Good

Humber NHS Foundation Trust

Community-based mental health services for older people

Quality Report

Willerby Hill
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV936	Trust Headquarters Willerby Hill	Hull Memory Service	HU3 2SG
RV936	Trust Headquarters Willerby Hill	Integrated Hull Older People's Community Mental Health Team	HU6 8QG
RV936	Trust Headquarters Willerby Hill	East Riding Intensive Home Treatment Team	HU16 5JQ
RV936	Trust Headquarters Willerby Hill	Hull Intensive Home Care Team	HU16 5JQ
RV936	Trust Headquarters Willerby Hill	Single Point of Access service	HU16 5JQ

Summary of findings

RV936	Trust Headquarters Willerby Hill	Goole and Pocklington Older People's Community Mental Health Team	DN14 6AL
RV936	Trust Headquarters Willerby Hill	Bridlington and Driffield Older People's Community Mental Health Team	YO16 4NG
RV936	Trust Headquarters Willerby Hill	Haltemprice and north bank villages Older People's Community Mental Health Team	HU13 9LZ

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for older people as GOOD because:

- patients had risk assessments in place which were reviewed regularly. Risk management was practised in daily and weekly multi-disciplinary meetings
- there were good safeguarding practices in place. Staff knew how to identify abuse and raise concerns
- there were lone worker protocols in place that staff understood and adhered to
- staff received regular supervision and appraisal and felt supported in their role
- staff assessed the physical health of patients at the initial contact and managed physical healthcare in collaboration with the patient's GP. Shared care protocols were in place to support this
- care was being delivered in line with the Mental Health Act and Mental Capacity Act
- care was delivered in partnership with patients and carers. Patients and carers were involved in decisions about care and treatment. Care plans were personalised and holistic
- feedback from patients and carers was positive. They described a good service with caring and skilled staff
- standard operational procedures were in place to manage waiting lists. Waiting list initiative teams were being used to reduce waiting times and numbers
- there were processes in place to prioritise referrals and respond to urgent referrals. Urgent referrals could be seen within either four or 48 hours
- a range of information was available for patients and carers. This included information on diagnosis and available services and support.

However:

- there were waiting lists in place for some teams. There were two teams with waiting times of 40 days and one team with a waiting time of 66 days.
- not all teams were compliant with mandatory training
- not all staff had received training on the Mental Health Act and Mental Capacity Act
- there was no routine monitoring of performance for the single point of access service. However we were being told this was being considered as part of the service review
- not all staff felt engaged in the service transformation programme. This meant that there was a level of uncertainty about the future and how services would work.

Summary of findings

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

Are services safe?

Good

We rated community-based mental health services for older people as **GOOD** for safe because:

- patients had risk assessments in place which were reviewed regularly. Risk management was practised in daily and weekly multi-disciplinary meetings
- caseloads were discussed within supervision and were mainly within recommended guidance as set out by the Department of Health
- there were good safeguarding practices in place. Staff knew how to identify abuse and raise concerns.
- there were lone worker protocols in place that staff understood and adhered to
- staff knew how to report incidents and what type of incidents should be reported
- buildings were clean and well maintained. Health and safety checks were undertaken. Fire safety procedures were in place.

However:

- not all teams were complaint with mandatory training.

Are services effective?

Good

We rated community-based mental health services for older people as **GOOD** for effective because:

- care plans were personalised and holistic
- staff received supervision and an annual appraisal. There was access to specialised training
- staff assessed the physical health of patients at the initial contact and managed physical healthcare in collaboration with the patient's GP. Shared care protocols were in place to support this
- the service reviewed clinical guidance from the National Institute for Health and Care Excellence in governance meetings. Audits against guidance were being undertaken.
- teams included a range of mental health disciplines and there was effective multidisciplinary working embedded in practice
- the service was delivered in line with the Mental Health Act and the Mental Capacity Act.

However:

- not all staff had received training on the Mental Health Act and Mental Capacity Act.

Summary of findings

Are services caring?

Good

We rated community-based mental health services for older people as **GOOD** for caring because:

- we observed positive, caring relationships between staff and patients and carers
- staff had supportive attitudes towards patients. They treated patients with kindness, dignity, respect and compassion
- patients and carers were involved in decision making about their treatment and in the development of care plans
- the feedback we received from patients and carers was positive.

Are services responsive to people's needs?

Requires improvement

We rated community-based mental health services for older people as **REQUIRES IMPROVEMENT** for responsive because:

- there were waiting lists in place for some teams. There were two teams with waiting times of 40 days and one team with a waiting time of 66 days.

However:

- there were processes in place to prioritise referrals and respond to urgent referrals. Urgent referrals could be seen within either four or 48 hours
- standard operational procedures were in place to manage waiting lists
- a range of information was available for patients and carers. This included information on diagnosis and available services and support
- there was access to translation services
- there was a process in place to manage complaints. Staff understood how to manage complaints and information leaflets were available for patients and carers

Are services well-led?

