Humber NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Avondale Westlands Newbridges Mill View Court Psychiatric Intensive Care Unit	RV945 RV933 RV934 RV942 RV945
Wards for older people with mental health problems	Maister Lodge Mill View Lodge	RV938 RV942
Long stay/rehabilitation wards for working age adults	Hawthorne Court St Andrew's Place	RV941 RV980
Forensic/Inpatient secure wards	Willerby Hill	RV936
Wards for people with learning disabilities or autism	Townend Court	RV915
Mental health crisis services and health based places of safety	Willerby Hill Miranda House	RV936 RV945
Community based mental health services for adults of working age	Willerby Hill	RV936
Community based mental health services for older people	Willerby Hill	RV936
Community mental health services for people with learning disabilities or autism	Willerby Hill	RV936
Specialist community mental health services for children and young people	Willerby Hill	RV936

Summary of findings

Community end of life care	Willerby Hill	RV936
Community health services for children, young people and families	Willerby Hill	RV936
Community health inpatient services	East Riding Community Hospital Whitby Hospital Withernsea Community Hospital Bridlington & District Hospital	RV9HE RV9X8 RV913 RV9X3
Community health services for adults	Willerby Hill	RV936
Substance misuse services	Willerby Hill	RV936
Urgent care services	East Riding Community Hospital Alfred Bean Hospital Whitby Hospital Withernsea Community Hospital Bridlington & District Hospital	RV9HE RV917 RV9X8 RV913 RV9X3
Adult Social Care	Granville Court	RV929
Out of Hours services	East Riding community Hospital	RV9HE

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We rated Humber NHS Foundation Trust as requires improvement overall because:

- The trust used restrictive interventions and practices in its mental health services in ways that did not comply with best practice or with the Mental Health Act 1983 and its code of practice. Staff did not have the proper safeguards in place when they subjected patients to seclusion or long-term segregation. Seclusion rooms and places of safety did not meet best practice guidelines.The trust policy on rapid tranquilisation was not up to date and staff did not always record its use or undertake the procedure safely. In particular, they did not always undertake the appropriate physical health checks.Staff restrained patients in a prone (face-down) position but did not always report it.Staff in forensic services still supervised all patients when they opened their mail - two years after being told that this was inappropriate.
- The trust did not always assess risks to patients and take action to eliminate or reduce them. It did not have effective systems and processes to support learning from incidents of harm or risk of harm across the organisation and to prevent them happening again.
- Staff vacancy rates were high in some services and a number of teams were operating below agreed staffing levels.This was a particular problem in mental health crisis services, the health-based places of safety, the five district nursing teams and seven community health services neighbourhood care teams.
- The trust did not ensure that its staff undertook basic training or received support for personal development.Staff compliance with training that the trust had deemed mandatory was only 61%; well below the trust's target of 75%. Fifty per-cent of staff had not received recent training in the Mental Capacity Act.The trust had kept a central record of how many staff had received recent training in the Mental Health Act but all of the training had not been recorded.The trust scored below the national average in the 2015 NHS staff survey on the number of staff reporting that they had been appraised in the last 12 months.
- Senior managers had not updated or put into effect a number of important policies and procedures that should have ensured a consistent approach to providing safe, caring, effective and responsive services. Their approach was, at times, chaotic. The trust's mechanism for assuring and improving the quality of care was not consistent at team, service and trust board levels. However, there was some good practice in teams in each service except acute admission wards.
- Although the trust had made significant progress since our previous comprehensive inspection in addressing concerns about services for children, young people and families and in community health services, they had failed to make the same progress in mental health services.

However

- The trust had a duty of candour policy dated December 2015. The policy guided staff understanding of the duty be open and honest with patients when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The trust was adhering to the principles of duty of candour.
- The trust provided good checklists and forms to ensure that correct papers were available on the wards for each detention under the Mental Health Act. Detention papers showed that there had been appropriate medical and administrative scrutiny to ensure that where patients were detained under the Mental Health Act, each detention was supported by a full set of well-completed detention papers. The section 17 leave forms (covering arrangements for leave for patients detained under the Mental Health Act) were completed, with clear conditions.

Summary of findings

- Across all services we visited, we observed positive interaction between staff and patients. We saw that patients were treated with kindness, dignity and respect, and were supported. Staff were committed to their roles and compassionate about the patients they were caring for.

The provider needs to take significant steps to improve the quality of its services and we find that it is currently in breach of regulations. We served the trust with a warning notice, giving the trust until 14 June to produce an action plan describing how it would improve services. The trust produced the plan before the deadline.

The warning notice related to three main issues:

- Arrangements for overseeing and improving the use of rapid tranquilisation were not effective and on occasion staff used rapid tranquilisation of patients inappropriately.
- Seclusion and long-term segregation of patients was not in line with the Mental Health Act code of practice. Monitoring checks were not effective and the senior team and staff did not ensure that safe care was being provided to patients in seclusion.
- In forensic services, staff supervised all patients when opening their mail rather than supervision being based on individual risk assessments. Arrangements for monitoring patients' mail were inappropriate.

We will be working with the trust to assist them in improving the standards of care and treatment

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Inadequate 

We rated safe as inadequate because:

- Staff across all seven forensic wards supervised patients while they opened their mail as a matter of routine. Following the last CQC inspection in 2014, we told the trust that staff should do this only in exceptional circumstances and based on an assessment of risk for the individual patient. At this most recent inspection, we found that the trust had not changed its practice. This practice compromised patients' privacy and dignity.
- Seclusion practices and procedures were poor. In acute services, we reviewed 23 seclusion records. We also undertook a seclusion review at Newbridges. In five of the seclusion episodes, staff had not ended seclusion despite the patient having been 'settled' for a significant period. Exit plans for termination of seclusion were not evident in any of the seclusion records that we reviewed in acute services. Basic care plans for seclusion were in place, but they did not detail what the patient needed to do, or what behaviour or settled period was required to end seclusion. Nursing seclusion reviews took place in acute services. However, in a number of records, one qualified nurse and one health care assistant had undertaken these when the Mental Health Act code of practice requires two qualified nurses to do them.
- Staff did not follow best practice guidance in relation to rapid tranquilisation. There was no record of any physical health monitoring. We looked at six prescription charts on Newbridges, Westlands and Avondale wards and four indicated use of rapid tranquilisation. The physical health monitoring of the patients was not carried out The trust had not reviewed the policy at the time of our inspection on 11 April 2016. We found a lack of understanding about the guidance on rapid tranquilisation among the nursing staff we spoke with.
- The trust had not ensured that all wards had the necessary emergency medicines. Some wards did not stock the medicines that the trust resuscitation policy said were essential. This included medicines that might be required in a physical health emergency when rapid tranquilisation was used. On three of the wards we visited, rapid tranquilisation had been used. However there was no flumazenil available as stated in the current trust policy.

