personal factors, social circumstances, personal development, physical health, emotional and wellbeing, interactions, family and education.

Following the assessment, staff, children and young people and their carer or parent if appropriate developed an individual care plan. We looked at the care and treatment records for 13 children and young people. Of these, 12 records had care plans. There was one record without a patient

care plan. This was because a diagnosis for the young person had not yet been agreed. However, staff had developed a care plan for the referrer in the interim period to support the young person.

The care plans observed were mostly personalised, holistic and recovery orientated. Staff updated the care plans at least six weekly.

Best practice in treatment and care

Staff followed national guidance in providing treatment and care for children and young people such as guidance from the National Institute for Health and Care Excellence. They participated in the Children and Young People's Improving Access to Psychological Therapies Programme. This evidence based programme was designed to create a culture of full collaboration between the child, young person and their parent or carer by embedding the principles of participation, awareness, accountability and accessibility. Staff from the service ensured they remained up to date with best practice by attending clinical focus meetings.

Staff delivered interventions recommended by, and in line with guidance. These included cognitive behavioural therapies and family therapies. Children and young people had opportunities to participate in group sessions for support. These sessions were age specific and underpinned by evidenced based interventions. They were delivered at varying times including evenings and weekends to encourage engagement. Staff delivered separate groups for parents and carers, which ran at the same times as the children's and young people's groups to support their needs. Children, young people and their parents or carers could attend these groups while on a waiting list to offer low level interventions while awaiting more structured or intensive treatment. Some young people who had completed groups, returned as ambassadors to support others.

The child and young person's GP mostly ensured physical healthcare needs were being met. Records demonstrated good communication between clinicians from the service and the patient's GP. We observed basic monitoring checks such as weight, height and blood pressure for some patients. Staff considered physical health during the assessment process.

Staff referred children and young people to external agencies to support them to live healthier lives. This included services addressing sexual health and smoking cessation.

The service used recognised rating scales to monitor patient outcomes. These included measures as part of the Children and Young People's Improving Access to Psychological Therapies Programme. Staff also used other recognised rating scales such as the strengths and difficulties questionnaire and the revised children's anxiety and depression scales.

This service participated in no clinical audits as part of their clinical audit programme from 1 September 2017 – 31 August 2018.

Managers from East Riding had completed a general service audit which included auditing referrals on their waiting lists. This resulted in the acknowledgement that some staff did not discharge inappropriate referrals due to lack of confidence. From this, East riding teams introduced a weekly multi-disciplinary meeting where staff could discuss potential discharges with a wider team to increase their confidence and reduce waiting lists.

Skilled staff to deliver care

Teams had a range of specialists required to meet the needs of the children and young people using the service. These included psychiatrists, psychologists, nurses, family therapists, speech and language therapists, social workers, play therapists and wellbeing practitioners. The trust ensured staff were experienced and qualified. They identified the required skills mix and reviewed this regularly. Additional to their mandatory training requirements, staff had completed and were booked onto accredited and evidenced based specialist training to further meet the needs of the people using the service. This included training in cognitive behavioural therapy, deliberate self-harm, incredible years, systemic conduct, interpersonal therapies, improving access to psychological therapies and mentalisation.

Team leaders and managers had completed the Children and Young People's Improving Access to Psychological Therapies Programme leadership training and the trust's leadership courses.

Children and young people using services in Hull also had access to a staff member delivering aromatherapy sessions to help reduce their anxieties.

The trust's target rate for appraisal compliance was 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 67%. This year so far, the overall appraisal rates was 68% (as at 31 August 2018). The wards with the lowest appraisal rate at 31 August 2018 were Children's Psychology with an appraisal rate of 25%, Hull CAMHS – Team 2 with an appraisal rate of 43% and Hull Community Core Team at 50%. At the time of this inspection, staff were above 85% compliant with appraisals for all teams.