Good

We rated community-based mental health services for older people as **GOOD** for well-led because:

- the trust's vision and values were displayed in all sites. The majority of staff we spoke to were aware of these
- there was good local leadership of teams
- staff were aware of the provider's whistle blowing and duty of candour policies
- there was strong team working and mutual support between staff
- there were regular team meetings where staff could provide feedback on services

Summary of findings

However:

- there was no routine monitoring of performance for the single point of access service. However, we were being told this was being considered as part of the service review.
- not all staff felt engaged in the service transformation programme. There was a level of uncertainty about the future and how services would work.

Summary of findings

Information about the service

Humber NHS Foundation Trust provided community-based mental health services for older people across Hull and East Riding. The trust provided a range of services including community mental health teams, intensive home treatment teams, single point of access and memory and dementia services. Within the trusts organisational structure the older peoples community mental health teams were part of the older people's mental health care group. The care group incorporated both inpatient and community based mental health services for older people.

The older people's mental health care group was undergoing a programme of service transformation. Within the community services that had included the merging of some community teams and a review of staffing establishments. As part of the inspection we visited the Integrated Hull older people's community mental health team. This team had just been created by merging the east Hull and west Hull older people's community mental health teams. Other services we visited were in the middle of the transformation programme and services such as the single point of access were being reviewed.

Older people's community mental health services have not previously been inspected by the Care Quality Commission under the Health and Social Care Act 2008 regulations 2014.

Our inspection team

The team was led by:

Chair: Dr Paul Gilluley, head of forensic services East London Foundation Trust and Care Quality Commission National Professional Advisor

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected the community mental health services for older people consisted of one inspector and three specialist advisors. The three specialist advisors were experienced clinicians working within older peoples mental health services and included two nurses and one social worker.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited one memory clinic, an intensive home treatment team, an intensive care treatment team, a single point of access service and four community mental health teams
- spoke with the manager of each team
- spoke with 42 other staff members including consultant psychiatrists, nurses, support workers, social workers, psychologists, occupational therapists and administrative staff
- spoke with 21 patients who were using the service and four carers
- attended and observed five home visits
- attended and observed two clinical appointments on site
- attended and observed two multidisciplinary meetings, one formulation meeting, two planning meetings and one ward liaison visit
- looked at 39 care records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

During the inspection, we spoke with 21 patients and four carers. We also observed seven clinical engagements including five home visits. The feedback from patients and carers who used services was positive. People told us that they found staff to be caring and supportive. Staff were described as understanding and willing to go 'the extra mile' to help. Patients and carers were involved in decisions about treatment and involved in their care. Our observations of staff interactions with patients were good. Staff showed a good knowledge of individuals and acted in a supportive manner. Staff engaged with individuals in a respectful manner and provided space for them to express their opinions.

Good practice

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that it reduces waiting times and completes assessments within 30 days of referral in line with the trust target

Action the provider SHOULD take to improve

- The trust should ensure that all staff receive training on the Mental Health Act and the Mental Capacity Act
- The trust should ensure that the single point of access service is properly staffed and works effectively. Performance monitoring should be put in place to assess this.
- The trust should ensure that mandatory training compliance across all services meets the trust target of 75%
- The trust should ensure that there is effective communication and consultation with staff around the transformation of community services

Humber NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hull Memory Service	Trust Headquarters Willerby Hill
Integrated Hull Older People's Community Mental Health Team	Trust Headquarters Willerby Hill
East Riding Intensive Home Treatment Team	Trust Headquarters Willerby Hill
Hull Intensive Home Care Team	Trust Headquarters Willerby Hill
Single Point of Access service	Trust Headquarters Willerby Hill
Goole and Pocklington Older People's Community Mental Health Team	Trust Headquarters Willerby Hill
Bridlington and Driffield Older People's Community Mental Health Team	Trust Headquarters Willerby Hill
Haltemprice and north bank villages Older People's Community Mental Health Team	Trust Headquarters Willerby Hill

Detailed findings

Mental Health Act responsibilities

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

Training in the Mental Health Act was not recorded as mandatory training by the trust. Only 20 staff across the service had received training. Despite this staff we spoke to demonstrated a good understanding of the Mental Health Act and how to apply it.

Services were following the Mental Health Act in practice. There was an understanding of consent to treatment, community treatment orders and requirements to read patients their rights. Paperwork around the Mental Health Act was in place and up to date.

Advice and support was available from a central team within the trust. Independent mental health advocate services were in place across the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was part of the trusts mandatory training programme. Compliance with training varied across teams. The average training rate across the older people's community mental health service was 60%.

Staff we spoke to demonstrated a good understanding of the Mental Capacity Act and the five statutory principles. Capacity assessments had taken place and there was evidence of best interests assessors being involved where appropriate.

