

# Humber NHS Foundation Trust

## Inspection report

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

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

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

**NOTE:** This report is an updated version of one originally published on 15 January 2018, correcting an error in the ratings table.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

# Summary of findings

## Background to the trust

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

The trust provides 10 of the core mental health services:

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

The trust also provide specialist substance misuse services.

The trust provides community health services:

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

The trust has recently acquired five GP practices which are:

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

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

Humber NHS Foundation Trust became a foundation trust in 2010.

# Summary of findings

## Overall summary

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

## What this trust does

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

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

## What we inspected and why

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

We inspected eight complete core services in total and substance misuse services. These were selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

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

## What we found

### Overall trust

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

- We rated effective, caring, responsive and well-led as good. We rated safe as requires improvement. Our rating for the trust took into account the previous ratings of services not inspected this time.

By applying the strict aggregation principles to the responsive key question the trust would be rated as requires improvement in responsive and requires improvement overall. However, we have decided to deviate from the aggregation rules because:

- All responsive ratings in community health services, primary medical services and adult social care were good at the time of this inspection.

# Summary of findings

- Of the seven mental health core services and substance misuse service that we reinspected the rating for responsive has improved, one of those to outstanding.
- All of the requires improvement in responsive are linked to services that we did not reinspect, we have checked our intelligence on issues that caused our services to be rated requires improvement in responsive and identified that there had been improvement in two of these three areas.
- We inspected four out of the five GP practices which the trust had acquired in the last 12 months, all four of these were rated good in all key questions.
- The adult social care location at Granville Court remains rated as good.
- Since our comprehensive inspection in 2016 the trust had lost two community health services due to a retendering process in early 2017. Due to the reduction in number of community health services if we now aggregated the ratings from the three core services within community health services it would be rated as requires improvement despite the community health adult core service which we inspected not changing in rating since April 2016, the responsive domain in this core service also improved. The rating for the community health services therefore remains as good and deviated from the aggregation principles.
- Our decisions on overall ratings take into account factors including the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- We rated well-led at the trust level as good.

## Are services safe?

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

- Staffing levels on all wards and departments didn't meet safe staffing levels and staff, patients and families told us that leave and activities were cancelled.
- Team meetings and supervisions were not taking place regularly across all the wards.
- The trust did not ensure that care and treatment was provided in a safe way for service users because they did not entirely assess all of the risks to the health and safety of service users of receiving the care and treatment and do all that was practicable to mitigate any such risks such as ligature risks.
- The trust did not ensure that all staff had the qualifications, competence skills and experience to provide care safely because mandatory training rates were lower in some core services than the trust's target.
- Appraisal rates were lower in some core services than the trust's target.
- The rooms at Miranda House used by the Crisis and Health Based Places of Safety service (Rapid Response Service) to see patients were not properly maintained.
- The trust did not maintain complete and contemporaneous patient records whereby staff could access results and update patient related information in a consistent manner across the services.
- Staffing numbers were not sufficient to meet all of the needs of the patients on the wards.
- Not all patients had a completed and up to date risk assessment and management plan.

However,

- Staff recognised safeguarding concerns and dealt with them in accordance with procedures

# Summary of findings

- Service managers reviewed all uses of restrictive interventions and gave feedback to staff when improvement was needed. The services encouraged external professionals to undertake reviews of long term segregation to ensure the oversight of patient safety.
- The trust had refurbished the health based place of safety at Miranda House. This was now fit for purpose and met the requirements of the Mental Health Act 1983 code of practice and the guidance from the Royal College of Psychiatrists on Section 136 standards.
- Staff managed and administered medicines safely. Prescribing practice met national guidance, good practice standards

## Are services effective?

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

- Staff worked well within multi-disciplinary teams and patients were involved in regular reviews of their care and treatment.
- The completion of Mental Health Act documentation had improved. Staff discussed patients' rights with them at the required frequency and undertook regular audits of paperwork to ensure compliance with the Mental Health Act. Staff were now trained in the Mental Health Act.
- Staff had access to trust policies which were based on national guidelines from the National Institute of Health and Care Excellence (NICE) in all care and treatment plans.

However,

- Patients did not always receive regular clinical reviews by the prescriber in substance misuse services.
- Staff in substance misuse services did not always review patients' recovery plans regularly in line with best practice.
- Not all wards and departments were compliant with supervision and team meetings were not always prioritised on all wards

## Are services caring?

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

- We observed that staff working within services were exceptionally caring, kind and compassionate. All levels of staff took the time to get to know patients and communicate with them.
- Staff could access interpreters, including sign language interpreters and there was spiritual support for patients on the wards. This included access to different faiths leaders and the provision of appropriate food.
- Staff maintained confidentiality of patient related information and supported them in attending physical health or specialist appointments.
- Patients and carers had opportunities to give feedback about the care and treatment the service provided. This was through surveys, comment cards, and regular meetings.
- Staff enabled patients to give feedback on the service they received.

However,

- Informal patients on Mill View Court told us that they felt unable to leave when they requested and did not always feel safe. Patients on Avondale and Westlands also told us they did not feel safe.

# Summary of findings

- Patients, carers and families on some wards told us that activities and leave were cancelled due to short staffing and annual leave.

## Are services responsive?

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

- Staff ensured that patients received personalised care and took account of their individual needs and choices.
- In older adults mental health services patients had access to their bedrooms and a locked space for their possessions. There was a range of rooms to promote dignified care to older people.
- Activities were available on older adult wards. They were committed to improving patient engagement by recruiting activity workers to ensure activities were available to patients all week.
- Discharge was embedded from the point of admission to services. Patients had clear discharge plans with actions to be achieved. Senior leaders met with commissioners weekly to discuss admission and discharge to protect patients from remaining in a hospital setting unnecessarily.
- The amount of complaints the services received had reduced since the last inspection. Staff told us that the trust investigated complaints and fed back information to staff and the complainant. Patients who used the place of safety received information on how to make a complaint.

However,

- Mill View Court, Westlands and Newbridges all admitted patients to leave beds, when patients were on leave the bed occupancy rates were greater than the 85% occupancy rate recommended by the Royal College of Psychiatrists. When there were no beds available staff admitted to sofas and mattresses. Charge nurses told us that they were not always able to refuse admissions when they felt it necessary.
- We saw no evidence of individual patient risk assessment for use of one of the gardens on Avondale; this was considered to be a blanket restriction.

## Are services well-led?

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

- The leadership and culture of most wards promoted the delivery of high quality person-centred care.
- Staff focused on the needs and the experiences of people who used the services and behaved in a way that was consistent with their vision and values.
- There had been an improvement in the overall governance of the learning disability service since the last inspection. Incidents and risks were routinely monitored and acted upon. Areas for improvement had clear time limited action plans.
- The learning disability leadership team had a clear strategy for the service, and were aware of concerns and risks within the service. Where we identified issues during the inspection, the service had already recognised these areas and had plans in place.
- There was a culture of openness and transparency and good team support among the managers and staff.

However,

- Staff felt there was a disconnect between the staff at ward level and the senior leadership team. Charge nurses, modern matrons and service managers were visible on the wards, although staff felt that the senior leadership team were not as visible.

# Summary of findings

- Some qualified nurses appraisal rates were low.
- There were no risk registers at ward level.
- The introduction of the 'paper light' and electronic record system wasn't fully embedded.

## Ratings tables

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

## Outstanding practice

There was a culture of development and improvement at the learning disability service. We saw examples of staff who were striving for excellence. Some members of the team had published research in relation to learning disabilities. Other team members had received national awards for good practice and leadership skills. Many members of the staff team had undertaken additional training courses to enhance their practice and improve patient care.

The learning disability service was undertaking innovative practices to support the discharge of patients into their local community. This included working closely with the commissioners of the service to set up new community provision for current inpatients. This allowed the service to continue supporting and monitoring the needs of patients, but outside of a hospital setting which the service did not view as a long term requirement of their care.

## Areas for improvement

We found areas for improvement including 15 breaches of legal requirements that the trust must put right. We found 76 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

## Action we have taken

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

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

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action

## What happens next

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

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# Summary of findings

The learning disability service was undertaking innovative practices to support the discharge of patients into their local community. This included working closely with the commissioners of the service to set up new community provision for current inpatients. This allowed the service to continue supporting and monitoring the needs of patients, but outside of a hospital setting which the service did not view as a long term requirement of their care.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations.

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

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

#### Trust wide

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

#### Wards for adults of working age and psychiatric intensive care units

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

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

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

#### Forensic inpatient or secure wards

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

#### Wards for older people with mental health problems

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

#### Wards for people with a learning disability or autism

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

#### Community based mental health services for adults of working age

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



# Summary of findings

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

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

## Substance misuse services

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

## Community health services for adults

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

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

## Trust wide

- The trust should consider developing a dedicated equality strategy.
- The trust should consider further engagement with staff to ensure that the strategy is embedded and that staff survey results are improved, whilst offering other opportunities for feedback.
- The trust should review its serious incident process to ensure that all incidents are coded correctly.
- The trust should review the current Lorenzo implementation plan and update as necessary.
- The trust should continue with its action plan to ensure all staff have the necessary disclosure and barring checks in place before they start work with the organisation.
- The trust should ensure that staff attendance at mandatory training meets their required target, to ensure staff are skilled and competent to perform their role.

## Wards for adults of working age and psychiatric intensive care units

- The trust should stop the practice of people sleeping on sofas and mattresses on the floor.
- The trust should ensure that patients are involved in making decisions about changes to the service within community meetings.
- The trust should ensure that patients feel safe on all wards.
- The trust should ensure that incidents and complaints are discussed and recorded at regular team meetings.
- The trust should ensure that all patients are actively involved in the development of care plans.
- The trust should review the process for clinic checks and ordering clinic stock.

# Summary of findings

- The trust should ensure that informal patients feel able to leave and that clear signs informing them of their rights are available.
- The trust should ensure that staff feel appropriately supported by senior management within the organisation.

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

- The trust should ensure that staff consistently document checks on emergency equipment and document physical health observations after staff have administered an intramuscular injection.
- The trust should ensure that compliance for staff clinical supervision meets the trust target.
- The trust should ensure that staff consistently document that they have offered patients copies of their care plan.
- The trust should ensure that staff share information effectively about patients at their handover meetings.
- The trust should ensure that staff consistently document capacity assessments and best interest decisions when patients lack capacity.
- The trust should ensure that all information held in the ward office is confidential at all times.
- The trust should ensure that the service has a local risk register and that all staff are aware of the risks.
- The trust should consider how staff are fully engaged in developments for the service and that all information about the service is up to date.
- The trust should consider that all patient records have an identifiable individual electronic staff signature.

## Forensic inpatient or secure wards

- The trust should ensure that staff review risk assessments in a consistent manner across all wards and that this is clearly documented.
- The trust should consider how staff document whether they have attempted to use de-escalation techniques in restraint records.
- The trust should ensure all patients on antipsychotic medication have the appropriate monitoring and investigations undertaken, in accordance with national guidance.
- The trust should ensure staff review care plans for patients with long term physical health conditions to ensure they are detailed and up-to-date.
- The trust should consider how they can reflect all types of staff supervision to accurately monitor compliance with this key performance indicator.
- The trust should consider how all equipment is portable appliance tested to remain in line with their policy.
- The trust should ensure personal emergency evacuation plans are in place for those patients who may be secluded at the time of an emergency.
- The trust should ensure staff clearly document action taken when fridge temperatures are outside of the desired range.

## Wards for older people with mental health problems

- The trust should ensure the refurbishment plans for Maister Lodge go ahead within the new proposed timeframes.
- The trust should ensure that staff at Millview Lodge have appraisals in accordance with the trust target.

# Summary of findings

- The trust should consider promoting similar levels of activities on Millview Lodge as they have planned for Maister Lodge.
- The trust should ensure they have robust systems in place for recording compliance with formal and informal supervision.

## Wards for people with a learning disability or autism

- The trust should ensure that communal dining areas are included on environmental ligature risk assessments.
- The trust should ensure that maintenance is carried out in a timely manner. This includes replacement of furniture on Lilac ward and providing obscured glass on Willow ward.
- The trust should ensure that they maintain the privacy and dignity of inpatients and that risk is monitored when allowing outpatients to access the clinic room on Lilac ward.
- The trust should ensure that all patients on Lilac ward have care plans for the use of 'as required' medications.
- The trust should ensure that seclusion and long term segregation reviews are always completed on time, in line with the Mental Health Act Code of Practice.
- The trust should ensure that Mental Health Act paperwork is well organised.
- The trust should ensure that all restrictive care plans have a thorough capacity assessment and best interests discussion before they are put into place.
- The trust should ensure that staff continue to have access to supervision as per trust policy.
- The trust should ensure that there is not a blanket restriction on patient's access to snacks between meals.