The rate of appraisal compliance for non-medical staff reported during this inspection was not comparable to the rate reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (previous year 1 April 2017-31 March 2018)
Youth Justice ER (Team)	1	1	100%	100%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 31 August 2018)	% appraisals (previous year 1 April 2017-31 March 2018)
Looked After Children (Team)	5	5	100%	60%
Hull CAMHS Contact Point (Team)	13	11	85%	88%
Hull CAMHS - Team 1 (Team)	13	11	85%	77%
Hull CAMHS - Team 3 (Team)	18	15	83%	72%
East Riding CAMHS - Team 1 (Team)	9	7	78%	45%
Children's LD - East Riding (Team)	4	3	75%	75%
Rivendell House Children's Admin (Team)	4	3	75%	20%
ER Contact Point & PMHW (Team)	8	6	75%	88%
CAMHS Crisis (Team)	11	8	73%	91%
Hull Children's Autism Service (Team)	7	4	57%	100%
East Riding CAMHS - Team 2 (Team)	10	5	50%	30%
CYP IAPT (Team)	2	1	50%	0%
Eating Disorders Service (Team)	12	6	50%	58%
Community Core Team - Rivendell (Team)	4	2	50%	67%
Hull Community Core Team (Team)	2	1	50%	100%
Hull CAMHS - Team 2 (Team)	14	6	43%	69%
Children's Psychology (Team)	4	1	25%	75%
Core service total	**141**	**96**	**68%**	**67%**
Trust wide	**2585**	**2001**	**77%**	**79%**

Staff informed us they received regular and effective supervision. This included clinical supervision, managerial supervision and peer support sessions. At the time of this inspection, all teams were above 80% compliance in delivering the sessions required.

The trust stated that they were only able to provide this information at team level not by ESR group, therefore data includes both medical and non-medical staff. Between 1 September 2017 and 31 August 2018, the average rate across all ten teams in this service was 78%.

The rate of clinical supervision reported during this inspection was not comparable to the rate reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Hull CAMHS - Team 1 (Team)	46	46	100%
Hull CAMHS Contact Point (Team)	70	68	97%
Children's LD - East Riding (Team)	50	47	94%
Hull CAMHS - Team 2 (Team)	43	39	91%
East Riding CAMHS - Team 2 (Team)	120	101	84%
CAMHS Crisis (Team)	118	92	78%
Eating Disorders Service (Team)	61	42	69%
Hull CAMHS - Team 3 (Team)	113	77	68%
East Riding CAMHS - Team 1 (Team)	122	81	66%
ER Contact Point & PMHW (Team)	58	28	48%
Core service total	**801**	**621**	**78%**
Trust Total	**11648**	**8989**	**77%**

Staff attended weekly team meetings and monthly business meetings. They participated in discussions cascaded down from clinical meetings, transformation meetings and managers meetings. The agendas included training, team risks, patient risks, complaints and compliments, lessons learnt, staffing and administration.

Multidisciplinary and interagency team work

The service held regular multi-disciplinary meetings. These mostly took place on a weekly basis and were care pathway specific. They were attended by a range of disciplines and enabled staff to take individual patients for discussion.

Teams also held weekly meetings to discuss referrals and high-risk children and young people.

We observed meetings showing effective detailed discussions, participation from all disciplines and with clear actions.

Staff working in the contact point teams held daily handover meetings to share information from the previous day and to discuss recent referrals and appointments.

Staff had good relationships with external organisations. The trust's community specialist services for children and young people in Hull, worked closely with other partners such as schools and social services, to develop an early intervention model. This lottery funded model called Headstart, aimed to improve outcomes for children and young people's emotional health and wellbeing. Headstart, supported by Hull's local authority and clinical commissioning group, provided a range of interventions aimed at giving young people (age 10 – 16) the support and skills needed to cope with life's challenges. This included a whole school approach, referrals to local groups and peer mentoring.

Staff from all teams had a good understanding of local services which they could signpost or refer children, young people and their parents or carers to, for additional support.

Good practice in applying the Mental Capacity Act

As of 31 August 2018, 100% of the workforce in this service had received training in the Mental Capacity Act – Level 1 and 85% in the Mental Capacity Act – Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

Staff could provide thorough explanations and good examples of how they had applied the Mental Capacity Act and of their understanding of Gillick competency. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The trust had a policy on the Mental Capacity Act. Staff were aware of who they could contact if they needed advice. They also had access to the trust's website which provided further guidance.

Staff considered confidentiality and consent during the child and young person's comprehensive assessment. They determined whether they had a sufficient level of understanding to make decisions. This was recorded on the patient's individual records. Parents and carers told us that consent was considered at all times.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours demonstrated a caring and respectful manner. We spoke with five patients and seven carers. All were highly positive of the service they were receiving. They informed us that staff treat them with dignity and showed compassion and support always. Staff spoke about the children, young people and their parent and carers with dedication to their needs and consideration of their confidentiality.