Staff were able to access Mental Capacity Act policies from the trust intranet. A central team was able to provide advice and guidance.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

The Hull memory service and the community mental health teams that we visited primarily saw patients in the community. Patients also attended team bases for appointments. Interview rooms were available for use. However, not all teams had alarms available for staff. The East Riding intensive home treatment team, Hull intensive home care treatment team and the single point of access service did not see patients on site.

Buildings had secure access and egress. Reception staff managed a signing in and out system for visitors and staff. The Haltemprice and north bank villages' older people's community mental health team was located within a wider GP surgery. However, there was no separate reception desk for the older people's community mental health team and patients reported to the main desk. This had the potential to compromise the confidentiality of patients. However, the team manager informed us that this was being reviewed.

Buildings were clean and well maintained. Furniture and décor were of a good standard. Cleaning records we reviewed showed that premises were cleaned regularly. Cleaning materials were stored in locked cupboards and control of substances hazardous to health assessments were in place. Staff showed an awareness of infection control. All of the teams were compliant with infection control training. Posters advising on proper hand washing technique were on display in toilets.

Buildings had a fire risk assessment in place. Staff had been identified to act as fire marshals and fire wardens in line with the trust policy. We reviewed maintenance records and found that appropriate checks were carried out and recorded. These included checks on fire safety equipment and environmental risk assessments. Portable electrical equipment had been tested and were in date.

Safe staffing

The staffing establishment in each team whole time equivalents (WTE) were:

Hull memory service

Band 6 qualified nurses – 2.0 whole time equivalent

Band 5 qualified nurse – 0.6 whole time equivalent

Support time and recovery worker – 0.6 whole time equivalent

Band 6 occupational therapist (OT) – 1.0 whole time equivalent

The Hull memory service was not carrying any vacancies. Over the previous 12 months there had been no staff turnover and a 1.0 % absence rate.

Integrated Hull older people's community mental health team

Band 7 team leader – 1.0 whole time equivalent

Band 6 qualified nurse – 2.7 whole time equivalent

Band 5 qualified nurse – 8.9 whole time equivalent

Band 6 OT – 1.0 whole time equivalent

Band 3 support staff – 2.4 whole time equivalent

The Integrated Hull older people's community mental health team had an O.2 whole time equivalent vacancy for a Band 5 nurse. Over the previous 12 months there had been a staff turnover of 8.8%. The absence rate for the same period was 7.7%.

East Riding intensive home treatment team

Band 6 qualified nurse – 1.8 whole time equivalent

Band 5 qualified nurse – 3.8 whole time equivalent

Band 3 healthcare assistant – 4.0 whole time equivalent

The East Riding Intensive home treatment team did not have any vacancies. Over the previous 12 months there had been a staff turnover of 8.2%. The absence rate for the same period was 11.2%.

Hull intensive home care team

Band 7 qualified nurse – 1.0 whole time equivalent

Band 6 qualified nurse – 3.0 whole time equivalent

Band 5 qualified nurse – 5.4 whole time equivalent

Band 3 healthcare assistant – 2.4 whole time equivalent

Good

Are services safe?

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The Hull intensive home care team did not have any vacancies. Over the previous 12 months there had been no staff turnover. The absence rate for the same period was 6.5%.

Goole and Pocklington older people's community mental health team

Band 6 qualified nurse – 1.5 whole time equivalent

Band 5 qualified nurse – 5.0 whole time equivalent

Band 3 healthcare assistant – 3.6 whole time equivalent

The Goole and Pocklington older people's community mental health team did not have any vacancies. Over the previous 12 months there had been a staff turnover of 10%. The absence rate for the same period was 4.1%.

Bridlington and Driffield older people's community mental health team

Band 6 qualified nurse – 2.0 whole time equivalent

Band 5 qualified nurse – 5.2 whole time equivalent

Band 6 occupational therapist – 0.5 whole time equivalent

Band 3 healthcare assistant – 1.2 whole time equivalent

The Bridlington and Driffield older people's community mental health team had vacancy for 0.5 whole time equivalent Band 6 OT and a whole time equivalent band 3 healthcare assistant. Over the previous 12 months there had been a staff turnover of 39%. The turnover rate of staff was in part due to staff retirement. The absence rate for the same period was 11%.

Haltemprice and north bank villages older people's community mental health team

Band 6 qualified nurse – 1.0 whole time equivalent

Band 5 qualified nurse – 4.0 whole time equivalent

Band 3 healthcare assistant – 1.0 whole time equivalent

Band 3 support staff – 1.4 whole time equivalent

Haltemprice and north bank villages' older people's community mental health team did not have any vacancies. Over the previous 12 months there had been a staff turnover of 22. %. This turnover was in part due to staff retirement. The absence rate for the same period was 4.4%.

The single point of access service was manned by staff from the East Riding intensive home treatment team and the Hull intensive home care team. Staffing of the single point of access was on a rota basis. The staffing levels for the service was one qualified nurse. Administrative support also came from the East Riding and Hull teams.