## Community based mental health services for adults of working age

- The trust should inform the community mental health team when patients are being discharged from wards.
- The trust should establish good communication methods with the prison in reach service.
- The trust should ensure all written care plans reviewed are kept up to date.
- The trust should ensure staffing in the services are adequate at all times.
- The trust should ensure caseloads within the services are weighted regularly.
- The Trust should ensure the waiting time from assessment to treatment local targets.

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

- The trust should ensure that the section 136 health based place of safety is cleaned after each use to ensure this is ready to use.
- The trust should ensure that vacancy rates for the Rapid Response Service are lowered through the recruitment and employment of suitable staff.
- The trust should ensure that the electronic patient records system is used consistently across the trust to ensure that the storage of information is consistent in all patient records.
- The trust should ensure that staff complete the records fully for patients using the health based place of safety.
- The trust should ensure that staff receive a regular appraisal.

# Summary of findings

- The trust should ensure that the right to confidentiality for patients detained in the 136 health based place of safety are upheld. Staff should ask patients for their consent to inform nearest relative of the section 136 detention and not be required to opt out.
- The trust should ensure that staff provide and explain information to carers about carers' assessments.
- The trust should consider staff involving carers more; including the information and experience of patients' mental health needs.
- The trust should ensure that staff conduct themselves in a professional way.
- The trust should consider seeking the feedback of patients and carers.

## Substance misuse services

- The trust should ensure the risk management plans include all identified risks with clear interventions to manage or mitigate them.
- The trust should ensure objectives in recovery plans are specific and timely.
- The trust should ensure they update information provided on their website relating to the service.
- The trust should ensure information sharing agreements are easily accessible for staff.
- The trust should ensure patients commencing prescribing treatment in Bridlington and Goole hub do not experience delays due to their location.
- The trust should consider making agreements with patients detailing actions to take if the patient unexpectedly disengages with the service
- The trust should consider clearly informing patients at the start of their treatment their expectations in terms of behaviours in order to minimise potential incidents.

## Community health services for adults

- The trust should ensure learning from incidents is shared with staff and there are formal processes for this.
- The trust should consider ways to improve learning from complaints across teams.
- The trust should consider ways to improve record keeping across the services.
- The trust should consider ways to further engage staff during service changes and improve morale across the services.
- The trust should consider ways to communicate the service vision and strategy to staff.
- The trust should consider ways to engage staff in the wider trust.
- The trust should consider ways to implement regular team meetings and ensure sustainability with team meetings.
- The trust should continue to address issues around appraisal and clinical supervision completion at Whitby community services.
- The trust should consider the use of a recognised tool to recognise deteriorating patients.

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level.

We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was our first review of well led under our next phase methodology. We rated well led as good because:

- The trust had a five year strategy 2017-2022, 'Caring learning and growing together to deliver excellent health and social care'.
- The trust had a distributed leadership framework which was aligned to the strategic objectives and the national leadership developmental framework.
- The board had the appropriate range of skills, knowledge and experience to perform its role. Fit and proper person checks were completed on appointment.
- We saw that medicines safety was integrated into the governance structure for the trust.
- The Duty of Candour requirements were fully met by the trust.
- Staff were consulted on and agreed to a new set of core values, these values were visible on trust literature and their website.
- The trust was involved in the and reviewed the progress on delivery of the sustainability and transformation programme and how this plan aligned with the trusts overall strategy 2017-22.
- The equality and diversity annual report to the board in 2016/17 included preparation for future and ongoing legislative and contractual requirements for example gender pay gap reporting and the workforce disability equality standard.
- A significant amount of work had been undertaken by the trust in the area of the Mental Health Act since our inspection in April 2016. Seclusion practice was now in line with the trust policy and the Mental Health Act code of practice. We also found that 79% of staff had now been trained in the Mental Health Act.
- The trust had an updated complaints procedure. Complaints we reviewed followed the trusts own guidance and national policy.
- We found that the restrictive practices were being monitored by the board.
- The trust had a safeguarding policy and procedure and their requirements were fully met under safeguarding.
- The trust now had an extensive audit process and plan.
- The trust recognised staff success by staff awards and through feedback.
- We inspected four GP services in June 2017, July 2017, August 2017 and September 2017 these fell into the scope of this inspection and all four of these were rated as good.
- We inspected Granville Court an adult social care inspection in April 2016 and this was rated as good. We did not include this rating in our aggregation of ratings because of the relative size of this service.

# Summary of findings

However

- There was no dedicated equality strategy and whilst diversity was mentioned within the workforce and organisational development strategy, only one of 43 strategic targets related specifically to equality work.
- Staff expressed mixed opinions about the vision and values of the trust and whether these had been embedded.
- Staff survey results showed that the trust had worse results than other similar trusts in 22 key areas.
- Staff focus groups showed an overwhelming theme from staff that they were not fully engaged in the trust's goals, strategy and vision. They felt that the trust did not listen or make any changes based on their feedback or felt unable to give this feedback in the first place.
- Whilst the trust wide compliance with training was 78% there were still a number of subjects which had not met this threshold.
- The trust's target rate for appraisal compliance was 85%. At 31 May 2017 the overall appraisal rates for non-medical staff was 83%.
- We reviewed ten incidents which had been categorised as other and found that four of these were still incorrectly coded.
- The electronic patient record system implementation remained problematic across the trust.
- 49 people within the organisation did not have a current disclosure and barring check in place

## Ratings tables

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

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

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

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018

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

### Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Mental health	Requires improvement ↑ Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018
<b>Overall trust</b>	Requires improvement ↑ Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018

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

### Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ⬆️ Jan 2018	Requires improvement ➡️⬅️ Jan 2018	Requires improvement ➡️⬅️ Jan 2018
Community health services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
<b>Overall*</b>	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018	Good ➡️⬅️ Jan 2018

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



## Ratings for mental health services

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

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

### Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Field House Surgery	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Hallgate Surgery	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Market Weighton	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
The Chestnuts Surgery	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Northpoint Medical Practice	N/A	N/A	N/A	N/A	N/A	N/A

### Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Granville Court	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

# Community health services

## Background to community health services

We inspected only one of the three community health services provided by the trust. Further information on the services provided appears in the Background to the trust section at the start of this report.

## Summary of community health services

Good  → ←

Our rating of these services stayed the same. We rated them as good because:

- Although we rated the service we inspected as requires improvement, taking into account previous ratings for the trust's other two community health services gave an overall rating of good.

# Community health services for adults

Requires improvement   

## Key facts and figures

Humber NHS Foundation Trust provided community health services for adults from two locations, Whitby hospital and Pocklington Group practice. The services were provided to the areas of Whitby and East Riding of Yorkshire.

Services offered from these locations included community physiotherapy, community occupational therapy, tissue viability and community nursing services. There was a heart failure nursing service offered from the locations. Administrative support was available at both sites.

The service was previously inspected in April 2016 when Humber NHS Foundation Trust provided more community health services for adults. Previously the service provided speech and language therapy services, bladder and bowel services, dietetics, musculoskeletal (MSK) service and a stroke service. These services were transferred to another provider in May 2017.

The previous ratings for community health services for adults were requires improvement overall and safe was rated as requires improvement, effective as good, caring as good, responsive as requires improvement and well led as requires improvement. The previous inspection included all services the service previously provided before being transferred to another provider.

The Whitby hospital base had an office area for community nursing and an office area for therapy services which included occupation therapists, physiotherapists and assistant therapy practitioners. Pocklington neighbourhood care service (NCS) was a multidisciplinary team of nurses and therapists based at The Beckside Centre with the Pocklington Group Practice. There was also a physiotherapy musculoskeletal (MSK) service based here. Both sites had administrative teams as part of the service.

The inspection was announced a day prior to the inspection taking place.

We spoke with 28 staff including nurses, physiotherapists, occupational therapists (OT's), managers and administrative support staff. We looked at 13 patient records during our inspection. We spoke with eight patients and relatives during our inspection.

During this inspection, we observed patient care in a physiotherapy MSK clinic, a wound dressing clinic and visited 14 patients receiving care and treatment in their own homes

## Summary of this service

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

- Governance systems and processes at team level across Whitby neighbourhood care service were not fully embedded and learning from incidents had not been fully embedded into the Whitby community teams. Record audit results showed overall 25.3% compliance. This was for Whitby hospital and did not refer only to community health services for adults.
- Mandatory training completion rates did not always achieve the trust target.
- There was limited evidence of a local audit programme and benchmarking being used. Appraisals across Whitby community nursing services had not been kept up to date in the previous six months and clinical supervision in the Whitby community nursing team had not been fully embedded, however managers told us they were addressing this.

# Community health services for adults

- There were waiting lists in therapy services. These were longer than 18 weeks and although managers could tell us the action being taken to address waiting lists, there was no action plan and this was not included on the risk register.
- Morale varied across the services and staff told us there was a lack of communication between the trust and staff. There was variance in the governance systems between Pocklington neighbourhood care service and Whitby neighbourhood care service.

However:

- Staff could describe the level of safeguarding training received. Staff adhered to infection, prevention and control policies such as 'bare below the elbow' and carried hand gel during visits. Mobile working had been implemented in some services such as community nursing and was being introduced into services such as therapy services.
- Records were found to be mostly completed and staff had access to relevant policies. Policies checked during the inspection were found to be in date. Staff were aware of duty of candour and there had been two incidents at Pocklington neighbourhood care services which had been investigated and action plans produced.
- Staff were able to access information through the trust intranet and told us of the different risk assessments available for use. Compliance with appraisals was 100% in the Pocklington neighbourhood care service for June and July 2017. Staff across the services were able to describe the multi-disciplinary team working in the services, for example between the occupational therapists, physiotherapists and community nursing teams.
- Staff provided compassionate care and treatment to patients. Staff took time to interact with patients and feedback from patients was positive across the services visited. We observed staff introducing themselves by name to patients and speaking to them with courtesy and respect.
- Managers were able to describe how they carried out service planning for the services and told us they worked closely with commissioners in service planning.
- Managers were able to describe the governance arrangements at trust level and how governance was managed at locality level through to board level. Staff attended business meetings and governance meetings. Staff across Pocklington neighbourhood care service were positive about local leadership. Trust vision and values were displayed on notice boards in staff offices. Staff told us of good teamwork and a culture of openness and honesty in teams. The service had developed a quality improvement plan.

## Is the service safe?

**Requires improvement**   

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

- While overall compliance for mandatory training at Pocklington NCS and the health trainer service had improved in July 2017, there were still some areas of mandatory training compliance which were still below the trust target of 75%, for example basic life support and safeguarding mandatory training compliance.
- Learning from incidents was not embedded into the Whitby community teams.
- We found a lack of security around medicines cabinet keys and the medicines cabinet a small number of out of date consumables at Whitby community services. Managers addressed this during our inspection.

However:

- Staff had knowledge of safeguarding and told us they had received safeguarding level one and level two training and had recently received a safeguarding talk from the trust safeguarding team.

# Community health services for adults

- While Pocklington neighbourhood care team and health trainers were at full establishment for staffing, staff across the Whitby neighbourhood care service told us staffing levels could feel low. There was one whole time equivalent registered nurse vacancy, one part time registered nurse vacancy and one part time healthcare assistant vacancy.
- Staff adhered to the 'Bare below the elbow' policy and carried hand gel on visits to patients to ensure infection control techniques. Staff had access to personal protective equipment such as gloves. Areas visited appeared visibly clean and tidy.
- Staff were provided with laptops to enable mobile working. Computer systems had electronic assessments available for staff to complete.
- Records were completed thoroughly in all but one record seen during the inspection. However this was raised and addressed by managers. We found policies to be in date and accessible. However staff across Whitby community therapy services would complete records once returned to base, this was raised at the previous inspection.
- Staff were aware of duty of candour. There had been two serious incidents at Pocklington neighbourhood care team and these had been investigated and action plans produced.

## Is the service effective?

Good   

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

- Staff could access trust policies and procedures on the staff intranet. We checked five policies relevant to community health service for adults and found they were all in date.
- Community nurses used a nationally recognised risk assessment tool, the Malnutrition Universal Screening Tool (MUST) to assess patients at risk of malnutrition.
- Compliance with appraisals was 100% in the Pocklington NCS for June and July 2017. All staff we spoke with confirmed they had completed their appraisal within the last year.
- Staff we spoke with told us there multi-disciplinary team working between community nursing, occupational therapists and physiotherapists across the services. Staff were able to offer joint visits where necessary. Therapy assistants worked between the different therapy services and were able to assist the physiotherapy team and the occupational teams to provide support to the services.