Young people and parents told us that staff provided information and full explanations regarding the treatment being delivered and understood their personal needs.

Involvement in care

Involvement of patients

Staff involved patients in their care and treatment. Children and young people we spoke with felt involved in their care plans. They were given choices around attending groups or receiving individualised interventions.

Involvement of families and carers

Staff involved the parents and carers of the children and young people receiving treatment from the service. We spoke with seven parents or carers. They felt involved and supported throughout. Staff worked closely with them establishing trusting relationships and offering kindness and compassion. They worked closely with carers and parents even when the child or young person was reluctant to engage; this ensured interventions could still be implemented in the home environment.

Staff enabled children, young people and their parents or carers to give feedback on the service they received. The service had participation leads to promote involvement. Children and young people could use technology to feedback on group sessions and individual interventions. The service's participation in the Children and Young People's Improving Access to Psychological Therapies Programme collated information from questionnaires completed at reviews, groups and at the end of treatment for the service to consider improvements.

The service involved children, young people and their parents and carers in the recruitment of staff assisting with short listing and by attending pre-formal interviews. The trust also had an internet page to explain how people could get involved in developing services.

Is the service responsive?

Access and waiting times

The service had waiting lists for children and young people to receive treatment. Under the NHS Constitution, no patient should wait more than 18 weeks for any treatment. However, there are no specific national standards for waiting times for child and adolescent mental health services apart from psychosis and eating disorders.

The trust provided the following information relating to their waiting times up to 31 August 2018.

The trust has identified the below services in the table as measured on 'referral to initial assessment' or 'referral to treatment'. The service met the referral to assessment target in two out of three of the targets listed.

The service met the referral to treatment target in 11 out of the 12 of the targets listed.

The average number of days from referral to initial assessment during this inspection (54 days) was lower than that reported at the time of the last inspection (88 days, April 2016). Number of days from referral to treatment during this inspection was not comparable to the previous inspection.

Name of hospital site or location	Name of Team	Please state service type.	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Willerby Hill	CAMHS Crisis Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	4hrs	0.0	None set	0.1
Willerby Hill	CAMHS Eating Disorder Service	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	15.0	7 Urgent 4 weeks Routine	16.1
Willerby Hill	East Riding Youth Justice Service	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	17.0	28 days - Urgent 126 days - Routine	18.1
Willerby Hill	East Yorkshire CAMHS L	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	21.0	28 days - Urgent 126 days - Routine	85.8
Willerby Hill	East Yorkshire Children's Learning Difficulties Community Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	62.0	28 days - Urgent 126 days - Routine	66.5
Willerby Hill	East Yorkshire	CAMHS (Service)	MH - Specialist community mental	None set	47.0	28 days - Urgent	90.9

Name of hospital site or location	Name of Team	Please state service type.	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
	Core CAMHS		health services for children and young people.			126 days - Routine	
Willerby Hill	East Yorkshire Primary Mental Health Worker Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	29.0	28 days - Urgent 126 days - Routine	30.8
Willerby Hill	East Yorkshire Social Mediation and Self Help	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	15.0	None set	15.5
Willerby Hill	EY Autism Spectrum Disorder	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	28 days– Urgent 126 days - Routine	29.0	None set	29.0
Willerby Hill	EY CAMHS Contact Point	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	7.0	28 days - Urgent 126 days - Routine	6.9
Willerby Hill	EY Paediatric Children's Psychology	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	84.5	28 days - Urgent 126 days - Routine	84.8
Willerby Hill	Hull Autism Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	126	439.0	None set	437.4
Willerby Hill	Hull CAMHS Contact Point	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	6.0	28 days - Urgent 126 days - Routine	5.7

Name of hospital site or location	Name of Team	Please state service type.	CCQ core service	Days from referral to initial assessment		Days from referral to treatment	
				Target	Actual (median)	Target	Actual (median)
Willerby Hill	Hull CAMHS L	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	20.0	28 days - Urgent 126 days - Routine	20.1
Willerby Hill	Hull Children's Learning Difficulties	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	62.5	28 days - Urgent 126 days - Routine	224.4
Willerby Hill	Hull Core CAMHS Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	85.0	28 days - Urgent 126 days - Routine	95.1
Willerby Hill	Hull SMASH	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	8.0	None set	7.7
Willerby Hill	Specialist Child Assessment Team	CAMHS (Service)	MH - Specialist community mental health services for children and young people.	None set	22.5	None set	24.1

Referrals for the service were received from GPs, professionals, voluntary agencies and education. Towards the end of 2017, the service introduced online forms for self-referrals by young people and their parents. Commissioning agreements set no criteria for referrals. The service was also used as a first point of contact for other external organisations such as MIND. In Hull, an external organisation previously carried out specialist assessments for autism and Attention Deficit Hyperactivity Disorder in addition to the trust's service. This arrangement was decommissioned; this meant that all assessments for autism and Attention Deficit Hyperactivity Disorder came through Humber NHS Foundation Trust. The introduction of self-referrals and changes in commissioning resulted in increased referrals for the service and longer waiting times.