Summary of findings

- It was not clear that the trust had a restrictive intervention programme led by a board member. However, there were references in minutes relating to forensic services of work being undertaken to reduce restrictive practices. We concluded that the trust were not fully aware of how much prone restraint was being used. There were 121 reported uses of restraint on 72 different services users between 1 November 2015 and 31 March 2016. Initial information provided by the trust showed that none of these incidents resulted in the use of prone (face down) restraint. However, we found that staff in the acute services had been using prone restraint but the trust recording systems had not identified this.
- Within the health-based place of safety, there was a lack of provision to adequately maintain people's privacy, dignity, and confidentiality and risks that meant it did not meet the Mental Health Act 1983 revised code of practice and guidance from the Royal College of Psychiatrists. There were potential ligature points (places to which patients intent on self-harm could tie something to strangle themselves) in the health-based place of safety.
- Staff vacancy rates were high in some services and teams were operating below agreed staffing levels. Mental health crisis services and the health-based places of safety had the highest qualified nursing vacancies with 23%. Five district nursing teams had qualified nurse vacancy rates above the trust average of 11.6%. The highest of these was the Withernsea team, with a rate of 28% (2.3 whole-time equivalent staff). Within community health services, seven of the neighbourhood care team areas were operating below the established staffing levels identified by the trust. One serious incident in relation to a grade four pressure ulcer had also identified poor district nursing caseload management as a contributory factor. Five district nursing teams had qualified nurse vacancy rates above the trust average of 11.6%. The highest of these was the Withernsea team, with a rate of 28% (2.3 whole-time equivalent staff).
- One learning disability unit was not fully compliant with Department of Health guidance on mixed sex accommodation. It did not have separate sleeping areas but we were told that no female patients were residing there.
- The current training compliance for trust-wide services was 61%, set against a target of 75%. Data supplied by the trust showed that it had not reached its 75% compliance rate for mandatory training in any month in the preceding 12.
- The trust was unable to comply with the recommendation that medicines reconciliation should be completed within 24 hours

Summary of findings

of admission (NICE 2015: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes). The trust had identified this as a risk and placed it on the risk register. However, the principle pharmacist (clinical services) told us there was no rolling audit programme to monitor compliance with this standard. Pharmacy staff checked (reconciled) people's medicines on admission to some wards but the process for reconciling and reviewing medicines was not robust. A transcription error at Withernsea community hospital had resulted in a patient receiving a lower dose of medicine than intended for 23 days. Another intervention had been written in a handover book seven times over a period of 28 days but had still not been resolved on the day of our inspection.

- We saw that staff in some neighbourhood care teams that we visited did not have access to all the basic equipment they needed. For example, these services were sharing two thermometers between the whole neighbourhood care teams.
- Ward activities and, at times, escorted leave needed to be cancelled due to staff shortages.

However:

- The trust had a duty of candour policy dated December 2015. The policy guided staff understanding of the duty be open and honest with patients when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The trust was adhering to the principles of duty of candour.
- The trust acknowledged challenges in recruitment and retention. The trust had conducted an internal audit that looked at and addressed recruitment arrangements to employ more staff within the trust. Each issue was positively controlled and linked to an action plan

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Outcomes for patients were below expectations when compared to similar services. The trust had participated in the 2014 National Audit of Schizophrenia. The trust developed an action plan from the results, which saw them in the bottom 10% of mental health trusts. Throughout 2015, the trust had taken part in 26 clinical audits but there was a gap in audit

activity for 2016. Failure to establish a robust approach to audit with particular reference to the National Institute for Health and Care Excellence (NICE) guidelines resulted in this issue being placed on the trust risk register.

- In the NHS Staff Survey 2015, 79% of staff said they had been appraised in the last 12 months compared to a national average of 91%. This score had reduced by 14 percentage points since 2014.
- Training in the Mental Health Act was not mandatory for staff at the trust. Only 99 of the trust's 2501 staff had completed Mental Health Act training. Mental Capacity Act training was part of the mandatory training set but overall compliance across the trust was 50% compared with the trust target of 75%.
- Assessment of needs and planning of care was variable in the mental health services. In the substance misuse service, there were no personalised, holistic or recovery-orientated plans. There were care plans in 20 of the 28 records we looked at in substance misuse services, 11 of which were more than three months out of date. In the wards for people with a learning disability, care plans were not always reflective of patients' holistic needs, objectives and recovery goals Multi-disciplinary working was not fully embedded as part of patients' treatment and recovery.
- Not all the information needed to deliver care was available to staff when they needed it. The trust used a number of paper and electronic systems that did not talk to each other. This resulted in duplication of work, some information being unreliable, and those working remotely not always being able to access information they required.

However:

- In community health services inpatients, patient care was personalised in line with patient preferences and with individual and cultural needs. The service engaged with the local population when planning new services. This ensured flexibility, choice and continuity of care. Each member of the multidisciplinary team (of doctors, nurses, therapists and other staff) completed comprehensive assessments of patients, discussed their progress at daily team meetings and communicated in a timely manner with patients and their families.
- The trust provided their General Medical Council (GMC) revalidation information broken down by team and all teams were 100% compliant. Revalidation is the process of confirmation by professional bodies that staff are up to date with their skills and continue to be fit to practice in the UK.

Summary of findings

- There was effective multidisciplinary team working across the trust. In community health services, staff of all types worked well together across all teams. In acute mental health services, multidisciplinary team meetings took place weekly on all the wards. This gave professionals involved in patient care the opportunity to discuss the treatment provided to patients and any possible changes. We were unable to observe any multidisciplinary meetings but we saw documentation that showed that they were attended by a range of professionals.
- Staff in community health services obtained consent to care and treatment from patients in line with legislation and guidance, including the Mental Capacity Act 2005.
- Uptake of primary immunisations in 2014- 2015, was 98%. This was above the England average of 94%. Immunisation rates for measles, mumps and rubella (MMR) were comparable with the England average at 96% for first dose and 93% for the second dose uptake. School aged immunisation uptake rates were above 85%, apart from the flu pilot, which was 69%. Uptake of the human papilloma virus (HPV) vaccine was 88%, which was above the England average of 86% in 2013/14.
- The trust provided good checklists and forms to ensure that correct papers were available on the wards for each detention under the Mental Health Act. Detention papers showed that there had been appropriate medical and administrative scrutiny to ensure that where patients were detained under the Mental Health Act, each detention was supported by a full set of well-completed detention papers. The section 17 leave forms (covering arrangements for leave for patients detained under the Mental Health Act) were completed, with clear conditions.

Are services caring?

Good

We rated caring as good because:

- Across all services we visited, we observed positive interaction between staff and patients. We saw that patients were treated with kindness, dignity and respect, and were supported. Staff were committed to their roles and compassionate about the patients they were caring for.
- Staff knew patients well and understood patients' needs, working with them in an individualised way.
- Patients and carers were mostly involved in their care and treatment.
- Patients were encouraged to feed back into the services they were accessing and take part in different trust activities, such as recruitment.

Summary of findings

- Most of the comments that came from patients and carers were positive about the care and treatment they received from services.