Not all of the teams had used a recognised tool to estimate the number of staff required. However a staffing tool was being utilised as part of the review of community services. Team managers told us that some staff who had recently retired had not yet been replaced. This was in line with the community transformation programme. Use of bank and agency was low. Bank and agency use was mainly related to administrative posts.

Teams had access to Psychiatrists within their structure. Staff told us they did not have problems accessing doctors including in an emergency. There were locum doctors in place covering vacancies in Goole and Pocklington and the integrated Hull older people's community mental health team.

Caseloads and caseload management was discussed within supervision sessions and at team meetings. Caseloads within older people's community mental health teams varied but were within the recommended figure of approximately 35 laid out in the Department of Health Policy Implementation Guidance (2002). Staff felt that although their workload was high they were supported to deliver it by colleagues and team managers.

The trust had a mandatory training programme in place for staff. Training was delivered in both face-to-face and e-learning formats. Team managers received a monthly update on mandatory training compliance within team performance reports. However, they told us this data did not always match locally held records. The overall target for mandatory training compliance within the trust was 75%. There were also targets for individual courses, which ranged from 75% to 95% (for information governance). Not all of the teams we visited were compliant with mandatory training targets set by the trust.

The Hull memory service were overall 81% compliant with mandatory training. However, they were not compliant with training around managing conflict (50% compliant against a target of 75%). The integrated Hull older people's community mental health team was overall 50% compliant with mandatory training. However this was due to the figures including 20 members of social care staff who were being transferred over from East Hull as part of the team

Good

Are services safe?

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merger. These staff were included in the figures but had not yet had the opportunity to undertake the training. The West Hull older people's community mental health team was overall 82% compliant.

The East Riding intensive home treatment team were overall 74% compliant with mandatory training. However, they were not compliant with PREVENT training (50% compliant against a target of 80%) or equality and diversity training (62% compliant against a target of 75%).

The Hull intensive home care team were overall 69% compliant with training. They were not compliant with PREVENT training (44% compliance against a target of 80%); information governance training (50% compliant against a target of 95%) and equality and diversity training (67% compliant against a target of 75%).

Goole and Pocklington older people's community mental health team were overall 81% compliant with mandatory training. However, they were not compliant with moving and handling training (27% compliant against a target of 75%) or managing conflict training (50% compliant against a target of 75%).

Bridlington and Driffield older people's community mental health team were overall 91% compliant with mandatory training. Figures for the Haltemprice and north bank villages older people's community mental health team incorporated figures for the Beverley older people's community mental health team. The combined figures showed a mandatory training compliance of 65%. The teams were slightly below the trust target for health and safety training (72% compliant against a target of 75%). However, PREVENT training (50% compliant against a target of 80%) or managing conflict training (39% compliant against a target of 75%) was much lower than the trust target.

Assessing and managing risk to patients and staff

We examined 39 patient risk assessments during the inspection. Patients received a comprehensive assessment of risk in a timely manner. Risk assessments had been reviewed and were up to date. Reviews occurred when patients circumstances changed or at minimum of six monthly. Risk management plans were in place where applicable. The plans detailed actions to help manage or reduce identified risks. There was evidence of patient and carer involvement in some of the plans. Assessment tools used by the service and any changes to them were ratified by the care group clinical governance meeting.

Patient risk was discussed in daily meetings with teams and at weekly multidisciplinary meetings. We observed five meetings in which patients who were using the service, or had been referred into it were reviewed. This included a review of their risks. Patients who were on the waiting list for the service were also monitored. There was an effective discussion of risk in the meetings. The need to prioritise individuals based on risk was considered. We saw evidence of individuals on the waiting list being prioritised in response to new information provided by GPs.

Safeguarding training was part of the trusts mandatory training programme. Staff received training in safeguarding both vulnerable adults and children. The trust target for safeguarding training compliance was 80%. Not every team achieved this.

- in the integrated Hull older people's community mental health team only 57% of staff had attended the training courses. However, this was due to the figures including 20 members of social care staff who were being transferred over from East Hull as part of the team merger. These staff were captured on the figures but had not yet had the opportunity to take the training.
- East Riding intensive home treatment team were 71% compliant with safeguarding adults training
- Hull intensive home care team were 63% compliant with safeguarding adults training
- Figures provided for Haltemprice and north bank villages older people's community mental health team included the Beverly older people's community mental health team. The combined teams were only 33% compliant with safeguarding adults training.

Compliance for courses in the other teams varied between 78% and 100%.

Staff we spoke with demonstrated a good understanding of safeguarding and how to identify concerns. Staff were knowledgeable on the process for raising safeguarding alerts and knew how to access advice when it was required. We found that safeguarding issues were documented in care records and staff liaised with local authorities.

Good

Are services safe?

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

There was a lone worker policy in place and each team followed local protocols. These included the use of a board or book to record planned visits. Staff were required to phone the office to confirm their arrival and departure from appointments. Code words were in place so that staff could inform the team that they required assistance. Where risk assessments indicated the need staff attended appointments in pairs.