Staff in East Riding worked closely with the Early Help & Safeguarding Hub. They had an agreement where referrals for primary aged children went first to the hub. This meant that some

referrals could be signposted elsewhere or offered low level interventions instead of being taken by the trust's services onto their waiting lists.

As at 31 December 2018, both Hull and East Riding had waiting lists above 18 weeks for children and young people to receive treatment. There were 336 children and young people on the Hull waiting list and 23 for East Riding who had waited over the 18-week constitution. The longest wait being 106 weeks in Hull. The longest of these waits were on the Attention Deficit Hyperactivity Disorder pathway where people were awaiting assessments.

Following referral, staff triaged children and young people to determine the urgency and the care pathway required. Staff included consideration of risks, reasons for contact, consent and capacity during the triage process. The clinician in the team input into decisions regarding the next steps. This was done in daily handover meetings and weekly multi-disciplinary meetings specifically for referrals. Both locations met the target times for assessments for those children and young people deemed as urgent.

Parents, carers and young people were clear on actions they could take if circumstances changed. Staff responded in a timely manner to ensure the safety of the child or young person was not at risk. Low level interventions were offered whilst awaiting treatment, this involved group sessions and guidance and advice. The service's crisis team was available 24 hours a day, seven days a week.

The trust was in the process of introducing a specific autism team in Hull to respond to the increase in autism and Attention Deficit Hyperactivity Disorder referrals. Recruitment into this new team was underway at the time of our inspection. This included psychologists, assistant psychologists, a speech and language specialist and specialist nurses. This meant that staff could carry out specialist assessments for autism and Attention Deficit Hyperactivity Disorder in Hull in a timelier manner therefore reducing waiting times.

Waiting times were discussed as agenda items in all governance meetings and regularly with commissioners. Waiting times were included on risk registers with action plans to reduce them.

Staff were flexible in appointment times and locations. We observed records and staff conversations evidencing occasions where staff sought suitable locations to reduce travel arrangements and to work around the child's, young person's, carer's or parent's other commitments.

The service had a Did Not Attend policy. Staff took steps to encourage those who found it difficult to engage to attend appointments. Following offering further appointment and attempting communication via telephone and letter, they contacted the referrer to see if there had been further information or changes in risk.

Facilities that promote comfort, dignity and privacy

The Hull service in Hessle had facilities that promoted comfort, dignity and privacy. There were sufficient rooms including a relaxing environment for aromatherapy. Rooms were welcoming with appropriate furnishings. The location had a sports hall. However, we were told this was too cold to be effectively used in the winter time.

In East Riding, the Beverley location shared a building with other services. The environment was welcoming with a good range of information displayed and comfortable furnishings. However, staff told us that there were often difficulties in obtaining room space for appointments. Although we were informed that appointments never got cancelled, they told us that sometimes appointments were cut short due to a booked room which interrupted negatively with therapies. They told us that they often spent valuable time trying to source a room to ensure appointments took place on time.

Patients' engagement with the wider community

Staff worked closely with schools to ensure children and young people had good access to and remained in the school environment as appropriate. The service was involved in the Headstart model which was a whole school approach to focussing on the positive mental health outcomes for young people.

Parents and carers were fully involved in the child or young person's treatment journey where this had been agreed. There was a friendly, non-judgemental attitude from staff towards the wider families.

Staff encouraged young people to engage in wider community activities. For example, a member of staff established groups to build battery operated cars. This was for young people in the community who may struggle with formal therapies and to help build their self-esteem promoting social relationships and inclusion. Staff sourced support and funding from local organisations for this project.

Meeting the needs of all people who use the service

Staff endeavoured to ensure locations for appointments met the needs of people using the service. They offered groups and appointments outside normal working and education times. Locations were accessible for those patients with mobility needs.