However:

- In acute inpatient services, some patients told us how that they felt staff were too busy to respond to requests for one-to-one time and they did not feel there was always enough staff on duty. Patients told us staff were not always available to respond to requests from patients to open their bedroom doors as they did not have their own keys.
- In the health-based place of safety, we saw that the safety, dignity, and confidentiality of people detained under Section 136 of the Mental Health Act were compromised. Emergency staff brought people through the main door of the reception area at Miranda House, through a public area and into the health-based place of safety. This meant that privacy; dignity and confidentiality were compromised and put the person detained and others at risk. Staff observed people detained in the health-based place of safety at all times to reduce the identified risks in the room. This meant that staff observed people using the toilet facilities, which compromised their dignity.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Patients could not access services when they needed to including in an emergency. The psychiatric intensive care unit was closed to female admissions due to a male patient being in long-term seclusion in the female sleeping area. This meant that any new referrals or female patients being transferred to psychiatric intensive care needed to be cared for outside the trust area. In mental health acute wards and psychiatric intensive care units, there was no dedicated individual or team responsible for bed management. This put staff under pressure to admit new patients into beds that should have been kept vacant for patients returning from leave. We saw how this also meant long-stay rehabilitation wards taking new patients with no clinical rationale for admission into that environment.
- The trust did not plan or deliver services in order to meet patient need. In substance misuse services, patients were required to travel to different locations as their needs changed during treatment. This adversely affected patients' ability to access local treatment. Daily travel was time-consuming and patients could not always afford to pay for travel.

Summary of findings

- There were long waiting times for patients. The trust worked in partnership with another agency and had a target of three weeks from referral to open access to the specialist drug services but patients waited more than three weeks and longer than the national average. Patients told us that waiting times were up to six weeks when they were transferred between services. This resulted in high percentages of patients dropping out of treatment. In community health services, some services, such as speech and language therapy and pulmonary rehabilitation, had waiting times in excess of 18 weeks. Neighbourhood care teams were not meeting performance targets for triage.
- Facilities did not promote recovery. In mental health acute wards, patients' bedrooms were locked and would be opened by staff at the patient request, as the patients were not given a key. In forensic inpatient and secure wards, patients had limited access to meaningful activity to support their recovery. The wards had facilities to provide activities but shortages of staff often meant they did not take place. Staff were not always clear on how activities were linked to recovery goals. In forensic inpatient and secure wards, staff did not monitor whether patients were engaged in meaningful activity or if activities were cancelled.
- Some services did not have a service specification.

However:

- Patients we spoke with knew how to make a complaint about services. Most felt able to speak to staff about any concerns and staff were able to describe how complaints were dealt with supporting patients with this process when needed. Although, in mental health acute wards and psychiatric intensive care units, we were unable to find evidence that complaints from patients had led to changes to how services or treatment was provided.
- In community mental health services for children and young people, the service website provided access to online counselling and self-help tools.
- In community mental health services for children and young people, a gender identity pathway had been developed to support this growing population.
- In substance misuse services, specific advice and support was available to patients who used performance-enhancing drugs, which also altered peoples images
- Services were accessible to disabled people, including those using wheelchairs.
- The service met patients' spiritual and faith needs.

Summary of findings

Are services well-led?

Requires improvement 

We rated well led as requires improvement because:

- There was a lack of mental health knowledge at board level with the exception of the medical director and the deputy director of nursing. Senior managers had not updated or put into effect a number of important policies and procedures that should have ensured a consistent approach to providing safe, caring, effective and responsive services. Whilst the seclusion policy had been reviewed it had only been done in March 2016 when the Mental Health Act code of practice changes came into effect in April 2015, with provider expected to review and implement by October 2015. The rapid tranquilisation policy was out of date and staff were not following best practice in order to keep patients safe. Restrictive practices used in the forensic core services compromised patients' dignity and respect.
- The trust had a clear strategy but it was not communicated clearly to staff at service level. This resulted in individuals feeling that the consultation period was not inclusive of all staff. Although there was evidence of information being presented to the board by senior management through the governance structure, there were challenges in the communication from the board to ward level. This resulted in staff not feeling valued.There was evidence of a culture that did not promote the wellbeing of staff, particularly those in middle management positions. This theme came through in focus groups and individual interviews.
- There was a high level of staff vacancies and posts remained vacant for long periods, which was placing extra pressure on remaining staff.
- There were waiting lists to access services in the mental health directorate and some community health services, which could put individuals at risk.
- The trust did not have effective systems in to support learning from incidents of harm or risk of harm across the organisation. There was a lack of clinical audit activity over the last 12 months. The trust did not ensure that all staff received the necessary mandatory training and managerial appraisal of their work performance.
- IT systems were a challenge to staff. The trust used a number of systems that were not linked up and this resulted in duplication of work, some information being unreliable, and those working remotely not always being able to access information they required.

However:

Summary of findings

- The trust had clear vision and values and had developed a strategy to support this.
- There was a clear system for maintaining and improving service standards, which worked well from a ward to board perspective.
- A clinical audit and effectiveness strategy 2016-19 set out key priorities.
- The complaints process was robust and staff handled complaints with respect.
- There was a strong safeguarding structure and the trust was building a culture of safeguarding that was supportive and accessible to those working in services.
- Staff working in services described feeling valued and supported by local managers.
- The trust had good working relationships with commissioners.
- The trust met the fit and proper person requirements.
- The trust met the requirements of the duty of candour regulation

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

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

Cathy Winn, Inspection Manager (Acute), Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, Mental Health Act reviewers, occupational therapists, pharmacists, psychologists, registered nurses (general, mental health and learning disability nurses), senior managers and social workers.

Why we carried out this inspection

We inspected this Humber NHS Foundation Trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit the inspection team:

- requested information from the trust and reviewed the information we received
- asked other organisations for information, including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, the Royal College of Psychiatrists, other professional bodies, and user and carer groups
- sought feedback from patients and carers through attending four group meetings involving detained patient groups and three groups and meetings involving carers
- received information from patients, carers and other groups through our website.

During the announced inspection visit from 11 to15 April 2016, the inspection team:

- visited 73 wards, teams and clinics
- spoke with 218 patients and 96 relatives and carers
- collected feedback from 133 patients, carers and staff using comment cards
- joined service user meetings
- spoke with 471 staff
- attended 31 focus groups
- interviewed 31 senior staff and board members
- attended and observed 73 handover meetings and multidisciplinary meetings

Summary of findings

- joined care professionals for 16 home visits and clinic appointments
- looked at 309 treatment records of patients
- observed patients on the older adults wards who were unable to communicate with us using the short observational framework for inspection
- conducted a Mental Health Act (1983) seclusion review for the Humber Centre and Newbridges Ward.
- carried out a specific check of medication management across a sample of wards and teams
- looked at policies, procedures and other documents relating to the running of the service
- requested and analysed further information from the trust to clarify what we found during the site visits.

We carried out an unannounced visit on19 April 2016, 21 April 2016 and 22 April 2016 to St Andrew's Place, Newbridges and Millview Court.

Information about the provider

Humber NHS Foundation Trust provides a range of community and inpatient mental health services, learning disability services, community services (including therapies), children's and addictions services to people living in Hull, the East Riding of Yorkshire and, since 10 March 2016, Whitby, North Yorkshire. The trust serves a large geographical area with a population of 600,000. It employs 2501staff across more than 70 sites at locations across the catchment area.

The trust provides 10 of the core of mental health services:

- Community-based mental health services for working age adults.
- Mental health crisis and health-based places 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.

They also provide five core community health services:

- Community health adult services.
- Community health end of life care.
- Community health services for children, families and young people.
- Community inpatient services.
- Community health urgent care.

Services at Whitby Hospital had recently transferred to the trust (March 2016).