Track record on safety

The service had not reported any serious untoward incidents in the previous 12 months. A policy was in place to support the investigation of any such incidents. Some staff we spoke to had received training to undertake incident investigations.

Reporting incidents and learning from when things go wrong

Staff reported incidents using Datix. Datix was a web based risk management system. Staff understood the reporting process and were aware of what to report. Across the older peoples community mental health service 86 adverse incidents were reported between October 2015 and March 2016. Hull memory service reported the highest number of incidents with 23. The East Riding intensive home treatment team was the second highest reporter with 17 incidents.

Incident forms were reviewed by local team managers. A monthly adverse incident report was discussed at care group level in the clinical network group. Submitted incident forms included details of immediate action that had been taken in response to the incident. A policy and process was in place to carry out further investigation if this was required.

Staff received feedback on adverse incidents in team meetings where relevant. Learning was also shared within the care group through the clinical network group. Some staff we spoke to had attended learning events following adverse incidents but this was not consistent across all teams. Learning was shared across the trust in a global weekly email and blue light alerts.

Staff had an understanding of duty of candour. There was a module on the Datix system to identify incidents where duty of candour was appropriate.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We looked at 39 care records across the service. Each care record had an assessment in place that had been completed in a timely manner. Assessments were comprehensive in nature and captured areas such as mental and physical health, social circumstances, personal and family history and a mental state examination. Care plans evidenced multidisciplinary input.

Thirty-four of the care records we reviewed included care plans. Care plans were personalised and holistic. They captured and reflected the views of patients and carers. There was only one care plan that was out of date and overdue for review.

Records were stored in both paper and electronic form. Care plans and assessments were stored in paper form. Risk assessments were captured on a system called egrist. There was another recording system, Lorenzo that stored contacts and letters.

Paper based records were stored securely in lockable cabinets. Electronic records were password protected. This meant that records were stored securely and that information and data was protected.

Best practice in treatment and care

The service was delivered in line with the National Institute for Health and Care Excellence guidelines (NICE). These were reviewed in the care group clinical network to ensure that care pathways met the guidance. New clinical guidance was discussed in the care group clinical network and disseminated to staff through practice notes on the trust intranet. Guidance was circulated via blue light emails sent to staff. Where medics were prescribing medication, they followed relevant National Institute for Health and Care Excellence guidance. Prescribing protocols were in place to support this.

Patients had access to psychological therapies either within the team or by referral to improving access to psychological therapies services. Psychological therapies were delivered in both 1:1 and group formats and included cognitive behavioural therapy and anxiety management.

The physical health of patients using the service was considered on initial assessment and managed in collaboration with GP surgeries. Shared care protocols were in place to support this. We reviewed 39 care records and found that a physical health assessment had been carried out in all but four. There was evidence of ongoing monitoring of physical care where appropriate. Guidance was in place to support staff monitoring individuals on lithium, antipsychotics and antidementia medication. Teams took responsibility for monitoring physical health over the first few months of prescribing before responsibility was transferred to the GP. There was good liaison between teams and GPs.

Services used mental health cluster type to measure outcomes. Mental health clusters group patients together based on their diagnosis and severity of symptoms. Patients were reviewed on a regular basis and could move between clusters as their condition improves or worsens. Information on cluster groups and patient numbers was provided to team managers on a monthly basis in performance reports.

Clinical staff undertook regular case note audits. These were discussed in supervision. The care group was in the process of developing a formal programme of audit. This included a prescribing observatory for mental health audit on the prescription of antipsychotics to individuals with dementia. The audit had commenced in April but was not yet complete. Audit was an agenda item on the care group clinical network meeting.

Skilled staff to deliver care

Teams were multidisciplinary in nature. Staffing establishments varied according to the service but included nursing, occupational therapy, psychologists, psychiatrists and social workers. Social workers within the East Hull locality had previously been employed by the local authority. As part of the merging of the east and West Hull older people's community mental health teams these staff were being transferred over into the community mental health team. The West Hull team had integrated social workers prior to the merge.

Staff were skilled, experienced and qualified to complete their roles. Staff we spoke to had received both a trust and local induction. Staff told us they received regular supervision and had access to team meetings. Each team had a supervision structure in place. Data provided by the trust showed a high level of compliance with supervision. The Hull memory service, Goole and Pocklington and Haltemprice older people's community mental health teams were all fully compliant. The East Hull older peoples

Are services effective?

Good

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

community mental health team was 90% complaint and the West Hull older people's community mental health team 98% compliant. The Bridlington and Driffield older people's community mental health team was 85% compliant. The Hull intensive home care team was 80% compliant.

We reviewed records that confirmed supervision was occurring every four to six weeks. Supervision paperwork that we reviewed was fully completed and showed meaningful discussion. Staff we spoke to told us they felt the supervision they received was beneficial and that they felt supported in their role.

Staff were able to access specialised training. We spoke to staff who had undertaken modules in dementia at the local university. Staff had also completed training in psychological therapies such as cognitive behavioural therapy and psychosocial interventions.