However:

- We did not find any evidence of involvement in local and national clinical audits or benchmarking in order to improve the quality of care for patients.
- Appraisals had not been kept up to date in the previous six months at Whitby NCS, however managers were addressing this.

## Is the service caring?

Good   

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

# Community health services for adults

- Staff provided compassionate care and treatment to patients. Staff took time to interact with patients and feedback from patients was positive across the services visited. Staff took into account patient dignity and privacy during visits and were aware of ensuring privacy and dignity was maintained when visiting patients. Patient survey results between April 2017 and August 2017 had been positive.
- We observed staff introducing themselves by name to patients and speaking to them with courtesy and respect. Staff took into account pain management with patients and assessed patients for pain management during visits.
- Staff provided patients with as much time as they required during visits. We observed staff giving support to patients and carers in making difficult decisions about their care.
- Staff in therapy services told us they discuss with patients their goals for therapy and support patients as required. Staff provided patients with contact details and community nursing were available 24 hours.
- We saw that staff communicated clearly with patients so that they understood their care and treatment and the options available to them. Staff explained clearly and gave patients and relatives the opportunity to ask questions.

## Is the service responsive?

**Good** ● ➡ ➡

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

- Service planning was carried out alongside clinical commissioning groups and the services that community health services for adults. Managers attended business and contract meetings for service planning and service managers were part of a transformational group led by commissioners.
- The service had recently recruited to a specialist continence nurse post to improve care for continence patients.
- Staff and managers in community nursing told us there was no waiting lists at the service and referrals were assigned to a community nurse by the administrative team and staff would attend to the patient as required once placed on their caseload.
- Services across community nursing at Whitby hospital and Pocklington did not have waiting lists for treatment. There were no known waiting lists over 18 weeks at the Pocklington neighbourhood care service.

However:

- There were waiting lists in therapy services at Whitby neighbourhood care team. These were longer than 18 weeks and although managers could tell us the action being taken to address waiting lists, there was no action plan.
- Whilst information was available on how to make a complaint, learning from complaints was not found in team meeting minutes across the services.

## Is the service well-led?

**Requires improvement** ● ➡ ➡

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

- There was still low morale across the service. Lack of communication between senior management and staff was found in the 2016 staff survey and staff told us communication at Whitby community services could be improved, for example there had been a lack of communication and engagement when a new post had been advertised.

# Community health services for adults

- Staff still did not always feel part of the wider trust; this was raised at a previous inspection. Previous inspection findings included staff not feeling part of the trust, low levels of mandatory training compliance, lack of audit plans and clinical supervision levels. Governance systems and processes at local team level varied between Pocklington and Whitby. Whitby community services had not fully embedded systems for learning from incidents for example and the risk register did not include all risks to the services. We did not find evidence of a robust programme of clinical and internal audit to monitor quality.
- Regular team meetings at Whitby community nursing service had only recently been implemented and had increased formal weekly engagement, however team meetings prior to this had been less frequent. Lack of staff engagement was raised at the previous inspection.

However:

- There had been changes to the service recently with the addition of a new clinical lead nurse post and service manager across the two sites. Senior managers were aware of issues across the services such as morale and processes within teams such as appraisal completion rates and were addressing this during our inspection. The trust provided us with a quality improvement plan for improvements across the service.
- Staff told us teamwork was good and there was open and honesty within teams. Staff were proud of the service they provided to patients. Staff across the Pocklington NCS felt able to raise concerns and felt these would be acted upon.
- Managers attended a monthly business meeting across the services where representatives from human resources, finance and performance attended. Trust governance structures fed into the care groups and then down to the locality groups.

## Areas for improvement

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



# Mental health services

## Background to mental health services

We inspected seven core mental health services plus substance misuse services. Further information on the services provided appears in the Background to the trust section at the start of this report.

## Summary of mental health services

**Good**  

Our rating of these services improved. We rated them as good because:

- Five services improved overall from requires improvement to good.

However:

- We continue to rate as requires improvement acute wards for adults of working age and psychiatric intensive care units, and community mental health services for adults of working age.
- The rating for mental health crisis services and health based place of safety went down.

# Community-based mental health services for adults of working age

Good  

## Key facts and figures

Humber NHS Foundation Trust delivers community mental health services to adults of working age across Hull and the East Riding of Yorkshire. The community mental health service delivers an integrated community mental health service in Hull through a single contract for health and social care and in the East Riding of Yorkshire through a Section 75 partnership agreement with the Council.

The team comprised community mental health nurses and support workers employed by Humber NHS Foundation Trust and social workers and case workers (trainee social workers) employed by the local authority.

There were eight community mental health teams and these were based at nine sites. Hull (West) was based at the Waterloo Centre and Hull (East) was based at The Grange. In addition to these two teams, there were Goole and Pocklington, Bridlington and Driffield, Beverley, Haltemprice and Holderness.

Some of the teams were based on the premises of a multi-disciplinary, multi-professional unit, providing a service to adults, 18 and above, with a full range of mental health problems and needs ranging from moderate to severe with a degree of complexity, within clusters 5 to 17. The service is a needs-led, recovery-focused, intervention and treatment community team. A full range of multidisciplinary professionals worked effectively together within the teams, with very quick and easy access to consultant psychiatrists and psychologists.

We inspected three of these community mental health team across five sites, namely, Hull West, Pocklington Adult, Goole Adult, Bridlington Adult CMHT and Driffield Adult.

Pocklington Adult team will cease to operate under Humber NHS Foundation Trust on 31 December 2017. The service based at the Pocklington location will be managed by Tees, Esk and Wear NHS Foundation Trust from 1 January 2018.

During our inspection, we:

- spoke with 16 patients by telephone and one patient in a clinic.
- visited four patients in their own homes.
- spoke with 42 members of staff, including consultant psychiatrists, psychologists, team leads, clinical leads, nurses, social workers, care officers, healthcare workers and support workers.
- reviewed 27 patients' care records.
- reviewed a range of documents relating to the running of the service.

## Summary of this service

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

- Patients, carers and family members were pleased with the service. Patients felt respected and involved in their care and treatment.
- The trust had introduced a number of initiatives to improve the standard of clinical governance.
- Staff knew how to report incidents using the online incident reporting system.
- Consultant psychiatrists and psychologists were readily available in all the services.

# Community-based mental health services for adults of working age

- Staff adhered to the trust lone working policy and they had not experienced any incidents.
- Staff carried out a comprehensive assessment of each patient, which included mental and physical health needs.
- Staff had regular supervision and appraisals.
- Staff supported patients to get involved in the local community. Bridlington service provided a therapy garden to support patients in therapeutic activities.
- There was a culture of openness and transparency and good team support among the managers and staff.

However:

- The trust target for six mandatory training courses had not been achieved.
- Some premises were in need of refurbishment and redecoration.
- The interface with prison in reach services for obtaining medical information about offenders was not working satisfactorily.
- Incidents had increased and had not always been investigated and documented appropriately.
- The transfer of Pocklington to a different trust had led to uncertainty and low staff morale.
- Precise caseload weighting was often not carried out.

## Is the service safe?

**Requires improvement**   

See guidance note ICS 4 then add your text after the standard text paragraph below (and delete this help text).

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

- Staff compliance rates were low for six mandatory training courses, including basic life support, infection prevention and control, information governance, and equality and diversity
- The staffing for the community mental health service was under-established.
- The caseload weighting tool to allow for the complexity and demands of cases in arriving at a balanced allocation of cases to staff, was often not used consistently.
- The trust reported an increased number of serious incidents during the period 1 June 2016 to 31 May 2017 when compared with the six serious incidents reported at the last inspection.
- The premises at Pocklington, Goole and Bridlington were in need of refurbishment and redecoration.

**However:**

- Staff knew how to report incidents using the online incident reporting system.
- Consultant psychiatrists and psychologists were readily available in all the services.
- Staff adhered to the trust lone working policy and they had not experienced any incidents.
- The 27 patient records we looked at contained up to date risk assessments and crisis plans

# Community-based mental health services for adults of working age

## Is the service effective?

Good  → ←

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

- Staff carried out a comprehensive assessment of each patient, which included mental and physical health needs.
- Staff had access to trust policies which were based on national guidelines from the National Institute for Health and Care Excellence (NICE) to inform all care and treatment plans.
- The community mental health service participated in two national clinical audits.
- Generally there was good multidisciplinary and interagency working.
- Staff had regular supervision and appraisals.
- Staff were given support by the trust Mental Health Act office on matters regarding the Mental Health Act and community treatment orders (CTOs). Staff were trained in and had a good understanding of the Mental Capacity Act.

## Is the service caring?

Good  → ←

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

- Patients, carers and family members gave positive feedback about the care and treatment they had received.
- We observed staff being respectful and kind towards patients.
- Patients had been involved in their care and treatment. Their condition had improved as a result of receiving good care, support and treatment from the doctors and the staff.
- Staff supported patients to get involved in social activities in the local community

## Is the service responsive?

Good  → ←

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

- The community mental health team served members of the local community who required ongoing specialist care.
- The facilities in the clinics promoted patients' comfort, dignity and privacy.
- Staff supported patients to get involved in the local community. Bridlington service provided a therapy garden to support patients in therapeutic activities.
- Staff learnt from concerns raised by patients and their relatives.

However:

- Most of the services continued to exceed the local assessment to treatment target of 14 days.

# Community-based mental health services for adults of working age

- At Hull West, it had proved difficult to engage meaningfully with the staff of prison inreach services to obtain important information about offenders' conditions needed to plan their care and treatment.
- Patients were often discharged from the trust hospital without informing the community mental health team prior to patients' actual discharge date. This exposed patients to risk of not receiving appropriate follow-up care on time.

## Is the service well-led?

**Good** ● ↑

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

- The trust conveyed information to all staff by email, the trust intranet and through management meetings.
- Staff were well supported by the consultant psychiatrists, psychologists and team and clinical leads.
- There was a culture of openness and transparency and good team support among the managers and staff.
- The trust risk register was constantly reviewed and staff were aware of the escalation process.
- Staff were consulted and they had been involved in improvement initiatives.

### However,

- Some staff reported uncertainty and low morale in relation to the planned takeover of the Pocklington site by another trust,
- Staff were experiencing problems using the electronic patient record system.

## Areas for improvement

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

# Forensic inpatient or secure wards

Good  

## Key facts and figures

The Humber Centre for Forensic Psychiatry is a purpose built hospital at Willerby Hill in Hull. Humber NHS Foundation Trust manages the hospital. There are seven inpatient facilities based on this site. It is registered to take up to 79 patients who have been detained under the Mental Health Act 1983. The Humber Centre provides medium and low secure care for mentally disordered or learning disabled male offenders, and men with a personality disorder who require assessment, treatment and rehabilitation within a secure environment.

- The trust refers to Derwent ward and Ouse ward as The Bridges. Derwent ward provides care for up to 10 male patients with complex mental health problems, who require high levels of support, assessment and intervention. Ouse ward provides care for up to 14 male patients who require less intensive support than those on Derwent ward. Staff focus on working with patients to enable them to move on to the next stage of their care. At the time of inspection, Derwent ward had six patients and Ouse ward had twelve patients.
- Swale ward provides care for up to 15 adult male patients with personality disorders that are functionally linked to their offending and risk behaviours and had 15 patients at the time of inspection.
- Ullswater ward provides care and treatment for up to 12 male patients with a learning disability and a diagnosed mental disorder and had six patients at the time of inspection.
- Greentrees ward provides medium secure facilities for up to 16 male patients who may be seen as a risk to others and had 13 patients at the time of inspection.
- Darley House ward supports up to eight male patients who have not made the anticipated progress within traditional low secure services and may have been involved with services for a number of years, They had five patients at the time of inspection.
- South West Lodge is a secure community preparation unit. It provides individually graded levels of independence, supervision and security and had four patients at the time of inspection. Staff from the transferring ward continued to provide care and treatment for their patients once they moved to South West Lodge, to enable continuity of care.

The Care Quality Commission (CQC) inspected the forensic and secure inpatient services in April 2016. Forensic and secure wards were rated inadequate with breaches of the following regulations:

- Regulation 9, Person centred care.
- Regulation 12 (2) (a) Safe care and treatment.
- Regulation 15 (1) (a), (c) and (e) Premises and equipment.
- Regulation 17 (1) and (2) (c) Good governance.
- Regulation 18 (1) and (2) (a) Staffing.

The trust received two warning notices for forensic inpatient services as follows:

- Effective processes and procedures were not in place to provide systematic assurance that there was not inappropriate use of seclusion and that safe care was being delivered whilst patients were in seclusion.

# Forensic inpatient or secure wards

- There was a blanket policy of monitoring patient mail within the forensic services. There was an ineffective governance arrangement in place to oversee the monitoring of patients mail in the forensic services.