Staff gave patients appropriate information about community groups representing specific characteristics such as LGBT patients.

Staff had access to interpreters where this was needed.

Listening to and learning from concerns and complaints

This service received 13 complaints between 1 September 2017 to 31 August 2018. Five of these were upheld, one was partially upheld and six were not upheld. One was referred to the Ombudsman. The most common complaint themes were communications (4) and patient care (4).

Staff aimed to resolve complaints informally in the first instance. If this was not possible, they referred the complainant to the trust's patient advice and liaison service.

Parents and carers we spoke with told us they had been informed of how to raise concerns and make complaints. Feedback from complaints and compliments were discussed in team meetings.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Westend – Children's Unit	11	5	1	4	1	1	0	0
Rivendell House	2	0	0	2	0	0	0	1

This service received six compliments during the last 12 months from 1 September 2017 to 31 August 2018 which accounted for 1% of all compliments received by the trust.

Is the service well-led?

Leadership

Managers were experienced and had the skills and knowledge to perform their roles. They understood their responsibilities and had a good understanding of daily operational activities. Staff felt managers were approachable and so did the people who used the service.

Some staff told us that senior leaders did not visit the locations where they worked and they were uncertain who they were.

Vision and strategy

Staff mostly knew and understood the trust's vision and values. They were displayed at the locations we visited. We evidenced how staffs' behaviours reflected these.

The service used value based recruitment with the aim of employing staff who would deliver high quality care in line with their vision and values.

Culture

Staff felt respected, supported and valued amongst their teams. They were proud of the work they carried out. Managers and team leaders spoke highly about the staff. All staff were aware of the trust's Freedom to Speak Up Guardian and the whistle blowing policy. They felt able to raise concerns without fear of retribution.

Staff had access to the trust's independent occupational health service as well as a range of other health and well-being initiatives. This included an extra day leave incentive if training was up to date and staff had accessed a flu jab. The trust offered counselling services that all staff could use in any circumstance. Staff informed us this was very responsive and did not need to be work related.

The service offered opportunities for staff to develop their skills and had conversations about career progression and how staff could work towards this. Managers knew how to deal with poor performance in line with the trust's policy if this was required.

The trust held an annual awards scheme inviting staff to nominate colleagues and teams. This was aimed at celebrating innovative and inspiring work to improve the lives for the people using the service.

Governance

The service had systems and processes in place to ensure that the premises were safe, staff were experienced and well trained and incidents were monitored and lessons learnt. They followed procedures to reduce or mitigate the risks for the children and young people and ensured that they and their parents and carers were kept informed.

There were clear frameworks to ensure that essential information was shared and discussed. This included regular conversations among staff teams, managers, senior leaders and commissioners relating to concerns such as waiting lists.

Staff were supported through supervisions and team meetings. The service's sickness and leavers rates were below the trust's average. Managers had improved supervision and appraisal rates to meet targets. They had a good oversight of staff's caseloads and monitored training compliance amongst their teams. Staff felt able to contribute to recommendations from incidents, complaints, audits and reviews. There were effective agreements with external organisations to work in collaboration to improve the health and well-being of children and young people in both Hull and East Riding.

Management of risk, issues and performance

Staff knew how to escalate their concerns to risk registers when required. This was done through team meetings and supervisions. They were aware of local risk registers; their concerns relating to waiting times matched what was on the register. There were clear action plans for identified risks.

Information management

Staff had access to equipment to do their work. They used portable technology when this was required. Some historical information was still in the form of paper records. However, this was accessible to staff if needed.

Staff used an electronic patient recording system. They reported that this was sometimes slow and that there were inconsistencies as to where some information was stored. They were knowledgeable about information governance including confidentiality.

Managers had access to information to monitor their team's performance, patient care and staffing.

Engagement

Staff had access to information on the trust intranet. Children, young people and their parents or carers could access the trust internet. When we looked at the trust's website, we found some information was out-of-date. This related to an intensive intervention team which was now incorporated into the teams relating to pathways.

Children, young people, their parents and carers had opportunities to give feedback following groups, individual appointments and at the end of their treatment. This was done as part of the Children and Young People's Improving Access to Psychological Therapies Programme which provided the service with data and reports to enable managers to improve the services offered.

All those involved in the service felt there were opportunities to be involved in decision making about changes and that their opinions would be listened to.

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 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.

None of the services within this service have been awarded an accreditation.