There was a trust policy in place to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required.

Multi-disciplinary and inter-agency team work

The teams operated within a multidisciplinary team framework and we observed a collaborative approach to care and treatment. Regular and effective multidisciplinary meetings took place. We observed six multidisciplinary meetings including a formulation meeting. Discussion was effective and comprehensive covering areas such as risk, changes in presentation and safeguarding concerns. Patient and carer needs were discussed. Referrals were allocated and prioritised based on risk. Peer support and advice was offered within the meetings.

There were good links with other teams and services within the trust. The East Riding intensive home treatment team and Hull intensive home care team linked in with older peoples inpatient wards at Maister Lodge. They attended daily care review meetings on the functional older people's wards. The daily review meetings allowed staff to consider whether patients could be discharged from the ward earlier with input from community staff. The intensive home treatment team and intensive home care team also linked in with the organic older people's wards but attendance was less frequent and centred around patients ready for discharge.

Teams had good links with primary care, social services and other external organisations. These included care homes, private providers, GP surgeries and voluntary sector organisations.

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

Mental Health Act training was not recorded as mandatory training by the trust. Staff within teams told us they had received training and they demonstrated a good knowledge of the Act. However, figures provided by the trust showed that only 20 staff across the service had received training. They were:

- Haltemprice and north bank villages older people's community mental health team: two staff
- Bridlington and Driffield Older peoples Older people's community mental health team: eight staff
- East Hull older people's community mental health team: one staff member
- Goole and Pocklington older peoples CMHT: eight staff
- East Riding Intensive home treatment team: one staff member

Staff we spoke to demonstrated a good understanding of the Mental Health Act and how to apply it. There was an understanding of consent to treatment, community treatment orders and requirements to read individuals their rights. Records we reviewed included consent to treatment and capacity assessments that had been reviewed. We reviewed three records of patients that were subject to a community treatment order. All three records had appropriate risk assessments and documentation in place. There was evidence that patients had been read their rights. Paper work was up to date.

Staff were able to access Mental Health Act policies from the trust intranet. A central Mental Health Act team was able to provide advice and guidance.

An independent mental health advocate service was in place across the service. Staff and patients were aware of the independent mental health advocates and how to access the service.

Good practice in applying the Mental Capacity Act

Training on the Mental Capacity Act was recorded as part of the trusts mandatory training programme. However, compliance with training varied. Training figures were:

Are services effective?

Good

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

- Hull Memory service: 80% (four staff out of five)
- East Hull older people's community mental health team: 31% (10 staff out of 32)
- West Hull older people's community mental health team: 91% (10 staff out of 11)
- East Riding Intensive home treatment team: 50% (seven staff out of 14)
- Goole and Pocklington older people's community mental health team: 100% (11 staff out of 11)
- Bridlington and Driffield older people's community mental health team: 40% (four staff out of 10)
- Haltemprice and north bank villages older people's community mental health team: 30% (three staff out of 10)

Across the older peoples service overall compliance with Mental Capacity Act training was 60%.

Staff we spoke with were knowledgeable about the Mental Capacity Act and the five key principles. They understood that capacity fluctuated and that a patient may have capacity to consent to some things but not to others. Care notes we reviewed contained capacity assessments. There was evidence that these had been regularly reviewed and the majority were up to date. Patients were supported to make decisions about their care and treatment. We saw evidence of the involvement of best interest assessors where appropriate.

Staff were able to access Mental Capacity Act policies from the trust intranet. A central team was able to provide advice and guidance.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed two consultations on-site and five home visits during the inspection. Staff were respectful and treated patients and their carers with dignity and compassion. Staff displayed good listening skills and discussed care and treatment options in a clear manner. Patients and carers were given space to express their opinions and decisions were made in a collaborative manner. Staff showed a good understanding of individual need and were person centred in their approach.

We spoke to 21 patients and four carers. Patients were very positive about the service they received and the staff who delivered it. Patients and carers felt that they were listened too and involved in their care. They discussed positive relationships with staff. Staff were considered to be caring and responsive.

The involvement of people in the care that they receive

Patients told us they were involved in decisions about their care. The care records we reviewed demonstrated this. We reviewed 34 care plans within patient records. We found that care plans were up to date. The majority of care plans were personalised and holistic although we reviewed six that were not. Care plans captured the views of patients and carers. However, it was not always clear that a copy of the care plan had been offered to the patient.

Families and carers were involved in care with the consent of the patient. We observed evidence of carer involvement within risk assessments and care plans. In two of the home visits and one of the consultations, we observed family members were present. They were able to contribute to the discussion and their views were considered.

Patients and carers were able to give feedback on the care they received by completing a Friends and Family Test. The Friends and Family Test asked the respondent to describe how likely they were to recommend the service to others. The respondent could identify as extremely likely, likely, don't know, unlikely or extremely unlikely to recommend the service. The trust had a target in place for 90% of patients and carers who responded to the survey to be either extremely likely or likely to recommend the service to others. The most recent survey data showed that teams were hitting this target and regularly achieving 100% compliance.