They also have one adult social care location at Granville Court and one primary and medical services location which is an out of hours GP service at Goole Primary Care Centre

Humber NHS Foundation Trust has a total of 17 registered locations: East Riding Community Hospital, Withernsea Community Hospital, Goole Primary Care Centre, Granville Court, HMP Wakefield, Hawthorne Court, Hedon Primary Care Centre, Mac Milan Wolds Unit, Maister Lodge, Millview, Miranda House, Newbridges, St Andrew's Place, Townend Court, Westlands, Willerby Hill and Whitby Hospital (registered 10 March 2016).

Humber NHS Foundation Trust became a foundation trust in 2010.

Humber NHS Foundation Trust has been inspected nine times since registration. A comprehensive inspection took place on 20 to 23 May 2014 and all 16 locations were inspected. However, the trust was not rated at that time.

During that inspection, we found breaches of regulations and told the trust to make improvements.

Summary of findings

In the community child and adolescent mental health service we found that the safeguarding procedures were not always adhered to, staff were not appropriately trained and the waiting list was not being risk managed for the young person.

In forensic and secure inpatient services there were ligature points within the seclusion rooms and one door frame needed repair.

In long stay/rehabilitation wards for adults of working age there ligature points within the environment without adequate mitigation, there were also environmental issues with the seclusion room.

In community health services for children, families and young people, we found a backlog of records that had not been scanned to the electronic system. Staff felt unsupported by local and senior managers

We checked during this inspection and all the necessary improvements had been made.

What people who use the provider's services say

We spoke with 218 patients and 96 relatives and carers who were using the service and collected feedback from 133 patients, carers and staff using comment cards

We received both positive and negative feedback about the trust 105 of these comment cards were positive and seven were negative, 16 were mixed 2 were blank and 3 were unclear. The patients stated that staff were excellent, very helpful, considerate, professional and responsive. and that they explained things clearly. They felt listened to and treated with dignity and respect.

However we also received some negative feedback. That there were not enough staff or activities. Management plans were done without their input and that they found it difficult to cope when they were not allowed to contact their community psychiatric nurse.

The CQC Community Mental Health Survey 2015 surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. The survey involved 55 NHS trusts in England and had 13,292 respondents, a response rate of 29%.

At the start of 2015, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 247 people (29%) which is exactly in line with the England average. The trust scored 'about the same' in all ten questions.

Patients told us they know how to make a complaint and cares felt confident to raise complaints.

In the community based mental health services for adults of working age a monthly patient survey took place to gather patient feedback on the services. The feedback we saw from January and February 2016 was very positive. Information from the survey was fed back to the services through their key performance indicators. Action plans were in place to address any concerns raised within the responses and also to address some identified problems with the uptake of patients completing the survey. Overall responses from the patient survey were good, which reflected the information we were given from families, patients and carers.

Good practice

In learning disability inpatient services several patients had tablet computers provided by the trust. These incorporated an application called 'my health guide app'. This app had come from an original concept commissioned by Humber NHS Trust. It had been adapted for use in the learning disability services. One of the deputy managers at Townend Court had worked with the developers on the app.**The app** helped patients to own their information and take a role in their own health care. Patients could customise the app so that it was personal to them. Information could be recorded in a number of ways such as

Summary of findings

text, audio, video and images. The app also allowed professionals, with the patient's agreement, to add content that could help in understanding and reinforcing professional advice.

In the CAMHS community services a member of staff had been recognised nationally for a peer support group for patients with attention deficit hyperactivity disorder. The group was called #.H.A.S.H.T.A.G. They won a £1000 grant to help with the group.

In community health services for adults the community falls service was working in conjunction with the local fire service and health providers to offer joint a rapid response falls assessments service at risk of falls. This was designed to offer clinical support to patients who had been injured in a fall and increase confidence in patients to avoid a fear of falling reducing confidence, independence and social contact.

Areas for improvement

Action the provider MUST take to improve

Forensic/Inpatient secure wards

- The trust must ensure that the withholding of patients' mail in secure/forensic services is stopped.
- The trust must maintain accurate, complete and contemporaneous record in respect of each patient and document when they had administered medication to patients. They must also ensure that Mental Health Act documentation is up to date and fit for purpose.
- The trust must ensure the cleanliness of the seclusion rooms and that they are well maintained, in particular Derwent ward, Ouse ward, Greentrees ward, and Darley House ward.
- The trust must ensure that the seclusion rooms on Greentrees ward and Derwent ward are fit for purpose and meet the requirements of the MHA code of practice. Attention should also be given to the shower facilities on Derwent and Ouse wards.

Acute service, forensic/secure services and St Andrew's place

- The trust must ensure that essential medicines, including those for administration for resuscitation and after rapid tranquilisation are present and are in date on all wards.

Acute services

- The trust must ensure that staff have a clear understanding of what constitutes rapid tranquilisation and as a result, the required physical checks and observations of patients are being carried out in accordance with the trust's policy.
- The trust must ensure that all qualified staff are trained in immediate life support, so they know what action to take should a patient have an adverse effect from rapid tranquilisation including the use of emergency medication.
- The trust must ensure all staff have the knowledge to work in accordance with their responsibilities under the Mental Health Act 2008 and in line with the current code of practice.

Trust wide

- The trust must urgently review their rapid tranquilisation policy which was dated for review in February 2016 and their safeguarding children policy which was due for review in March 2016.
- The trust must ensure that mandatory training reaches its compliance rate of 75% in all services.
- The trust must ensure that suitable and trained members of staff are deployed to fill their current vacancy rates.
- The trust must ensure that accurate, complete and contemporaneous patient records are kept. The trust must ensure that all records, electronic or paper based, are accurate, up-to-date, fit for purpose.
- The trust must ensure that the trust has an effective governance system in place to include the assurance and auditing of systems and processes, to asses, monitor and drive improvement in the quality and safety of the services provided.
- The trust must urgently review the access to toileting facilities whilst patients are in seclusion when they are displaying settled behaviour.

Summary of findings

- The trust must ensure that all staff are trained in the use of seclusion and ensure that adherence to trust and national guidance addresses how, when and by whom the clinical reviews are undertaken
- The trust must ensure that physical health monitoring is undertaken whilst patients are in seclusion.
- The trust must ensure that they provide patients with sufficient activities to aid their recovery.
- The trust must ensure that the persons employed by the services receive such support training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that staff have an understanding and feel engaged with the trust vision and strategy.
- The trust must ensure that interventions where service users were controlled or restrained are subject to review to ensure these were necessary to prevent, or a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint.
- The trust must ensure that restrictive practices within the forensic and acute mental health services are reviewed.

Mental health rehabilitation services

- The trust must ensure that patients of the mental health rehabilitation services are supported to participate in making decisions relating to their care and treatment to the maximum extent possible.

Crisis services and health based place of safety

- The trust must ensure that the environment of the health-based place of safety at Miranda House is suitable for the purpose for which it was being used as per the live improvement scheme.

Substance misuse services

- The trust must ensure that staff from all substance misuse teams fully assess or monitor a person's physical health.
- The trust must ensure that substance misuse care plans are up to date, personalised, holistic and recovery focused. Staff must deliver recovery focussed psychosocial interventions.
- The trust must urgently review the geographical issues with the substance misuse care pathways.
- The trust must review the high waiting times and high unplanned exits resulting from the substance misuse pathway.