Forensic and secure inpatient services then received a focused inspection by the CQC in December 2016 to review the warning notices. The warning notices were replaced with requirement notices for breach of Regulation 12 (2) (a) (b) (c) of the HSCA (RA) Regulations 2014.

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

During the inspection visit, the inspection team:

- visited all seven wards, looked at the environments and observed how staff were caring for patients
- spoke with the care group director, clinical care director, assistant director, service manager, two modern matrons and interim associate medical director
- spoke with 47 other staff, including doctors, nurses, psychologists, occupational therapists, social workers, domestic staff and associate practitioners
- spoke with 15 patients who were using the service
- spoke with six carers of patients who were using the service
- looked at the care and treatment records of 31 patients, five seclusion records, 11 restraint records, six restrictive intervention plans for patients whose mail was monitored and the Mental Health Act documentation of 12 patients
- looked at four staff supervision files
- reviewed medication management including the medication administration records of 19 patients
- attended and observed one morning meeting, one reflective practice session and two multi disciplinary meetings
- attended and observed three activities with staff and patients
- looked at policies, procedures and other documents relating to the running of the service, including cleaning records, portable appliance testing and health and safety files.

## Summary of this service

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

- The service had acted upon our feedback from our previous inspections and there had been improvements in the quality of patient care. Staff had made substantial improvements.
- Staff treated patients with kindness, dignity and respect. Staff understood the needs of the patients and involved them in the planning of their care. The service sought feedback from patients and carers to ensure their involvement in service development.
- Staff understood the use of seclusion and it was used in line with the Mental Health Act Code of Practice and trust policy. The trust had decommissioned two seclusion rooms that were not fit for purpose.
- The service had undertaken work on reducing restrictions for patients and restrictive practice was based on an individual assessment of risk and need.

# Forensic inpatient or secure wards

- Staffing levels had improved and patients had greater access to Section 17 leave and activities on the wards to aid their recovery. Staff ensured patients could attend medical appointments in the community and the physical healthcare provision within the service had improved.
- Staff understood risks in the environment and used supportive engagement to manage patient risks. Staff completed risk assessments using validated tools and reviewed them regularly. Learning from incidents was shared with staff across the service.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act. Staff completed documentation as required and this was monitored by the trust.
- Managers had a good understanding of the service and were proactive in monitoring service delivery. The service involved clinical staff in audit to assess compliance and performance. Staff developed action plans in response to these to track improvements.
- The environments across the wards had been improved. The wards were clean and well maintained, with furnishings in good order.

However:

- Staff attendance at mandatory training and clinical supervision was below the trust target.
- Staff did not always ensure that the appropriate monitoring was in place for patients who were prescribed anti-psychotic medication. Patients did not always have care plans in place for their physical health needs.
- The trust did not ensure that all electrical equipment was portable appliance tested in line with their policy.

## Is the service safe?

**Requires improvement** ● ↑

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

- Staff attendance at mandatory training was below the trust target of 75% for nine training courses.
- Staff did not take a consistent approach to reviewing patients risk assessments, making it difficult to monitor how regularly they were reviewed.
- Staff did not always ensure that patients who were prescribed anti-psychotic medication had the necessary monitoring in place.
- The trust did not ensure all equipment was portable appliance tested in line with their policy.
- The trust did not have personal emergency evacuation plans in place for patients who may be secluded at the time of an emergency.
- Staff did not document their attempts at de-escalation when recording an incident of restraint.
- Staff reported the electronic case record system was slow and difficult to use.

However:

- The trust had made improvements to the quality of the environments on the wards. Furnishings, curtains and windows had been replaced and wards were clean and maintained.
- Staff understood environmental risks on the wards and used supportive engagement to manage patient risks.



# Forensic inpatient or secure wards

- The trust had undertaken work on reducing restrictions and used individual risk assessments in making decisions about restrictions placed on patients.
- The four seclusion rooms were fit for purpose. Staff understanding, recording and use of seclusion had improved and was in line with the Mental Health Act Code of Practice.
- Staffing levels had improved and staff ensured patients had access to medical appointments and Section 17 leave as a priority.
- Emergency medicines and equipment were available on all wards in line with the trust's policy.
- Staff reported incidents as required and learning from these was shared across the service

## Is the service effective?

Good   

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

- Staff worked well as a multi-disciplinary team and patients were involved in regular reviews of their care and treatment.
- The completion of Mental Health Act documentation had improved. Staff discussed patients' rights with them at the required frequency and undertook regular audits of paperwork to ensure compliance with the Act.
- Staff had a good working knowledge of the Mental Capacity Act. We saw the use of a two stage test to assess patients' capacity with best interest meetings held where required.
- The service had developed audits to monitor their progress and service development, which involved clinical staff.
- Staff used validated tools to monitor outcomes for patients and provided patients with care and treatment in line with best practice and national guidance.

However:

- Staff did not always ensure that patients had a detailed and up to date physical health care plan in place.
- The trust did not accurately monitor levels of staff supervision and reported supervision rates were below the trust target.

## Is the service caring?

Good   

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

- Staff supported patients in a caring way and treated them with kindness and respect.
- Staff understood the needs of patients and provided individualised care and treatment.
- The service provided patients with the opportunity to give feedback through surveys, comment cards and regular meetings.
- We saw evidence of changes being made to the service because of feedback from patients and their families and carers.

# Forensic inpatient or secure wards

- The service engaged with families and carers, holding regular carers meetings and inviting them to patient reviews. Families and carers were also involved in a reducing restrictions group.

Patients had weekly access to advocacy services

## Is the service responsive?

**Good** ● ↑

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

- The service had made improvements in the level of activities available to patients on the wards. Patients reported good access to activities.
- Patients reported the quality of food had improved and staff were reviewing the dining experience in response to patient feedback.
- Staff supported patients to plan for discharge and involved other relevant agencies in these plans.
- Staff supported patients to maintain contact with their families and make links with the wider community.
- Staff used easy read methods to share information with patients who had difficulty communicating.
- Patients knew how to complain and felt comfortable doing so. Learning from complaints was shared with staff across the service.

## Is the service well-led?

**Good** ● ↑

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

- Managers had a good understanding of the service and were proactive in driving and monitoring service improvements.
- Staff understood the trust's vision and values.
- Staff felt valued and happy in their work. They felt supported by their managers.
- Staff used audit tools to monitor the service and developed action plans to ensure improvement where required.
- The service measured themselves against the Quality Network for Forensic Mental Health Services.
- The service had developed a reducing restrictions group and a road to recovery academy. These aimed to ensure continuous service development and improve the quality of care and treatment offered to patients.

However:

- Some staff felt the senior leadership team were not visible and they were not always able to input to service development.

## Areas for improvement

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

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

Requires improvement   

## Key facts and figures

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

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

- Mill View Court provides intensive care and treatment for people who are in the most acute and vulnerable stage of mental illness and are unable to be supported at home. It has 10 beds and treats both men and women. The ward is based on Castle Hill Hospital site to the north of Hull.
- Newbridges provides care and treatment to men who are experiencing an acute mental illness and crisis. It has 18 beds and treats only men. The ward is a standalone unit located in east Hull.
- Westlands provides care and treatment to women who are experiencing an acute mental illness and crisis. It has 18 beds and treats only women. The ward is a standalone unit located in west Hull.
- Avondale is an acute assessment ward that provides assessment and treatment for a period of up to seven days for adults experiencing acute episodes of mental ill health who cannot be safely treated in other settings. It has 14 beds and treats both men and women. Patients who require care for more than seven days are transferred to alternative services within the trust.

The trust also has a psychiatric intensive care service for people who present higher levels of risk and require greater observation and support. It has 14 beds and treats both men and women. Both Avondale and the psychiatric intensive care unit are based in Miranda House, which is on the outskirts of Hull city centre.

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups. We visited the five wards between 12 and 14 September 2017.

During the inspection visit, the team:

- visited all five inpatient wards, looked at the quality of the environment and observed how staff were caring for patients
- we carried out a review of the four seclusion rooms and reviewed four seclusion records
- spoke with 19 patients who were using the service
- reviewed feedback from 11 patients who completed comments cards
- spoke with 8 carers
- spoke with the managers of each ward
- spoke with 37 other staff members; including consultant psychiatrists, junior doctors, modern matrons, psychologists, nurses, healthcare assistants, domestic staff, occupational therapists, activity coordinators and the senior leadership team

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

- attended and observed one patient meeting, two patient activity groups, one morning community meeting, two care programme approach meetings, one section assessment, one morning multidisciplinary team meeting and one staff handover
- reviewed 61 patient prescription charts
- carried out a specific check of the medication management on the wards
- reviewed 26 treatment records of patients, including Mental Health Act documentation of detained patients and six seclusion records
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- Staffing levels on the wards didn't meet safe staffing levels and staff, patients and families told us that leave and activities were frequently cancelled. Team meetings and supervisions were not taking place regularly across all the wards.
- Mandatory training rates and appraisal rates were lower than the trust target.
- On Westlands, clinic checks were not allocated to a specific staff member and checks not always completed. We could not identify the frequency that controlled drugs were checked on Newbridges.
- We found an inconsistent approach to recording data. We saw no clear protocol for recording discussions and actions that related to patients on the electronic records system. The electronic system did not allow for easy access to blood results. Patients care plans were of inconsistent quality; 12 care plans of 26 were generic with little patient contribution or personalisation.
- Patients on Avondale and Westlands told us they did not feel safe. Informal patients on Mill View Court told us that they felt unable to leave and did not feel safe. Signs informing patients of their rights to leave were unclear. Information for patients on notice boards was out of date on Mill View Court and Avondale, and incorrect on Newbridges.
- Patients were able to feedback at community meetings and directly to staff but we saw no evidence of patients being involved in making decisions about changes to the service.
- Mill View Court, Westlands and Newbridges all admitted patients to leave beds, when patients were on leave the bed occupancy rates were greater than the 85% occupancy rate recommended by the Royal College of Psychiatrists. When there were no beds available staff admitted to sofas and mattresses. Charge nurses told us that they were not always able to refuse admissions when they felt it necessary.
- Staff felt there was a disconnect between the staff at ward level and the senior leadership team. Charge nurses, modern matrons and service managers were visible on the wards, although staff felt that the senior leadership team were not.
- There was no risk register at ward level.

However:

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

- Patients had clear seclusion exit plans; reviews were conducted and seclusion was ended appropriately with multidisciplinary input. Staff completed collaborative risk assessments that reflected the patients' voice in line with trust policy.
- Staff on the wards had a good understanding and knowledge of safeguarding and incidents and reported them. We saw examples that changes were being made following incidents. Staff were knowledgeable in the application of the Mental Health Act and Mental Capacity Act. Patients had access to independent mental health advocates that regularly visited the wards.
- We observed kind and respectful interactions between staff and patients on the wards and found staff to be knowledgeable about patients' needs. Patients and carers described staff as genuinely caring, respectful and working for the best interests of the patients.
- Staff orientated patients and carers to the wards on admission and provided them with key information in an accessible format. Patients, families and carers were involved in care planning and risk assessments. Patients, families and carers felt confident to complain and feedback on the service and told us that they were listened to.
- Staff could access interpreters and there was spiritual support on the ward for patients. On the wards there were activities and facilities suitable to the patient group. Wards were clean and staff complied with infection control guidance.
- Staff planned for patients' discharge. Patients had care programme approach meetings with care coordinators, families and the multidisciplinary team.
- The service had effective mechanisms in place to monitor ward performance, including staffing, discharges, readmission and bed occupancy. Staff completed care records audits, infection control and seclusion audits. Charge nurses and ward managers were aware of the challenges within their wards and had a good understanding of their services.
- Ward leaders were very proud of their staff and spoke of their teams' resilience and pride in care given. Staff were also proud to work at the service and teamwork was demonstrated in the support the staff gave each other regardless of role. There were effective working relationships on and off the wards, including the multidisciplinary team and external organisations.

## Is the service safe?

**Requires improvement**  

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

- Staffing levels on the wards didn't meet safe staffing levels. The wards relied on bank and agency staff and regular staff worked additional hours and overtime. Newbridges and the psychiatric intensive care unit both had a two month period where staffing levels were red rated against the safer staffing planned levels and all other wards, with the exception of Mill View Court, had multiple instances where they were rated amber for staffing levels. Medical staff felt there was a lot of pressure in their roles and cited patient numbers and a lack of cover as their main concerns.
- There were not appropriate systems in place for patients to summon assistance from staff.
- On Westlands, clinic checks were not allocated to a specific staff member and checks were not always being completed. Missing clinic stock was ordered on a monthly basis by one member of staff. On Newbridges we could not identify the frequency that controlled drugs were checked.