Patients and carers at the Hull memory service could also provide feedback in a comments book kept in the main waiting area. We reviewed the book and found that comments about the service and staff were positive.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

Referrals into community mental health teams, intensive treatment teams and memory services were managed through a single point of access service. The single point of access reviewed referrals and escalated urgent referrals into crisis and intensive treatment services. Urgent referrals could be seen within either four or 48 hours dependent on need and risk. Non-urgent referrals were allocated to the appropriate community mental health team or memory service.

Staff we spoke to expressed concern over the suitability and effectiveness of the single point of access service. The single point of access was not a separate dedicated team. It was staffed by one nurse daily drawn from either the Hull intensive home care team or the East Riding intensive home treatment team. Those teams also provided administrative support to the single point of access. Staff told us that on occasion other staff within the teams would also have to support the single point off access. We spoke to one community mental health team manager who had previously had to support the single point of access to clear a backlog of 70 referrals. Staff we spoke to across the teams we visited felt that the service needed a dedicated single point of access service. Provision of the single point of access function was under review as part of the wider transformation programme within the care group.

The trust did not routinely collect performance data for the single point of access service. However, they provided data for March 2016, which showed that 100% of referrals were assessed within 30 days with an average wait of five days.

Data provided by the trust for other services showed that:

East Riding intensive home treatment team:

- Number of patients awaiting assessment: 0
- Assessment waiting times: 0 days
- Percentage of assessments completed within 30 days of referral: 100%
- Percentage of first treatment started within 14 days of allocation to a cluster: 100%

Hull intensive home treatment team:

- Number of patients awaiting assessment: one
- Assessment waiting times: nine days
- Percentage of assessments completed within 30 days of referral: 92.9%
- Percentage of first treatment started within 14 days of allocation to a cluster: 100%

Integrated Hull older people's community mental health team:

- Number of patients awaiting assessment: 180
- Assessment waiting times: 66 days
- Percentage of assessments completed within 30 days of referral: 21%
- Percentage of first treatment started within 14 days of allocation to a cluster: 100%

The Integrated Hull older people's community mental health team had just been created by merging the east and west Hull teams. A work stream was in place to create a single referral process and address the existing waiting list in line with the standard operating procedure for waiting lists.

Goole and Pocklington older people's community mental health team:

- Number of patients awaiting assessment: eight
- Assessment waiting times: 13 days
- Percentage of assessments completed within 30 days of referral: 90%
- Percentage of first treatment started within 14 days of allocation to a cluster: 75%

Bridlington and Driffield older people's community mental health team:

- Number of patients awaiting assessment: 51
- Assessment waiting times: 40 days
- Percentage of assessments completed within 30 days of referral: 36%
- Percentage of first treatment started within 14 days of allocation to a cluster: 100%

Haltemprice and Beverley older people's community mental health teams:

- Number of patients awaiting assessment:57

Are services responsive to people's needs?

Requires improvement

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

- Assessment waiting times: 40 days
- Percentage of assessments completed within 30 days of referral: 71%
- Percentage of first treatment started within 14 days of allocation to a cluster: 71%

Data provided for the Hull memory service showed that there was a waiting list of 170. The target from referral to assessment was eight weeks. Data showed that the average wait was just over the target at 8.8 weeks. An action plan and waiting list initiative team was in place to manage the waiting list. The waiting list initiative teams were additional staff drafted into services on a time-limited basis to help carry out assessments and reduce waiting lists. Staff discussed waiting lists and identified individuals who need to be prioritised in team meetings. The service had standard operational procedures in place to manage waiting lists and were proactive in doing so.

Teams were proactive in re-engaging with individuals who did not attend appointments. Follow up calls and letters were utilised to maintain contact and book a new appointment date. Teams responded promptly when patients phoned in. Patients and carers we spoke with made reference to being able to contact staff by telephone. They told us staff were responsive and returned calls if they were not available.

The facilities promote recovery, comfort, dignity and confidentiality

Buildings that patients visited were clean and well maintained. Rooms were available for individual consultations. The Hull memory service had a waiting area which included a television offering quizzes about past decades and information on services. Tea and coffee making facilities were also available to patients and carers whilst waiting. This facility was mentioned as a positive in feedback in their comments book. The Hull memory service also had appropriate signage in place including dementia friendly signs on toilets.

There was a range of information available in the reception areas of each of the teams we visited. This included information on services and treatments, local support and advocacy groups, general healthcare and patient rights.

Teams also displayed the results of their most recent patient surveys as well as information on how to complain. Information on display was up to date and was kept neat and tidy.

Meeting the needs of all people who use the service

All of the buildings that we visited had disabled access. However, the Goole and Pocklington older people's community mental health team building had narrow corridors, which were difficult to navigate in a wheelchair. All of the services offered appointments at home or at other locations if patients had difficulty accessing the building.