Learning disability inpatient services

- The trust must, must ensure that all risks relating to the health and safety of service users, receiving care or treatment are assessed In inpatient learning disability services,
- The trust must ensure that all risks plans are always reviewed and updated as required inpatient learning disability services
- The trust must ensure that systems and processes operate effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse in inpatient learning disability services
- The trust must ensure that incidents that met the threshold for safeguarding consideration are always referred to, or discussed with, the safeguarding team in inpatient learning disability services
- On Beech ward, the provider must ensure compliance with guidance on mixed sex accommodation.

Community health services

- The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties
- The trust must take action to seek and act on feedback from relevant persons.
- The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties
- The trust must deliver the public engagement strategy and improve delivery of, and action on friends and family test.

Summary of findings

- The trust must engage staff to improve morale and staff understanding of the vision and strategy for community children's services.

Action the provider SHOULD take to improve

Trustwide

- The trust should ensure that ward based activities and staffing shortages do not impact on patient activities.
- The trust should ensure that an audit programme is developed for 2016-2017 including pharmacy audits.
- The trust should comply with the recommendation that medicines reconciliation should be completed within 24 hours of admission (NICE 2015).

Forensic/Inpatient secure wards

- The trust should ensure that the sharing of information about incidents and lessons learned is consistent and documented across all wards.
- The trust should ensure that patient records are in order to ensure paperwork is easy to locate.
- The trust should ensure that staff document clearly in patient records when decisions are made about a patient's capacity or consent to treatment, using the two stage assessment of capacity as recommended in the Mental Capacity Act.
- The trust should urgently review the use of the seclusion facility on Greentrees ward and decide if this should be decommissioned.

Crisis and health based place of safety

- The trust should ensure that the safety, dignity, and confidentiality of people detained under Section 136 are not compromised.

Community health services

- The trust should ensure that all out of date policies are reviewed and ratified.
- The trust should asses risks within end of life services so these are highlighted on the corporate and local risk registers and that these are regularly reviewed to ensure that actions to mitigate risks are considered and evidenced.
- The trust should ensure that all staff are trained to enable them to identify and escalate when patients are in pain.
- The trust should ensure that all teams providing end of life care use the recognised care pathway 'caring for me advanced care plan' for end of life patients and that staff document patients' wishes.
- The trust should consider a 'do not attempt cardio pulmonary resuscitation' audit for the patients in community hospitals to benchmark and evidence compliance with policy and national guidance.
- The trust should ensure that Neighbourhood Care Teams have access to basic equipment to enable them to carry out their role.
- The trust should take steps to introduce a formalised clinical audit plan within the service to ensure patient outcomes can be monitored.
- The trust should consider how learning from complaints and incidents is shared across the service, particularly with community health adult services.
- The trust should continue work to ensure that service specifications are in place for all areas.
- The trust should take steps to ensure consistent working practices can be embedded between Neighbourhood Care Teams.
- The trust should develop a strategy for auditing community children's services to monitor and improve quality and safety.
- The trust should continue with the work to ensure ligature risk assessments are undertaken in all clinical areas, including community clinics.
- The trust should implement cleaning schedules for toys to ensure adequate infection prevention and control procedures are in place.
- The trust should review access to therapy support within Withernsea Community Hospital**;**
- The trust should review the arrangements within community inpatients services for obtaining medication outside designated delivery times.

Humber NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Training in the Mental Health Act (MHA) was not mandatory and we could not establish what training staff had completed because the trust did not monitor compliance consistently. The Mental Health Act code of practice was updated in April 2015. The trust had not adjusted all policies and procedures to reflect these changes and the trust had not offered staff training to all staff in relation to the amended code of practice.

The trust had a Mental Health Act administrator who scrutinised documents. Detention documentation was easy to locate and clearly filed. Mental Health Act documentation for detained patients was in place and completed correctly. Patients appeared to be detained under the correct legal authority.

We found that detention under emergency powers was used and there were a high number of section 4 admissions, due to the lack of available doctors. This was a concern raised within the approved mental health professional focus group and corroborated by data received from the trust. This was not in line with good practice. The trust had a voluntary rota rather than a clear system to ensure the second section 12 doctors were available to undertake Mental Health Act assessments. Because this rota was not mandatory doctors were often choosing to not undertake Mental Health Act work.

Staff informed patients of their rights verbally on a regular basis. This could be provided in easy read format. Staff recorded the outcome on each occasion; including making a record of how the patient responded and their understanding.

There was an independent mental health advocacy service available to all patients. Information about the advocacy service was displayed on all wards. The hospital had a system to refer patients who lacked capacity to this service.

There was a standardised process for authorising section 17 leave and leave forms were written clearly. However, staff did not always strike out old copies of section 17 leave forms and did not always give patients a copy of the leave form.

Staff made referrals to second opinion appointed doctors appropriately. There was no discrepancy between medications being administered and medications authorised by the second opinion appointed doctors. However in some services we could not see how the responsible clinician had recorded how the decision was reached about the patient's capacity to consent to medication. Completed consent to treatment authorisation forms were located with prescription charts. In some areas old copies were in current files and it was unclear which was in use.

We found the trust seclusion policy had been updated in March 2016 following a CQC seclusion review. However, staff were not following the new policy. In some areas there was confusion about the new policy. It was unclear when the new policy had been implemented and this

implementation was not consistent across the trust. On reviewing seclusion records we were concerned seclusion was not following the code of practice guidance. Patients were not given adequate safeguards because of this.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act was part of the mandatory training, however we found that the overall compliance rate for Mental Capacity Act training across the trust was 50%, far below the 75% trust target.

In older adults inpatient services staff ensured health decisions were made based on mental capacity or in the best interest of the person. We observed staff seeking informed consent prior to giving care, for example, when moving people. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible.

The trust provided information around the Deprivation of Liberty Safeguards applications they had made in the last six months. The trust data does not provide an exact date range but application dates run from 3 June 2015 to 25 February 2016.

There were 31 Mental Health Deprivation of Liberty Safeguards applications made. 18 (58%) out of 31 applications were classed as 'urgent'. These broke down as wards for older people with mental health problems 20, wards for people with learning disability or autism six, community health inpatient services four and learning disabilities one.

The CQC records show that we received nine Deprivation of Liberty Safeguarding notifications from the trust between the same period (3 June 2015 to 28 October 2015). The details are Townend Court four, Maister Lodge three, Willerby Hill one, Millview one

Inadequate

Are services safe?

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

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

Summary of findings

Our findings

Safe and Clean Care Environments

Humber NHS Foundation Trust scored 99% overall in relation to cleanliness in the 2015 patient led assessment of the care environment (PLACE). This figure was 1.8% above the national average. Of the 14 locations inspected McMillan and Buckrose wards at Bridlington & District Hospital' was the only location which did not score above the England and trust average. It scored 97%.

Wards and community team bases that we visited were generally clean and tidy. However, at Newbridges, the ward décor looked tired, with graffiti on the walls in a number of areas.

On Forensic services records indicated domestic staff cleaned the wards regularly although certain areas still appeared to be unclean. On Greentrees ward, patients smoked with the door open into the lounge and cigarette smoke could be smelt throughout the ward.