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

- Mandatory training rates were lower than the trust target of 75%. Acute services averaged 64% completion for basic life support training and 74% for immediate life support training. Newbridges and the psychiatric intensive care unit had fire safety figures of 66% and 53% respectively, and search training figures and 66% and 50%; both below the target.
- Staff, patients and families told us that leave and activities were frequently cancelled. Staff told us that this was because of staff shortages, increased ward engagements and annual leave.
- We found an inconsistent approach to recording data. We saw no clear protocol for recording discussions and actions that related to patients on the electronic records system. For patients that had been admitted prior to the new electronic care records system, staff found it difficult to access archived patient records. Staff described the electronic care record system as slow to load and they felt that this impacted on being able to log patient engagements on the system. The electronic system did not allow for easy access to blood results.
- Team meetings were not taking place regularly across all the wards.

However:

- Ligature audits were comprehensive and staff were conducting and recording patient engagements.
- Wards were clean and staff complied with infection control guidance.
- Medicines cabinets were orderly, well stocked and in date and medicines fridge temperatures were being monitored.
- Staff completed collaborative risk assessments that reflected the patient's voice in line with trust policy.
- Patients had clear seclusion exit plans, reviews being conducted and seclusion was ended appropriately. This was discussed at multidisciplinary team meetings and recorded in patient notes.
- Charge nurses and matrons from the acute and psychiatric intensive care wards participated in the provider's restrictive interventions reduction programme.
- Staff on the wards had a good understanding and knowledge of safeguarding policies and procedures.
- Staff had a clear understanding of what constituted an incident and how to report it. We saw examples that changes were being made following incidents.

## Is the service effective?

**Requires improvement**   

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

- Patients' rights were recorded but not always in the same place. Cancelled or expired leave forms were not always crossed through. Staff struggled to find a record of consent to treatment recorded on the electronic record system and informal patient notices, informing patients of their rights to leave on the wards, were unclear.
- The electronic system did not allow for easy access to blood results and there was an inconsistent approach to updating the electronic records.
- Patients care plans were of inconsistent quality; 12 care plans were generic with little patient contribution or personalisation.

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

- With the exception of Newbridges, all wards were non-complaint with supervision and team meetings were not prioritised on all wards, excluding Mill View Court. Appraisal figures for qualified nurses were lower than trust target on four of the five wards; the lowest being the psychiatric intensive care unit at 58% and Westlands ward at 64%.
- There was limited continuity or pull through from previous handovers and varying attendance from the multidisciplinary team due to ward activity.

However:

- Physical health checks were being carried out in line with trust policy. Patients were referred to specialists when needed.
- Staff on Westlands were working with NHS Improvement and other trusts to reduce observation levels on the wards and focus on meaningful engagement.
- Staff completed care records audits, infection control and seclusion audits. The trust was in the process of implementing an app to create and monitor ward audits and improve the service.
- There were effective working relationships on and off the wards, including the multidisciplinary team and external organisations such as commissioners and local drug and alcohol services.
- Staff were knowledgeable in the application of the Mental Health Act and Mental Capacity Act. Patients had access to independent mental health advocates that regularly visited the wards. Patients understood why they were on the wards and the wards discussed and recorded Section 117 aftercare at care program approach meetings.

## Is the service caring?

**Good**   

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

- We observed kind and respectful interactions between staff and patients on the wards and found staff to be knowledgeable about patients' needs. Patients and carers described staff as genuinely caring, respectful and working for the best interests of the patients.
- Staff could access interpreters, including sign language interpreters and there was spiritual support for patients on the wards. This included access to different faiths leaders and the provision of appropriate food.
- Staff maintained confidentiality of patient related information and supported them in attending physical health or specialist appointments.
- Staff orientated patients and carers to the wards on admission and provided them with information about the wards, their keyworkers, expectations, rights and medications. Patients, families and carers were involved in care planning and risk assessments.
- Patients were able feedback on the service via community meetings and wards sought feedback from carers and families.

However:

- Informal patients on Mill View Court told us that they felt unable to leave and did not feel safe. Patients on Avondale and Westlands also told us they did not feel safe.
- Patients, carers and families on all wards told us that activities and leave were cancelled due to short staffing and annual leave.



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

- Patients were not involved in decisions about the service such as staff recruitment.
- Information for patients on notice boards was out of date on Mill View Court and Avondale, and incorrect on Newbridges.

## Is the service responsive?

**Good**  

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

- There was clear evidence that staff planned for patients' discharge and discharge plans were visible in all of the patient records we viewed. Patients had care programme approach meetings with care coordinators, families and the multidisciplinary team.
- There were activities and facilities suitable to the patient group on wards. The wards were in the process of rolling out individualise key fob access to patient rooms.
- The wards displayed information on how to complain on notice boards and in the patient welcome packs. Patients felt confident to complain either directly to staff or to the patient advice and liaison service and told us that they were listened to.

However:

- Mill View Court, Westlands and Newbridges all admitted patients to leave beds. When patients were on leave the bed occupancy rates were greater than the 85% occupancy rate as recommended by the Royal College of Psychiatrists. When there were no beds available staff admitted to sofas and mattresses. Charge nurses told us that they were not always able to refuse admissions when they felt it necessary.

## Is the service well-led?

**Requires improvement**   

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

- Staff felt there was a disconnect between the staff at ward level and the senior leadership team. Charge nurses, modern matrons and service managers were visible on the wards, although staff felt that the senior leadership team were not as visible.
- There was a mixed awareness of the role of the Speak Up Guardian and there were mixed views as to whether staff could raise concerns without retribution. We were told that the senior leadership team developed the values without input from staff.
- Qualified nurses' appraisal rates were below trust target on all wards except Mill View Court.
- There was no risk register at ward level. The introduction of the 'paper light' and electronic record system wasn't fully embedded. The service had not highlighted this as a risk in advance of the inspection. We saw no items relating to admissions to leave beds or sofas on the risk register, although this was monitored via ward performance reports.
- Patients told us that they were able to feedback at community meetings and directly to staff but we saw no evidence of patients being involved in making decisions about changes to the service.

However:



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

- Charge nurses and ward managers were aware of the challenges within their wards and had a good understanding of their services. Leaders on acute and psychiatric intensive care wards had the skills, knowledge and experience to perform their roles.
- Staff had been supported to create an internal self harm prevention training program when they had identified that a standard external training program was unsuitable; this training was then rolled out throughout the trust.
- Staff morale varied, but the majority felt respected, supported and valued by their immediate leaders on the wards.
- Ward leaders were very proud of their staff and spoke of their teams' resilience and pride in care given. Staff were also proud to work at the service and teamwork was demonstrated in the support the staff gave each other regardless of role.
- The service had effective mechanisms in place to monitor ward performance, including staffing, discharges, readmission and bed occupancy.

## Areas for improvement

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

# Substance misuse services

Good  

## Key facts and figures

Humber NHS Foundation Trust deliver community substance misuse services for adults across the East Riding of Yorkshire in partnership with the Alcohol and Drug Service (ADS).

The service, part of the East Riding Partnership, is contracted to support people who have difficulties with their drug or alcohol use. Services delivered are as follows:

### Open Access Service

This is the first point of contact for all people who are misusing any substance and entering into treatment. Drop in services are available at a variety of locations to people living in the East Riding area. Staff assess patients who can then be offered brief interventions, advice and signposting or be referred onto the community drug and alcohol teams for longer periods of treatment and clinical interventions if required.

### Addictions Recovery Team

This is located in central Hull. The addictions recovery team provide support for patients requiring intensive clinical support referred from open access, the community drug and alcohol teams or from primary care. At the time of our inspection, staff were seeing five patients at this location.

### Community Drug and Alcohol Teams

These teams work from three locations, central Hull, Bridlington and Goole. They provide clinical and psychological interventions for patients with drug and alcohol issues. Staff from these teams also deliver treatment at ten outreach locations.

### Shared Care Service

Additionally, staff from the community drug and alcohol teams may work alongside the patient's own GP to deliver support. The clinics are delivered at the locations of participating GP's. At the time of this inspection, the service was working with patients from 16 participating GP surgeries.

### Aftercare

Staff provide a period of structured appointments for patients following their detoxification discharge if required. This was predominately for alcohol users.

At the time of our inspection, the service was working with approximately 500 patients.

At the last inspection in April 2016 we rated four key questions as requires improvement (safe, effective, responsive and well-led) so we re-inspected all five key questions.

The inspection was announced (staff knew we were coming) one working day before our visits to ensure everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

# Substance misuse services

- visited all three hubs in central Hull, Bridlington and Goole and looked at the quality of the environments where appointments were held
- visited three of the drop in locations and one shared care service
- attended and observed four appointments
- spoke with 17 patients who were using the service
- spoke with one carer of a patient using the service
- spoke with the care director and two team managers
- spoke with 14 other staff members; including consultants, doctors, nurses, keyworkers
- spoke with staff from the partner organisation
- attended and observed two multi-disciplinary meetings
- collected feedback from patients using comment cards
- looked at 22 care records of patients
- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service had enough staff with the right qualifications to keep people safe from avoidable harm and abuse and to provide the right care and treatment. They identified risks and recorded actions on how they would manage, reduce or mitigate them. They had effective systems to safely store and dispense medications.
- The premises used were clean, well maintained with a welcoming atmosphere. There was a variety of locations offering patients a choice of where to be seen.
- The service was continually improving to provide a recovery focussed treatment system. Staff delivered psychosocial interventions to encourage a patient's improved health and wellbeing. Peer mentors provided patients with additional support and encouragement to commence their treatment journey.
- Patients felt involved in their care. The service met their individual needs and families and carers were involved if this was agreed. They were able to give feedback on the service and knew how to complain. Information relating to health, support groups and activities in the wider community was available and displayed.
- Staff showed a caring and respectful attitude. They were committed in their roles and embraced the service's vision.
- Governance systems provided managers with a clear oversight of the service's performance. They recognised and took responsibility where improvements were needed and involved patients, staff and commissioners in discussions. Managers and staff from the service were involved and committed to continual improvements

### However:

- Staff did not review a patient's recovery plan or review clinical interventions in line with best practice. Interventions on recovery plans lacked detail to enable a patient to clearly understand how or when they could achieve a goal.

# Substance misuse services

- Staff did not have timely access to patient information agreements.

## Is the service safe?

**Good** ● ↑

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

- Staff had now received the training required to provide the right care and treatment and to keep people safe.
- Staff now identified risks and put plans in place to manage or mitigate these.
- The premises and equipment used to deliver care were clean and well-maintained.
- There was sufficient staff to ensure a patients' needs were met and that appointments were not cancelled.
- Medicines were stored and administered safely.

### However:

- The service did not agree plans with patients in advance to record what actions staff should take in the event that the patient unexpectedly disengages from treatment.
- The service did not formally agree service expectations relating to behaviours at the start of a patient's treatment in order to reduce possible incidents.

## Is the service effective?

**Requires improvement** ● → ←

See guidance note ICS 4 then add your text after the standard text paragraph below (and delete this help text).

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

- Staff did not review patients' recovery plans regularly.
- Actions required in the recovery plans lacked detail; they were not specific, measurable or timely.
- Patients did not receive regular prescribing reviews.

### However:

- The culture of the service had improved to a recovery-focused model with the emphasis on psychosocial interventions and encouraging improved health and social functioning.
- Patients entering treatment received a comprehensive and timely assessment.
- Staff ensured that a patient's physical healthcare needs were being met including screening and immunisations for blood borne viruses.

Staff had access to training specific to the patient group

# Substance misuse services

## Is the service caring?

Good   

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

- Staff attitudes and behaviours when interacting with patients showed that they were caring with an empathic attitude.
- Staff involved patients in their treatment planning and risk management.
- Staff enabled patients to give feedback on the service they received.
- Staff involved families and carers appropriately.

### However:

- Staff did not have easy access to information sharing agreements.

## Is the service responsive?

Good  

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

- The service took account of a patient's individual needs.
- Patients had flexibility in where they attended their appointments.
- Staff managed transfers in and out of the service effectively ensuring minimal disruption.
- Premises were welcoming promoting recovery and dignity.
- Staff took proactive steps to engage with patients missing appointments.

### However:

- Prescribing titration was slower for patients wishing to commence prescribing interventions from the Bridlington or Goole hub.

## Is the service well-led?

Good  

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

- Managers had the right skills and knowledge to do their job.
- Governance systems provided managers with a good oversight of the service's performance.
- Staff behaviours demonstrated the trust's values and they showed a commitment to service improvements.
- Staff felt supported and able to contribute to service improvements.

### However:

# Substance misuse services

- The trust had not updated their website to reflect the service's model.
- The trust's electronic system required further development to meet the needs of the service.