Staff had access to translation services. This included face to face and telephone translation. Information leaflets were not routinely displayed in other languages. However, staff were able to access services to have documents translated where required. Language needs were identified through referral and assessment information. Staff told us translation services were responsive and of a good quality. However, one staff member did report that they had difficulty in accessing a signer for a patient who was deaf although this was resolved.

Listening to and learning from concerns and complaints

Data provided by the trust showed that older people's mental health services had received six complaints over the last 12 months. Three of these complaints were fully upheld and three were not upheld. None of the complaints were escalated to the Parliamentary Ombudsman. Over the same period, the service received four formal compliments.

Information on how to complain was on display in team buildings that we visited. Not all of the patients and carers that we spoke with were aware of how to complain. However, those that did not know the formal complaints process stated they would be comfortable raising their concerns with staff. All of the patients and carers we spoke with felt confident that any complaint would be dealt with professionally and taken seriously.

Staff we spoke with were aware of the complaints process and how to escalate a formal complaint. Learning from complaints was disseminated through team meetings and supervision.

Are services well-led?

Good

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

Our findings

Vision and values

The trust's vision and values were on display in buildings that we visited. The majority of staff that we spoke with were aware of these. We spoke with staff who had attended focus groups and workshops in which they had been developed. Staff told us that there was a new appraisal process being introduced that was based on the trusts values.

Service managers and modern matrons were a visible presence and staff knew who they were. There were posters on display detailing the directors of the care group but staff were less certain who they were. Some staff had attended focus groups and events where senior trust managers were present. The chair had visited Goole and Pocklington older people's community mental health team and attended each trust induction session.

Good governance

There was a good governance structure in place within the care group. There was a clear line management structures in place supported by a framework of governance meetings. These included a clinical network group, a performance and assurance group and a patient experience group. The structure linked into trust wide governance forums. A range of policies and procedures were in place to offer guidance to staff.

Services monitored performance through key performance indicators. There were regular business meetings at team and care group level where performance was discussed. Managers received monthly performance reports. These included information on referrals, waiting times, mental health clusters, results of patient surveys and data completeness. The reports also provided managers with information on workforce, absence rates and training and appraisal figures. Managers were also able to access performance data through dashboards on the trust intranet. However, managers expressed concern that some of the data particularly around training rates and sickness was not as up to date as locally held records. Managers told us that data in these areas could be up to a month behind. The trust did not routinely collect data on the single point of access service. However they provided us with performance data for March 2016 and we were told that performance monitoring was being considered as part of the review of services.

Some of the teams we visited were being managed by staff who were acting up into the role. This was either the result of a vacancy or sickness. Where vacancies were in place recruitment was under way. The Integrated Hull older people's community mental health team had just appointed to their vacant managers post and were waiting for the individual to assume the role. Staff who were acting up told us they felt supported by the team and the management above them. Team managers felt supported in their role but some were managing more than one team or service. For example, the manager at Haltemprice older people's community mental health team also managed the Beverley older people's community mental health team. The manager at Goole and Pocklington older people's community mental health team oversaw wider community services for older people including district nursing.

There was a risk register in place at care group level. Staff could raise risks through the governance structure. The risk register was discussed and reviewed in the clinical network group.

Leadership, morale and staff engagement

Within the eight teams that we visited, sickness and absence rates varied but averaged 6.0%. There was no bullying or harassment cases open in the teams we visited. One staff member referred to an incident she had raised under a previous team manager that was not addressed to her satisfaction at the time but had been dealt with subsequently.

There was good evidence of teams working well together. Staff told us colleagues were supportive. Morale was generally good. However, there was concern relating to the ongoing transformation programme and redesign of community services. Although we saw evidence of meetings and some consultation around the changes staff told us they did not always feel involved or informed about the process. Staff within the East Riding intensive home treatment team and the Hull intensive care treatment team expressed concern over how the changes were being managed and how they were being consulted.

Staff reported they were able to raise concerns without fear of victimisation. Staff were aware of the trust whistleblowing process and duty of candour requirements. Managers were considered approachable.

Staff had regular team meetings and supervision sessions in which they were able to give feedback on the service.

Are services well-led?

Good

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

Commitment to quality improvement and innovation

Teams we visited did not hold any accreditations with relevant bodies. The Hull memory service was reviewing applying for the Memory Services National Accreditation Programme.

The Hull memory service was involved in a range of active research projects. This included research being undertaken by the Department of Health to evaluate different models of memory assessment services. They were also involved with a University of Cardiff study looking at Alzheimer's disease genetics and the valuing active life in dementia programme within occupational therapy services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Less than 75% of individuals were being assessed within the 30 day time frame at the integrated Hull, Bridlington and Driffield and Haltemprice and Beverley older people's community mental health teams. The Hull memory service was narrowly missing its eight week referral to assessment target. This was a breach of regulation 9(1)b