All community health services inpatient wards were bright and well organised, staff and patients spoke positively about the facilities and environment. The standard of fixtures and fittings in ward kitchens was high and improved the service to patients.

We found that the health based place of safety appeared clean and well maintained however, there were environmental concerns that meant it did not meet the Mental Health Act 1983 revised code of practice and guidance from the Royal College of Psychiatry on section 136 standards.

There were apparent ligature risks in the section136 suite. A ligature is a place where someone intent on self-harm might tie something to strangle themselves. There was a ligature risk assessment to identify the ligature risks and staff mitigated these risks by ensuring people were always under supervision. The toilet area contained the most ligature risks, which meant staff could not support people safely without compromising their privacy and dignity. The number of ligature points present in the room meant that the health-based place of safety did not meet the needs of people who might be in crisis and was not safe.

The forensic services had some blind spots in the environment on Darley House, Derwent ward and Ouse ward. Staff mitigated the risk of blind spots by positioning themselves outside the office to enable sight lines of both corridors. Two-way mirrors were present in some areas. Staff used the supportive engagement policy to closely observe and engage with patients whose risk to themselves or others was heightened. On Greentrees ward the staff office was located away from patient areas, however we observed there were staff members present in all patient areas during our visit. The ward manager for South West Lodge told us that ligature risks in that building were mitigated by only allowing patients to move there who were ready for discharge and not posing any risks of ligature, self-harm or suicide. At Brough primary care centre, there were loose blind cords, which were a ligature risk to small children in the clinic room. This was brought to the attention of the team leader at the time of inspection.

All but one of the wards we visited complied with Department of Health guidance for eliminating mixed sex accommodation. The exception was one learning disability unit: Beech had no facility for separate male and female sleeping areas. All bedrooms were situated along one corridor. There were no females on the unit during our inspection. A senior staff member said they would not currently accommodate females on Beech as it was not compliant with mixed sex accommodation. However, some other staff told us females would be located in bedrooms at the end of the corridor to sleep.

The trust had been flagged as a risk for the central alerting system (CAS), dealing with safety alerts in a timely way. This related to the number of alerts which the central alerting system stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the

date CQC extracted data from the central alerting system. The trust responded to this information and stated that there was one alert overdue; however this had now been closed.

Safe Staffing

The total number of substantive staff employed by the trust was 2501 at the time of the inspection. In the last 12 months 253 members of staff had left (10 %). In the 12 months ending 29 February 2016 the overall trust sickness rate was 5% which was in line with the national average for all other mental health and learning disability trusts.

Total number of substantive staff =2501

Total number of substantive staff leavers in the last 12 months = 253

Total substantive leavers in the last 12 months = 10%

Total vacancies overall (excluding seconded staff) = 9%

Total permanent staff sickness overall = 5%

Establishment levels qualified nurses (whole time equivalent) = 687.84

Establishment levels nursing assistants (whole time equivalent) = 417.39

Number of whole time equivalent vacancies qualified nurses = 62.53 (9%)

Number of whole time equivalent vacancies nursing assistants = 0.03 (0.01%)

Shifts filled by bank or agency staff to cover sickness, absence or vacancies (1 January to 29 February 2016) = 7258

Shifts not filled by bank or agency staff where there is sickness, absence or vacancies in the last 3 months (1 January to 29 February 2016) = 780

Seven of the core services had a higher qualified nursing vacancy rate than the trust average of 9%.

In Community health services urgent care at February 2016 had the highest qualified nursing vacancies at 16%. However, this only equated to three nurses and community health services for adults also had a 16% vacancy rate which equated to 26 nurses.

Of the mental health services, crisis services and health based places of safety had the highest qualified nursing vacancies with 23% which equated to 13 nurses at February 2016. Specialist community mental health services for children and young people have the lowest qualified nursing vacancies with no vacancies.

Nurse vacancy rates within community health services in urgent care were 16%. We saw shifts (February 2016) were covered by a reliance on internal bank and agency staff. However there was an internal bank which included substantive staff working additional hours so was a planned process . Nurse sickness rates within community health services urgent care were 8%.

Within community health services, seven of the Neighbourhood Care Team areas were operating below the established staffing levels identified by the trust. One serious incident in relation to a grade four pressure ulcer had also identified poor district nursing caseload management as a contributory factor. Five district nursing teams had qualified nurse vacancy rates above the trust average of 11.6%. The highest of these was the Withernsea team with a rate of 28% (2.3 WTE staff).

High caseloads for health visitors were identified in the previous inspection in 2014. Health visiting staff reported a positive impact of the 'Health Visitor – Call to Action' in that they had seen staff increases in their teams since the last inspection. Current caseloads were below the recommendation of 300 families. Staff working in areas with higher levels of safeguarding concerns had lower caseloads, however there was no weighting tool applied to caseload allocation to ensure parity across teams.

The school nurses had very high caseloads due to staff vacancies. Work had been undertaken to review school nurse caseloads to manage them effectively.

The trust had formal nurse staffing review processes in place for community health inpatient hospitals and had a staffing establishment based upon agreed methodology and professional judgment triangulated through benchmarking, relevant national guidance and acuity information. We found that on all inpatient wards, actual staffing levels were in line with those planned. There were temporary arrangements in place at Withernsea Community Hospital to provide medical cover for the ward and the trust had advertised a tender to contract medical cover for the ward.

Inadequate

Are services safe?

A safer staffing report from March 2016 showed Townend Court had not met safer staffing levels for the preceding three months. A shortage of nurses at night was the main concern.

According to data provided by the trust, three of the six wards in forensic wards were above the trust average for vacancy rates of 8.7% between 1 March 2015 and 29 February 2016. Greentrees ward (including South West Lodge) and Swale ward had a total vacancy rate of 19% and Darley House had a total vacancy rate of 10%. Although NHS England reported on the number of advertised vacancies from March 2014 to April 2015, there had been no refresh of this data since.

Sickness and absence rates were high across the community based mental health services for adults of working age. The information was provided by the trust for the period from March 2015 to February 2016. Pocklington community mental health team had the highest percentage of sickness at 13% and the lowest was at the Waterloo Centre at 4.5%. However, all community services apart from the Waterloo Centre were above the trust average figure of 4.8% for sickness. Staff told us that sickness was high due to a number of long-term physical illnesses but also a number of staff who had been off with stress-related illnesses. The total number of days lost from April 2015 to April 2016 for stress-related illnesses was 1,231 days, with 733 days of these being in the recovery community mental health team services in Hull.

Substance Misuse had the highest staff turnover rate with 22%.

The nursing inpatient units submitted shift fill data to NHS England. No national RAG (Red, Amber of Green) ratings had been set for fill rates, so for monitoring purposes the trust had developed their own. A review of other trusts' local fill rate targets showed a range of thresholds, but Humber NHS Foundation trusts were broadly in line with regional neighbours.

Although low fill levels were not necessarily a risk to patients, the trust had chosen to highlight them as they could indicate inefficiencies regarding establishment levels

As at December 2015 the adult wards with the highest fill rates were St Andrew's long stay rehabilitation, for night overall, with 148 and night health care assistants' with196 and Westlands Acute / PICU, night registered nurses with 144. St Andrew's long stay / rehab ward and Miranda House have the lowest fill rates for day registered nurses with 60 and 80 respectively.