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## Areas for improvement

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

# Wards for older people with mental health problems

Good  

## Key facts and figures

Humber NHS Foundation Trust provides assessment, treatment and care for people aged 65 years and older who have a functional mental health problem (such as depression, schizophrenia or bipolar disorder) or organic mental health problems (such as dementia). It has two wards for older people with mental health problems who live in Hull and East Riding:

- Maister Lodge. A 16 bed inpatient unit that provides inpatient services for older men and women who are experiencing predominantly organic mental health problems. The ward is currently commissioned for 14 beds only.
- Millview Lodge. A nine bed inpatient unit that cares for older men and women with functional mental disorders.

The wards offer a range of assessment and treatment including nursing care, medical input, occupational therapy, psychological interventions and physiotherapy and a range of recovery focused therapeutic interventions to aid patients' recovery as far as possible.

The Care Quality Commission inspected the older people's wards in April 2016. We rated the service rated requires improvement overall, with breaches of the following regulations:

Regulation 17 (1) and (2) (b) (c) (e) and (f), Health and Social Care Act (Regulated Activities) Regulations 2014, good governance.

Regulation 18 (1), Health and Social Care Act (Regulated Activities) Regulations 2014, staffing.

We carried out Mental Health Act monitoring visits to Maister Lodge in September 2016 and to Millview Lodge in July 2017. Following these visits, the trust provided an action statement telling us how they would improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

On this inspection, we looked at all five key questions. The inspection was unannounced.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information. During the inspection visit, the inspection team:

- visited both wards, looked at the environments and observed how staff were caring for patients
- spoke with the care group director, modern matron/service manager and one ward manager
- spoke with 13 staff, including a doctor, healthcare assistants, nurses, a psychologist, pharmacy technicians, an occupational therapist, and domestic staff
- spoke with 10 patients who were using the service
- spoke with seven carers of patients who were using the service
- looked at the care and treatment records of 11 patients
- reviewed medication management including the medication administration records of 23 patients
- attended and observed one morning meeting, one formulation meeting, one handover and one multi-disciplinary meeting

# Wards for older people with mental health problems

- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service had made improvements following feedback from our previous inspections. Maister Lodge had senior nurse cover for all day shifts and agency nurses were required to have the skills appropriate to the patient group. The ward now complied with safe medicines management.
- There were good patient risk assessments on each ward. The service provided a safe environment and managed risks well. Patients told us they felt safe. Risk assessments included monitoring of existing and potential physical health risks. At Maister Lodge, all patients had a bespoke risk assessment.
- Staff understood that the use of restraint was a last resort. They used de-escalation and low levels of restraint to manage incidents of aggression wherever possible. Staff ensured they documented episodes of seclusion, restraint, and rapid tranquilisation in accordance with trust policy. The ward took part in the trust restrictive interventions reduction programme and reported incidents of restraint appropriately.
- Patients on Maister Lodge had detailed, personalised care plans, which included information about physical health needs. Patients felt involved in decisions about their care. Staff gathered information from families and carers to produce an 'all about me' record for patients with cognitive impairment. This reflected a patient's history and preferences and contributed to their care plan.
- There was effective multi-disciplinary team working with regular reviews of patients care and treatment needs. We saw an improvement in staff adherence to the Mental Health Act, with detention papers and associated records completed appropriately. Staff understood the application of the Mental Capacity Act. They recorded best interest decisions including when significant decisions were made for patients who lacked capacity.
- Patients, families, and carers appreciated and spoke highly about the quality of care and treatment the service provided. Staff involved patients in decisions about their care where possible. They engaged with and supported families and carers where appropriate. Staff contacted families and carers with updates on patient progress, held regular carers meetings, and invited them to reception meetings.
- The service accommodated patients in local beds rather than send them out of area. When Millview Lodge was full, they admitted patients to Maister Lodge until a bed became available. Staff worked towards home discharges for patients on Mill View, implementing the correct levels of support to make this possible.
- Activities were available although the way staff offered activities varied between the two wards. At Millview Lodge, staff offered group activities, in which the current patient group did not always choose to participate. At Maister Lodge, activities were ad hoc and individualised. The ward was currently implementing plans to improve the provision of activities for their patient group.
- Internal changes within the service had led to a positive change in culture. Staff focused on the needs of the people using their service, providing high quality patient centred care, which reflected the trust's vision and values. Senior managers were committed to improving the environment at Maister Lodge and promoting best practice in dementia care.

However:



# Wards for older people with mental health problems

- The service could not always fill shifts. In particular, when increased staffing levels were required to meet changes in patient presentation. They relied on bank and agency staff and their own staff to fill shifts on a regular basis. This meant staff prioritised patient safety over individual staff clinical supervision and mandatory training needs.
- The trust had redecorated Maister Lodge and replaced broken furniture nevertheless the ward required a major refurbishment to make it appropriate to the needs of the patient group. Refurbishment plans had been in place since the previous inspections in 2016. The ward expected these plans to go ahead in October 2017.
- Both wards experienced delays in discharging patients. This was due to the lack of availability of suitable placements followed by delays in securing funding packages for patients.
- Systems and processes for reporting supervision were not robust. The system relied on staff remembering to sign the team's supervision chart. Ward managers completed a survey with information from the chart but received no feedback.

## Is the service safe?

**Requires improvement**   

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

- Although the service had improved to meet the regulation it failed to meet at the last inspection, we found a further breach of regulation at this inspection.
- The service was not always able to fill shifts on the wards to the required levels. Staff prioritised patient safety over their individual development needs.
- There was low compliance with mandatory training in some areas, in particular equality and diversity, and basic life support for healthcare assistants.
- Maister Lodge required a major refurbishment to make it appropriate to the needs of the patient group.

However:

- Staff used supportive engagement to manage patient risks. Patients we spoke with felt safe on the wards and felt staff provided appropriate levels of support.
- Staff assessed and identified mental and physical health risks and put plans in place to manage these.
- Staff managed and administered medicines safely. Prescribing practice met national guidance and good practice standards.
- The ward took part in the trust restrictive interventions reduction programme. Staff used de-escalation and low levels of restraint to manage incidents of aggression wherever possible.
- Staff at Maister Lodge had a dedicated debrief session at the end of each shift. Both wards received debriefing after serious incidents. They discussed incidents and lessons learned during handover and team meetings.

## Is the service effective?

**Good**   

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

# Wards for older people with mental health problems

- Staff at Maister Lodge completed good quality care plans. Patients had detailed personalised care plans that addressed mental and physical health needs.
- There was effective multi-disciplinary working with regular reviews of patients care and treatment. Each ward benefited from a range of appropriately trained specialists.
- Staff adhered to the principles of the Mental Health Act. Documentation was up to date and available on the wards.
- Staff received training in the Mental Capacity Act. Best interest decisions were well recorded where decisions were made about patients who lacked capacity.

However:

- The team records showed and staff confirmed that formal, individual clinical supervision did not always take place although staff received informal supervision.

## Is the service caring?

Good  ➡ ⬅

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

- Staff understood the needs of their patients and provided individualised care and treatment. They involved patients and their carers in decisions about their care.
- Patients and carers gave positive feedback about the care they received. We observed positive interactions between patients and staff.
- Staff supported patients in a caring way and treated them with kindness and respect. They acted in a professional manner and respected patients' privacy.
- Patients and carers had opportunities to give feedback about the care and treatment the service provided. This was through surveys, comment cards, and regular meetings.
- The service engaged with carers, holding regular carers meetings and inviting them to reception meetings and patient reviews. Carers said they felt supported.

## Is the service responsive?

Good  ➡ ⬅

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

- Patients could access a bed in their locality. Staff worked with the crisis team to arrange support packages to enable patients discharge to home wherever possible.
- Each ward was equipped to care and treat people with significant mobility issues. Disabled access was available on both wards including access to outdoor space. There was a range of equipment available to support patients' needs, such as sensor mats for those at risk of falls and assisted bathrooms.
- Patients had access to their bedrooms at all times of day and a locked space for their possessions. There was a range of rooms to promote dignified care to older people.

# Wards for older people with mental health problems

- Activities were available on both wards. Maister Lodge were committed to improving patient engagement by recruiting activity workers to ensure activities were available to patients all week.
- There was a good choice of food for patients including special dietary requirements whether that was for religious or health reasons or just personal choice.

However:

- Both wards experienced some delays in discharging patients, which they were unable to prevent. This was due to lack of availability of suitable placements for patients requiring ongoing care and delays with funding packages.

## Is the service well-led?

**Good**  

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

- The leadership and culture of the ward reflected the trusts vision and values. Staff provided high quality person-centred care and participated in reflective practice, which supported their learning.
- Senior managers had a good understanding of the service and governance systems and processes. They were committed to improving the environment at Maister Lodge and promoting best practice in dementia care.
- Staff morale had improved. Staff told us they felt valued, respected, and supported by their colleagues and managers and able to function as a high performing team.

However:

- The system and process for reporting formal supervision was not robust. This meant ward managers lacked assurance that staff were compliant with trust target rates for clinical supervision.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

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

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

Requires improvement  

## Key facts and figures

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

The Rapid Response Service is a single point of access into the trust's:

- community mental health services for adults
- inpatient services
- home based treatment
- improving access to psychological therapies
- counselling and psychology services
- early intervention teams
- addiction services
- trauma services
- eating disorder services
- perinatal services
- The service also signposts to third sector organisations and primary care.

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

From triage of referrals, the service provides urgent mental health assessment and mental health act assessments for people who are could be at risk to themselves or others including those at risk of severe self-neglect and those who are being considered for mental health hospital treatment. The service also provides non-urgent mental health assessments at assessment clinics across the Hull and East Riding areas and provides signposting to and information to people and organisations about other services that can be accessed in the local areas.

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

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

At the last inspection, the core service was rated as 'good' overall. We rated the key question 'safe' as 'requires improvement' and 'effective', 'caring', 'responsive' and 'well-led' as 'good'. At this inspection, we inspected all of the key questions. Our inspection was short notice 'announced' by one working day (staff knew we were coming) to ensure that everyone we needed to talk to were available.

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

During the inspection visit, the inspection team:

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

- Toured the care environments at the Rapid Response Service and place of safety at Miranda House and observed how staff were caring for patients
- completed four observations which included: a mental health assessment, a home based treatment appointment, an admission to the place of safety and a reflective practice session for staff
- interviewed the director and assistant directors of the care group with overall responsibility of the service
- interviewed eight other staff members including: service manager, team leader, consultant psychiatrist, approved mental health professional, nurses, social worker, health care assistant and a senior administrator.
- spoke with three former patients admitted to the place of safety
- spoke with three carers of patients using the Rapid Response Service
- spoke with two patients using the Rapid Response Service
- reviewed eight patient records of patients using the Rapid Response Service
- reviewed five patients records of patients who had used the place of safety
- reviewed a range of documents relating to the running of the service.

## Summary of this service

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

- The interview rooms used by the service were not properly maintained and were in poor condition. Chairs in the place of safety were soiled and required cleaning.
- The service had not ensured that all staff had received training in adult and paediatric basic and immediate life support. Staff did not receive training in managing violence and aggression. Staff training compliance rates for five mandatory training elements and appraisal rates for staff fell below the trust targets.
- None of the staff working in the service knew what a Freedom to Speak Up Guardian was or who performed this role. Two staff told us that they would be reluctant to raise concerns due to fear of retribution.
- The service had not undertaken or participated in clinical audits to assess the performance of the service.
- The service had escalated the high number of vacant posts to the trust risk register. Despite, the use of bank and agency staff, in six months a further 471 shifts were not filled.
- Staff had difficulty accessing information quickly when needed because the electronic patient record system was used inconsistently. The trust policy meant that staff would have difficulty in accessing medication for patients out of hours.
- We received variable feedback from patients using the Rapid Response Service and their carers. The service had limited engagement when making changes to the service and seeking feedback on the service with patients and carers.
- Patients using the place of safety were required to inform staff if they did not want their nearest relative to be provided with a copy of the information leaflet explaining their detention under the Mental Health Act.

However:

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

- The trust had refurbished the health based place of safety at Miranda House. Mental health assessments took place promptly and the average length of stay was less than 5 hours. The place of safety had a robust policy and information pack linked to national guidance.
- The Rapid Response service had a clear access and comprehensive criteria and process for the crisis, urgent and non-urgent mental health assessments of patients.
- Staff completed comprehensive mental health assessments for all patients. They agreed an immediate plan of care to meet assessed needs with patients.
- Managers ensured that staff received feedback from the investigations including lessons learnt, changes to practice and good practice identified.
- Staff monitored the physical health of patients in the place of safety to check for acute physical health warning signs. Staff providing mental health crisis services ensured that patients' physical health was monitored.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act.
- Observation of interactions between staff and patients showed staff treated patients with respect, compassion and acted in a supportive way.
- Staff had been invited to be involved and included in changes to the service. They had also taken part in development days which had resulted in the introduction of a service development and improvement plan.
- Staff had the opportunities for leadership development. Managers up to service manager levels were visible in the service and all staff felt they were approachable.

## Is the service safe?

**Requires improvement**   

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

- Despite addressing the breach of regulation from our last inspection, we found new concerns in relation to the maintenance of interview rooms used by the service. These were in poor condition and the chairs in the place of safety were soiled and required cleaning.
- The service had not ensured that all staff had received training adult and paediatric basic and intermediate life support or training in managing violence and aggression. They did not ensure that staff were up to date with all of the mandatory training elements. Five courses fell below 75% completion rate.
- The vacancy rate for staff was above the trust average and the service had escalated difficulties in recruiting staff to the trust risk register. In a six month period, agency and bank staff filled 1034 shifts however, a further 471 shifts were not filled.
- Staff could experience difficulties in accessing medication for patients out of hours due to the trust's policy and procedure.
- Staff had difficulty accessing information quickly when needed because the electronic patient record system was used inconsistently. This meant that information was not always stored in the places it should be in the patient records.

However:

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

- The trust had refurbished the health based place of safety at Miranda House. This was now fit for purpose and met the requirements of the Mental Health Act 1983 code of practice and the guidance from the Royal College of Psychiatry on Section 136 standards.
- All of the eight patient records reviewed contained comprehensive and up to date risk assessments. The service had a robust risk assessment process for patients in the health based place of safety.
- Managers ensured that staff received feedback from the investigations including lessons learnt, changes to practice and good practice identified.
- Staff monitored the physical health of patients in the place of safety to check for acute physical health warning signs. Staff providing mental health crisis services ensured that patients' physical health was monitored.
- Staff understood how to protect patients, adults and children at risk of significant harm. They knew how to identify safeguarding issues and how to escalate these.

## Is the service effective?

Good   

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

- The service had gone through a transformation since the last inspection. Since the formation of the rapid response service, they had implemented standardised operating procedures for the rapid response service and health based place of safety which linked to guidance from the National Institute of Health and Care Excellence.
- Staff completed comprehensive mental health assessments. They agreed an immediate plan of care to meet assessed needs with patients.
- Staff used recognised tools to assess the severity of side effects of medication and the use of substances and alcohol.
- The service had a local induction to introduce staff including bank and agency to the service and assess their competencies.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act. They demonstrated that they followed the principles of legislation and guidance in practice.
- The service had a robust section 136 pack linked to guidance and templates which provided staff with all of the tools required.

However:

- Records relating to the place of safety were incomplete with missing information including: GP details, evidence whether patients had been informed of their rights and the departure time of the police.
- The service had not undertaken or participated in clinical audits to assess the performance of the service.
- Appraisal rates for medical staff (62%) and non- medical staff (79%) fell below the trust target of 85%.
- Feedback from agencies outlined barriers to interagency working around communication with the service and access to information.
- Patients using the place of safety were required to inform staff if they did not want their nearest relative to be provided with a copy of the information leaflet explaining their detention under the Mental Health Act.

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

## Is the service caring?

Good  → ←

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

- Observation of interactions between staff and patients showed staff treated patients with respect, compassion and acted in a supportive way. They worked flexibly to accommodate patients.
- Staff captured patients' views and their preferred options for treatment interventions during mental health assessments and agreed immediate plans of care involving patients.
- Staff provided patients admitted to the place of safety with information to explain information they needed to know about what would happen and their rights under section 136 of the Mental Health Act.
- Patients had copies of their care plans and were aware of what information they contained.

However:

- We received variable feedback from patients using the Rapid Response Service and their carers.
- Staff did not always ensure carers understood that they could have a carer's assessment.
- The trust had only sought the views of a few patients and their carers across a number of months to gain feedback on the service.

## Is the service responsive?

Good  → ←

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

- The Rapid Response service had a clear access and comprehensive criteria and process for the crisis, urgent and non-urgent mental health assessments of patients. The service performed in line with trust targets.
- The average length of stay at the place of safety was under five hours and the average wait for mental health assessment was two and a half hours.
- The trust had improved the access to the place of safety. It had a dedicated entrance which meant patients had privacy on their arrival and entrance to the place of safety.
- The service gate kept access to a dedicated crisis pad in the local area.
- Staff could provide a range of information to patients using the place of safety. Patients accessing Miranda House could access a range of information available in the waiting area. Staff could access information in different languages, interpreters and signers when required.
- The amount of complaints the service received had reduced since the last inspection. Staff told us that the trust investigated complaints and fed back information to staff and the complainant. Patients who used the place of safety received information on how to make a complaint.



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

## Is the service well-led?

**Requires improvement** ● ↓

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

- None of the staff up to care group director level knew what a Freedom to Speak Up Guardian was or who performed this role. Two staff told us that they would be reluctant to raise concerns due to fear of retribution.
- The service did not participate in clinical audits to assess the performance of the service and identify actions to improve.
- The service had limited engagement with patients and carers to seek feedback on the service and involve them in changes.

However:

- Staff had been invited to be involved and included in changes to the service. They had also taken part in development days which had resulted in the introduction of a service development and improvement plan.
- Staff had the opportunities for leadership development. Managers up to service manager level were visible in the service and all staff felt they were approachable.
- Managers worked with human resources and within trust policies to address poor staff performance.
- Staff met regularly with managers where they discussed the outcome of investigations of complaints and incidents to understand and share good practice, lessons learnt and changes.
- Performance reports showed quantitative data in a dashboard. This tracked performance over time and rating assurance levels for managers and staff.

## Areas for improvement

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

# Wards for people with a learning disability or autism

Good



## Key facts and figures

Humber NHS Foundation Trust provide three inpatient wards for people with a learning disability or autism. All three units are located at Townend Court in Hull.

Townend Court has been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

Townend Court is a purpose built inpatient service, which is able to provide care to a maximum of 20 male or female patients. The location is split into three units:

- Willow ward has six beds and cares for male or female patients who are in the initial stage of assessment and need the most support such as people who have complex or challenging behaviour. At the time of the inspection, four patients were admitted.
- Lilac ward has eight beds and provides longer term assessment and treatment for male or female patients. At the time of the inspection, five patients were admitted.
- Beech ward has six beds and provides development of enablement skills with patients nearing discharge. At the time of the inspection, four patients were admitted.

All wards were able to admit patients who were detained for treatment under the Mental Health Act (1983), or those with Deprivation of Liberty Safeguards in place. The service also cared for patients who had capacity to stay at the units informally.

We carried out Mental Health Act monitoring visits at Townend Court in February 2017 and twice in June and July 2016. Following these visits, the trust provided action statements telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously inspected Townend Court in April 2015 and we found some areas for improvement. We rated the service as requires improvement in three key questions (safe, effective and well led) and rated the service as 'good' in caring and responsive at that inspection.

This inspection completed 12 – 14 September 2017 was unannounced (staff did not know we were coming) and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

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

During the inspection visit, the inspection team:

- visited all three wards in the Townend Court unit, looked at the quality of the environments and observed how staff were caring for patients
- spoke with seven patients who were using the service, and reviewed their comments on five feedback cards
- spoke with eight carers of patients who were using the service

# Wards for people with a learning disability or autism

- spoke with the care group director, service manager, modern matron and responsible clinician
- spoke with 16 other staff members including nurses, healthcare support workers, psychologist, social worker, occupational therapist and speech and language therapist.
- looked at the care and treatment records of 11 patients
- reviewed medication management including the medication administration records of all 13 patients
- attended and observed three meetings including ward handovers, and a multi disciplinary meeting
- looked at policies, procedures and other documents relating to the running of the service.
- carried out an observation using the short observational framework for inspection.

## Summary of this service

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

- The trust had acted upon our feedback from our previous inspection of this service and there had been improvements in the quality of patient care.
- Safety was high priority for staff and the leadership team. There were measures in place to ensure the safety and quality of the service was monitored and that any changes required were acted upon in a timely manner. Patient risk was closely monitored and risk assessments updated on a regular basis. Staff protected patients by reporting incidents and raising safeguarding concerns.
- Patients received effective care and treatment. Staff were trained in the Mental Health Act and Mental Capacity Act and worked to their principles. Care plans were holistic and highly personalised and contained the voice of the patient. Patient needs and wishes were clear, and all patients had a clear discharge plan.
- The staff team were passionate about ensuring patients had a voice and were involved in the service. We observed staff who were kind, caring, respectful and compassionate. Staff made efforts to communicate with patients in complex circumstances and provided high quality individualised care for all patients. Patients and carers spoke highly of the service and the staff team.
- The service was responsive to the needs to patients. The service was tailored to ensure each patient was treated as an individual and services were delivered according to patients' individual needs and choices. The staff team were significantly focussed on patient discharge and had found innovative ways to ensure patients could be safely discharged from hospital settings and enabled to live fulfilling lives in the community. The service ensured that patients were able to maintain close relationships with people who were important to them.
- The service was well-led. The staff team spoke highly of senior leaders and told us that they felt respected and valued. Governance systems in place ensured the safety of staff and patients. The service was focussed on continuous improvement and encouraged staff to take part in research and specialist training opportunities to enhance their skills and increase the quality of patient care. Staff spoke of a culture which was open, honest and supported them in their role.

However:

- The service continued to have difficulties with meeting optimum safe staffing establishment levels.

# Wards for people with a learning disability or autism

- Although the overall mandatory training rate for the service was 76%, not all staff had completed all of the required areas of mandatory training. Where the service was reliant on temporary staff, the trust did not ensure that these staff were trained to the same level of permanent staff to ensure the safety of patients.
- Areas of the ward which contained ligature points were not entirely risk assessed.
- The service allowed outpatients to use inpatient clinic rooms and this was not risk assessed or discussed with patients.
- Staff did not always adhere to guidance in the Mental Health Act and Mental Capacity Act Codes of Practice. This meant that seclusion and long term segregation reviews were not always completed on time, and that one patient did not have a best interests meeting for a restrictive care plan.
- Some areas of the units required re-decoration and were not entirely clean.

## Is the service safe?

**Requires improvement**   

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

- The service was not entirely safe for patients. Not all staff had undertaken mandatory training. The overall mandatory training compliance level was 76% for the core service which was above the trust total of 74%. However training levels in some areas were below 75%. There had been an improvement in the completion of mandatory and specialist training including courses suitable for staff working with people with learning disabilities and autism since the time of our last inspection when the overall compliance rate for the service was 72%.
- The service did not always meet optimum planned staffing levels. Although managers stated that there was not a risk to patients as staff who were supernumerary (managers and multi disciplinary team staff were not included on the staffing rotas), they did tell us that this had an impact on the ability of staff to complete training and supervision. The wards relied on bank staff to support shifts with low staffing levels. Bank staff were not trained to the same high standard as permanent staff.
- We identified ligature risks in the unlocked communal dining areas that were not included on the service's ligature risk assessment. Patients accessed these areas without supervision. However patients at increased risk had detailed risk assessments and increased levels of observation.
- Staff had not ensured that all the required equipment was fit for purpose in emergency grab bags, some items were out of date. However the trust had changed the ordering procedure temporarily and the service was aware of the issue.
- Staff allowed outpatients to use the Lilac ward clinic room for procedures and examinations and had not considered the privacy, dignity and risks this posed for current inpatients.
- Four out of five patients on Lilac ward had care plans in place for the use of as required medications.
- Staff did not always undertake reviews of patients in seclusion and long term segregation on time in line with the Mental Health Act Code of Practice.

However:

- Some areas of the safety of the service had improved since our last inspection in April 2015, because service managers were more aware of risks to patients and staff and the safety of the service and regularly reviewed and made changes to reduce these.

# Wards for people with a learning disability or autism

- All patients had up to date risk assessments which staff completed using a recognised risk assessment tool.
- Staff recognised safeguarding concerns and dealt with them in accordance with procedures.
- Service managers reviewed all uses of restrictive interventions and gave feedback to staff when improvement was needed. The service encouraged external professionals to undertake reviews of long term segregation to ensure the oversight of patient safety.
- The units were compliant with Department of Health guidance and the Mental Health Act Code of Practice on eliminating mixed sex accommodation.
- All patients told us that they felt safe and that their possessions were safe. Carers were not concerned about the safety of their relative.
- Staff were aware of duty of candour legislation and were able to explain its meaning.
- Senior managers had undertaken detailed reviews and analysis of serious incidents and had shared learning with the staff team and with the wider trust.