In the older adult's services, Maister Lodge had the lowest fill rates for day and night registered nurses, with 62 and 68 respectively, both fell below the trusts lower level of 75.

In forensic services, Darley House had the highest fill rates for day overall with 129, night overall with 147, day registered nurses with 174 and night health care assistants with 194. Green Trees ward had the lowest fill rate for day health care assistants with 59 and was below the trust lower fill level of 75.

Granville court had the highest fill rates for day health care assistants with 123. Townend Court had the lowest fill rates for night registered nurses with 63 and was below the trust lower fill level indicator of 75.

The trust acknowledged challenges in recruitment and retention and this was a theme that came through in both senior interviews and staff focus groups. The trust had conducted an internal audit which looked at and addressed recruitment arrangements. Each issue was positively controlled and was linked to an action plan.

Mandatory training:

The training compliance for trust wide services was 61%. Community mental health services for people with a learning disability or autism was the core service with the highest percentage of trained staff with an overall training rate of 74%. Wards for older people with mental health problems had the lowest aggregated rate of training of 45%.

Prevention and management of violence and aggression training had the highest rate of completion with 84%. Equality and diversity had the lowest rate at 44%. Display screen equipment closely followed this with 45%.

On reviewing data that was supplied by the trust, we could see that the trust had not reached its 75% compliance rates for mandatory training on any month in the preceding 12 month period.

Assessing and managing risk to patients and staff

The trust provided a copy of their trust risk register from December 2015 which detailed a total of 26 risks scoring 12 or higher. Also provided was a separate risk register which

lists nine local risks by care group. Two had a risk rating of 20, five had a risk rating of 16 and five had a risk rating of 15. The two items with a risk rating of 20 are summarised below.

1. Management of waiting list for Haltemprice community mental health team for adults of working age. Unable to prioritise who is most in need on the waiting list unable to provide any guidelines regarding when they will be allocated a care coordinator. Clients being seen by Specialist Psychotherapy service and requiring a Care Coordinator therefore unable to discharge from services.
2. CAMHS crisis and Tier 4 beds. Following the NHS England review, additional CAMHS beds have been made available within the region. However this did not reduce risk at weekends or out of hours as admissions follow a planned process. The key issues which remained were access to a local place of safety and managing disturbed young people out of hours. There were no clinical staff on-call Monday to Friday Out of Hours. The on-call rota is on a voluntary basis only and completely relies on staff good will. Until recruitment to Crisis provision is completed there is no service.

   The trust used a locally designed risk assessment tool, risk assessment and management plan within mental health services called Galatean Risk and Safety Tool (egrist). In addition, forensic services also undertook historical clinical risk management through a recognised tool HCR20 for all patients

Generally, we found that patients had detailed risk assessments and management plans that reflected the patients' needs.

We were made aware prior to our inspection that the electronic Galatean Risk and Safety Tool, which is the electronic risk assessment tool had encountered some issues and data could not be relied on as being accurate. Therefore this was communicated to all staff within the trust and the system was amended to be read only. The trust also put some measures in place to ensure that there were minimal risks to patient care.

Restrictive practices

Staff in the forensic service were undertaking a 'restrictive practice review'. Managers and staff were keen to reduce restrictive practice and had begun to have monthly meetings. Staff held a workshop for patients in February to discuss areas of restrictive practice and identify next steps. On Ullswater and Greentrees wards, recent changes included open smoking times and patients having control over their own finances. On Swale ward patients now had access to the TV remote as oppose to having to ask staff for it and were able to use the microwave in the patient kitchen. On Darley House, staff used observation and relational security to monitor any patient who had restricted access to certain areas. Managers reported there was some way to go with embedding the use of relational security and removing restrictive practice, but they felt a change in culture was occurring.

We found that staff across all seven forensic wards supervised patients opening their mail. This issue was identified as a restrictive practice and the trust advised they should review this in the last CQC inspection in 2014 but procedures had not changed.

Patients' privacy and dignity was compromised by the enforcement of this blanket procedure.

Managers informed us that staff would hand patients their mail and stand close by, but not close enough to read the mail. They stated this was to ensure patients did not miss necessary appointments. When asked what staff would do if a patient refused to open their mail, they stated they would try again later and in the meantime would withhold the patient's mail.

The trust had a procedure for managing patients' correspondence. This was last reviewed in February 2013 and stated that mail was monitored to prevent the unauthorised passage of contraband and to prevent intimidation of witnesses or distress to others. The procedure identified that 'the recipient will sign to accept receipt of appropriate packages on the understanding that any postal packet, in the interests of security and safety, must be opened in the presence of the nominated deputy" the supervising deputy will ensure that all packages are opened in full view'.

Section 134 of the Mental Health Act (1983) states that the withholding of mail is only allowed in high security psychiatric hospitals, and only then by agreement of the hospital managers 'a postal packet addressed to a patient detained under this Act in a hospital at which high security psychiatric services are provided may be withheld from the patient if, in the opinion of the managers of the hospital, it

is necessary to do so in the interests of the safety of the patient or for the protection of other persons'. If mail is withheld, the following procedure must be adhered to; 'Where a postal packet or anything contained in it is withheld under subsection (1)(b) or (2) above the managers of the hospital shall within seven days give notice of that fact to the patient and, in the case of a packet withheld under subsection (2) above, to the person (if known) by whom the postal packet was sent; and any such notice shall be given in writing and shall contain a statement of the effect of'.

There is no power to withhold the incoming mail of a patient who is detained in a hospital which is not a high security hospital. Paragraph 1.135 of the Mental Health Act Commissions (MHAC's) Thirteenth Biennial Report dated 2007-2009 stated: "some medium secure hospital policies stipulate that, whilst it is unlawful to withhold incoming mail from a patient, or to open mail addressed to a patient without the patient's permission, if a staff member has concerns about the possible contents of a particular package or a letter, it is acceptable for the patient to be advised that he or she may only open it in a controlled environment (i.e. nurses' office) in the presence of staff. Once open, the contents maybe treated like any other item of patient property and confiscated if necessary. The Mental Health Act Commission accepted the need for such arrangements as a last resort, but they should be carefully monitored and reviewed to ensure that they are and continue to be a justified interference with the patient's right to privacy, and must not be used as a blanket measure irrespective of an individual risk assessment".

Managers gave the reasons for observing patients opening their mail as wanting to avoid the patient missing key appointments, or in case of families sending restricted items through the post. Managers and staff did not report any issues with contraband on the wards. Patients were not subject to an individualised risk assessment for this issue

Restraint

Current Department of Health guidance entitled 'positive and proactive care' states; 'staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface'.

The trust had a management of violence and aggressive behaviour policy dated March 2014 and due for review in March 2017. This policy stated that the trust was committed to providing restraint free environments and in circumstances where this could not be achieved, a commitment to prevent the misuse or abuse of restrictive practices and to minimise all forms of restraint.

There were 121 reported uses of restraint on 72 different services users between 1 November 2015 and 31 March 2016. Initial information provided by the trust showed none of these incidents resulted in the use of prone restraint or the use of rapid tranquilisation. However the trust then updated this information and the type of restraint was added to the DATIX system the trusts online incident reporting system. They then reported two incidents of prone restraint, however did not stipulate where these had occurred.