## Is the service effective?

**Good**  

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

- All patients had up to date care plans which were detailed and highly person centred. All patients had been provided with copies of their care plans in an easy read format.
- The service employed a nurse who was responsible for ensuring all patients' physical healthcare needs were met. All patients had health action plans and health improvement profiles. The physical health of patients was high priority for staff,
- Staff had the necessary skills and specialist training to support patients with learning disabilities and autistic spectrum disorder.
- The service provided patients with care in line with national best practice guidance, and monitored patient outcomes using recognised ratings scales.
- Staff had completed capacity assessments and undertaken best interests discussions when patients did not have capacity to make specific decisions about their care and treatment.
- Patients were supported by a highly skilled on site multi disciplinary team who worked together to produce detailed care plans for patients which were holistic.

However:

- Patients' paperwork in relation to their detention under the Mental Health Act was disorganised. However, practice in relation to the Mental Health Act and Mental Capacity Act had improved since the last inspection. Staff had been trained and knew the basic principles of both Acts. Senior staff undertook detailed audits and we saw evidence of improvements being made after audits.
- The levels of supervision had reduced and staff felt that they needed more access to supervision.

# Wards for people with a learning disability or autism

## Is the service caring?

**Outstanding**  

Our rating of caring improved. We rated it as outstanding because:

- Patients, and their relatives and carers were positive about the care staff provided and held staff in high regard. Carers told us that the support of the service was excellent had improved the lives of patients and their families.
- We observed that staff working at the service were exceptionally caring, and we observed highly kind and compassionate interactions between patients and staff because all levels of staff took the time to get to know patients and communicate with them.
- There was a very strong, visible person centred culture. Staff were highly motivated to ensure that patient voices were heard and that their needs and wishes were very clear in the planning of their care.
- The service was passionate about patients being involved in the service including in the recruitment of staff.
- Care delivered ensured the entirety of patients' needs was equally important.
- Patients had access to a wide range of equipment and activities which was highly individualised to meet patient's needs.
- Patients were always treated with dignity and respect and the service took steps to ensure the dignity of patients was continually reviewed and monitored.
- Carers felt very involved and informed about the care of their relative and were invited to be part of all decision making.
- The service had employed a patient involvement lead who was supporting patients to voice their feedback through community meetings and advocacy. This staff member planned to increase their work to include carers.

## Is the service responsive?

**Outstanding**  

Our rating of responsive improved. We rated it as outstanding because:

- The service was specifically tailored to ensure each patient was treated as an individual and services were delivered according to patients' individual needs and choices.
- The service had a very clear admission process and professionals worked together to assess a patient's suitability for treatment.
- Discharge was embedded from admission to the service. Patients had clear discharge plans with actions to be achieved. Staff had written highly individualised service specifications for patients with complex needs to ensure the correct package of care could be delivered in the community to reduce the likelihood of readmissions to the service. This included arrangements to set up specific community accommodation for current patients.
- Staff went the extra mile to reduce and prevent hospital admissions and the use of other services in crises by providing a 24 hour telephone contact to people with learning disabilities in the local community.

# Wards for people with a learning disability or autism

- People with highly complex needs were offered the same opportunities as other patients such as access to activities and outings into the local community. Staff worked hard to ensure that patients with complex needs were not disadvantaged.
- The service had developed individual areas of care for patients who were unable to tolerate sharing spaces with other patients. Patients being cared for in these areas had very person centred care plans to work towards being cared for in a less restrictive setting in the future.
- Staff ensured that contact with people who were important to patients was high on their agenda. They found innovative ways to ensure contact was achieved and valuable. Patients and their families told us how much this had improved their lives.
- The service had received one complaint from two patients in relation to their feelings about being treated disrespectfully. The service supported patients to make this complaint officially and responded to them with a written apology in an easy read format. This meant that patients felt respected and valued and that the service had taken their feelings and opinions seriously and acted upon them.
- Staff were very passionate about being able to communicate well with patients. They provided accessible communication aids and staff learnt new ways to enhance their communication skills with the support of speech and language therapists who were highly trained in intensive interaction techniques.
- Some patients had voluntary employment on the wards, they enjoyed this and it gave them skills and enhanced their self esteem.

## Is the service well-led?

**Good**  

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

- There had been an improvement in the overall governance of the service since the last inspection. Incidents and risks were routinely monitored and acted upon. Areas for improvement had clear time limited action plans.
- The leadership team had a clear strategy for the service, and were aware of concerns and risks within the service. Where we identified issues during the inspection, the service had already recognised these areas and had plans in place.
- Staff were aware of the values of the trust and we saw that plans were in place to share the strategy for the service with the staff team and encourage them to input into it.
- Staff felt supported and valued and spoke positively about the leadership team. Staff felt able to raise concerns without fear of victimisation. Although the staff team felt stress at times, they spoke of a teamwork ethos within the service.
- There was a compassionate and caring culture at the service, where staff and patients were encouraged to input into the service.
- The management of risk was high on the agenda for the focus of the senior leadership team. The care group director was also aware of the risks for the service and their concerns matched the concerns at service level. Concerns relating to the service were on the corporate risk register.
- The service used a variety of tools and audits to measure the quality of the service and identified themes and trends from this data to continually improve the service.

# Wards for people with a learning disability or autism

- Systems were in place to ensure staff could share relevant information about risks and safeguarding concerns with other organisations.
- The service had patient involvement and engagement high on the agenda to ensure they were able to contribute to the service.
- Managers supported staff to take part in research and specialist training to enhance their skills and improve the service.

However:

- The trust had not ensured that all staff were able to undertake mandatory training and take part in regular supervision due to the high levels of vacancies on the ward. However there was an ongoing recruitment programme for qualified nurses.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

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



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

Good  

## Key facts and figures

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

Hawthorne Court is an 18-bed rehabilitation and recovery inpatient unit with a controlled access and exit via an airlock. It provides a specialist assessment, care, treatment and rehabilitation service for adults experiencing severe and enduring mental illness. The ward has a self-contained flat, used to assess patients for independent living before moving on to living in a community setting.

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

We previously inspected Hawthorne Court in April 2016. We rated the service 'requires improvement' overall and found that the service was in breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014, person-centred care. We also carried out Mental Health Act monitoring visit to Hawthorne Court in October 2016. Following these visits, the trust provided action statements telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We inspected the whole service looking at all five key questions.

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 6 patients who were using the service
- spoke with 2 carers of patients who were using the service
- spoke with the acting ward manager and senior managers
- interviewed 7 staff including healthcare assistants, nurses and nursing associate trainee, and pharmacist ,
- reviewed 6 care records of patients
- reviewed 18 patient medication charts
- attended and observed 3 meetings including ward handover, recovery meeting and referral meeting
- carried out a specific check of the medication management on all wards

looked at policies, procedures and other documents relating to the running of the service

## Summary of this service

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

- Patients told us that they felt safe on the ward and that staff were kind, helpful and supportive.

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

- The ward took part in the trust restrictive interventions reduction programme. Staff did not seclude patients and used de-escalation and low levels of restraint to manage incidents of aggression.
- Staff managed medications safely and made sure that the ward had enough medication available in case of an emergency.
- There was an effective multi-disciplinary team. Patients had access to a psychiatrist and a range of appropriately trained specialists who provided treatment, activities and therapies that focused on rehabilitation.
- Staff had improved the quality of the patient care plans. Patients were involved in their own care, and care plans were personalised and recovery-focused.
- The service was now admitting patients to the ward with an identified rehabilitation and recovery need. Staff provided an outreach service and worked closely with community teams to support successful discharges. Staff ensured that patients had access to opportunities in the local community, such as training and work skills.
- The leadership and culture of the ward promoted the delivery of high quality, person-centred care. Staff behaved in a way that was consistent with the trust's vision and values. Managers had acted to sustain the required improvements from the previous inspection.

However:

- The ward relied on bank and agency staff and staffing levels were often below the required establishment. Mandatory training rates for basic life support was low and the rotas did not identify how many staff on each shift had completed life support training. Staff did not always document that they carried out checks on resuscitation equipment.
- Staff did not document up to date patient risk assessments and safety plans or share information about risks consistently at their daily handovers

## Is the service safe?

**Requires improvement** ● → ←

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

- Although the service had improved to meet the one regulation it failed to meet at the last inspection, we found two breaches of regulation at this inspection.
- Staff did not complete a recognised risk assessment tool when patients were admitted to the ward. The electronic system was not ready to support staff to complete risk assessments and staff did not keep all risk assessments up to date.
- The service did not have enough staff and relied on bank and agency staff and regular staff to fill the shifts. There were gaps in staffing which meant sometimes staff cancelled patient activities and individual staff clinical supervision was difficult to arrange.
- Mandatory training rates were low in some areas. In particular, not enough staff completed training in basic life support limiting the number of staff who could respond to a medical emergency.
- Staff did not fully record physical health after they restrained one patient to give an intra-muscular injection.
- Staff did not consistently document that they carried out checks on resuscitation equipment.
- The electronic recording system did not generate an electronic signature for all staff when they documented electronic patient notes.

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

However,

- The ward had an up to date and comprehensive environmental ligature risk assessment.
- Patients said they felt safe on the ward and they could access staff support when they needed to.
- The ward ensured the proper and safe use of medicines. Staff managed medicines consistently and safely and prescribing met good practice standards in relation to national guidance.
- The ward took part in the trust restrictive interventions reduction programme, Staff did not seclude patients and used de-escalation and low levels of restraint to manage incidents of aggression.
- Staff understood their responsibilities to report safeguarding issues and incidents. Staff shared lessons learned and took action to keep patients safe and support staff

## Is the service effective?

Good   

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

- Staff involved patients in planning their care and ensured the plans were personalised and recovery focused. Care plans included information about physical health needs.
- There was a range of appropriately trained specialists in the team who provided treatment, activities, and therapies that focused on patients' rehabilitation.
- Staff received regular appraisals and accessed a range of opportunities for peer support and supervision.
- Staff had effective working relationships with outside organisations that supported patients' care and treatment plans.
- Training compliance in the Mental Health Act and Mental Capacity Act was high and patients had easy access to the Independent Mental Health Act and Mental Capacity Act advocates.

However,

- Staff did not consistently document evidence that they offered patients a copy of their care plan.
- Staff did not maintain compliance with the trust policy for formal individual clinical supervision.
- Staff did not share information consistently at their handovers.
- Staff did not consistently document capacity assessments and best interest decisions when a patient lacked capacity.

## Is the service caring?

Good  

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

- The ward had improved to meet the one regulation it failed to meet at the last inspection
- Staff fully involved patients and their carers in their recovery meetings and decisions about their care.

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

- Staff were kind, caring, and compassionate to patients. They respected patients' privacy and treated them in a friendly yet professional manner.
- Patients and carers gave positive feedback about the staff.
- Staff offered patients visits to the ward before they were admitted, and provided them with a tour and a welcome book.
- Staff encouraged patients to give feedback about the service in a variety of ways.

However;

- People could potentially view confidential patient information displayed in the ward office

## Is the service responsive?

Good  → ←

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

- Staff ensured that patients received personalised care and took account of their individual needs and choices.
- Staff focused on patients' rehabilitation and recovery and provided an outreach service that supported successful discharges.
- All patients had individual electronic key access to their bedrooms and all bedrooms had facilities where patients kept their possessions securely.
- All patients had a risk and relapse plan, developed with the community team, in place before they were discharged.
- Staff and patients had access to a range of rooms and equipment to support patients' treatment and rehabilitation needs.
- Patients told us that the food was of good quality.
- Staff ensured that patients had access to opportunities in the local community such as training and work skills.
- The ward displayed information on how to complain on notice boards and in the patient welcome pack.

## Is the service well-led?

Good  → ←

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

- The leadership and culture of the ward promoted the delivery of high quality person-centred care
- Staff focused on the needs and the experiences of people who used the service and behaved in a way that was consistent with the trust's vision and values.
- Senior managers had a clear vision about how they planned to maintain high quality and sustainable care
- Managers had acted to sustain the required improvements from the previous inspection. This had improved the patients' experience of their recovery meetings.

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

- The manager had a good understanding of the systems and processes that gave oversight to ward performance and the quality of the service.
- Staff worked well together and took action to make sure they had enough support when they needed it.

However:

- Managers still did not make sure all staff received training and individual clinical supervision to meet trust targets.
- Staff morale varied due to the low staffing and did not feel actively engaged or empowered to make improvements to the service delivery.
- Some information about the ward was out of date or incorrect

## Areas for improvement

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

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

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

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

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

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

# Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led this inspection. We had access to executive reviewers on this inspection, one who was a director of nursing and one who was a medical director. We also used two specialist advisors, who were leads in safeguarding and equality and diversity

The inspection team covered nine core services and included 10 inspectors one inspection manager, a Mental Health Act reviewer, an analyst, a member of CQC mental health policy team, two pharmacists, specialist advisers, and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.