During inspection we corroborated this restraint data and staff on the acute wards told us that prone restraint was sometimes used. We reviewed care records and found that prone restraint had been used. Staff had clearly documented this in patient notes, along with other techniques that had been used before prone restraint was initiated.

There were only two uses of restraint on two different patients in forensic services between 1 November 2015 and 31 March 2016, none of which resulted in the use of prone restraint or rapid tranquilisation.

Trust data for the six months prior to our inspection in learning disability services showed 25 uses of restraint and nine episodes of seclusion on Willow. On Lilac, there were seven uses of restraint and two episodes of seclusion. The trust did not supply figures for Beech. It was reported that none of these resulted in the use of prone (face down) restraint or rapid tranquilisation.

The highest use of restraint occurred on acute wards for adults of working age and psychiatric intensive care units (60% of incidents), wards for people with a learning disability or autism followed (28% of incidents).

Seclusion.

CQC inspected the trusts forensic services in December 2015 following concerns raised to us about an individual in long term segregation. At that inspection, it was evident that the trust did not have a long term segregation policy and CQC required the trust to put this right.

Inadequate

Are services safe?

The trust developed a seclusion and long term segregation policy and this was approved by the board in March 2016. This policy reflected the changes to the Mental Health Act code of practice 2015.

There were 79 uses of seclusion between 1 November 2015 and 31 March 2016. Acute wards for adults of working age and psychiatric care units had 47 incidents that accounted for 60% of the seclusion total.

The trust reported that there were two patients in long term segregation during the inspection. One in forensic services and one in the psychiatric intensive care unit.

Staff on the wards where long term segregation was taking place were not clear that the patients were in long term segregation. The staff did not complete the monitoring in line with the Mental Health Act code of practice and trust policy.

We found that the seclusion rooms on Derwent, Greentrees wards and those in the acute services were not fit for purpose, as they did not meet the requirements at chapter 26 of the Mental Health Act code of practice 2015.

- There was only one hatch on the seclusion room door meaning that staff would pass food, drink and bodily fluid through the same place. This was against infection control principles.
- The seclusion room at Mill View Court had no natural light into the room.There were no blinds on the viewing panels of the seclusion rooms.The Mental Health Act code of practice paragraph 26.109 states "rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)".
- Patients in seclusion were sometimes denied the use of toileting facilities, even when they were displaying settled behaviour.
- A patient was denied access to the toilet to change sanitary products. The seclusion record indicated that sanitary products had been provided to the patient via the hatch in the seclusion room door.
- Staff had not used the seclusion room on Greentrees ward for five years. There was no window blind in place, no hatch and it contained a blind spot. The seclusion room needed cleaning, it appeared dusty and the floor was not clean. The bathroom was not clean and was outside of the seclusion room. The ward manager told us that the risks were mitigated because the room had not been used in five years however; they also told us that it was an active seclusion room and could be used in an acute psychiatric emergency on the ward. We raised this concern with the trust on the day of our visit but we were told that a decision had not been made as to whether this seclusion room was to be closed and could potentially be used at any time.

In acute services, we reviewed 23 seclusion records. We also undertook a seclusion review which was completed on Newbridges as part of the inspection. We found that in five of the seclusion episodes, patients were observed as being 'settled' for significant periods of time. However, the seclusion was not ended.

In none of the cases of seclusion in acute services did we find that staff had created an exit plans for termination of seclusion at the time that seclusion was commenced. We found some basic care plans for seclusion. However, these did not detail what the patient needed to do for seclusion to end or what behaviour or settled period of time was required to end seclusion. There was no recorded evidence that this was discussed with the patient. The Mental Health Act code of practice paragraph 26.147 states that "A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objective
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for, and
- details of any family or carer contact/communication which will maintain during the period of seclusion in accordance with paragraph 26.16".

Nursing seclusion reviews took place on acute services, however in a number of records these had been undertaken by one qualified nurse and one health care

assistant. The Mental Health Act code of practice chapter 26, at paragraphs 132-26 and 134 requires two qualified nurses to undertake these nursing reviews. Furthermore this was against Humber NHS Foundation Trust's own policy on seclusion and long term segregation. At point 5.7ii of the trust policy it states "Following the commencement of seclusion, nursing reviews of the secluded patient should take place at least every two hours. These should be undertaken by two individuals who are registered nurses".

Physical health monitoring did not appear to be carried out whilst patients were in seclusion in acute services. We could find no evidence of physical health monitoring in records. Any physical health issues were therefore not assessed and managed whilst the patient was in seclusion.

Staff did not report any concerns about access to medical cover on the forensic services; however, eight seclusion records we viewed indicated that doctors did not attend within the required time frames on an evening.

Rapid Tranquilisation

Rapid tranquilisation is the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. (NICE guidelines NG10).

The trust had a rapid tranquilisation policy. This had not been reviewed at the time of our inspection on the 11 April 2016. This was dated for review in February 2016.

The trust reported that between 1 November 2015 and 31 March 2016 there had been no incidents of prone restraint which led to rapid tranquilisation. However we found a seclusion record on Newbridges, which detailed that one patient, had been restrained using prone restraint, and rapid tranquilisation had been used.

We found the provision of emergency medicines was variable and did not meet the essential stock requirements set out in the trust resuscitation policy, including medicines which should be immediately available when rapid tranquilisation was used. The trust's rapid tranquilisation policy stated all medical and nursing staff should be familiar with the use and administration of Flumazenil, however we found this was unavailable or expired on seven of the wards we visited. We found a lack of understanding about the guidance around rapid tranquilisation amongst the nursing staff we spoke with.

The live trust policy stated that CPR kits should contain amiodarone. Amiodarone was not available on Newbridges during the follow-up visit which was on 22 April 2016.

Trust policy states flumazenil should be available on all mental health and learning disability wards where rapid tranquilisation was planned. There were three episodes of rapid tranquilisation used on Newbridges, however we found flumazenil was out of date during the follow-up visit on 22 April 2016.

On Greentrees one member of staff weas not aware where emergency medication was kept, and told us that in the event of a collapse they, would call 999. They also stated they did not know how to use the emergency drugs.

National institute of health and care excellence guidelines (NG 10, May 2015) sets out clearly what staff should monitor following rapid tranquilisation. We found that Humber NHS Foundation Trusts own policy and National institute of health and care excellence guidelines were not being consistently and correctly implemented. If appropriate observations were not taken and recorded after administration of rapid tranquilisation, there was a risk the patient may experience an adverse reaction to the rapid tranquilisation drugs administered which may not be detected in a timely way leading to the risk of significant harm.

We looked at six prescription charts on Newbridges, Westlands and Avondale and in four of these they indicated use of rapid tranquilisation. The physical health monitoring of the patient had not been carried out in accordance with national guidance [NICE May 2015) or in accordance with the trust policy, which was due for review in February 2016.

We found a seclusion record on Newbridges, which detailed that one patient, had been restrained using prone restraint, and rapid tranquilisation had been used. There was no record of any physical health monitoring.

In three of the care records we reviewed on the acute wards, we found that rapid tranquilisation had been used. We were concerned that for some incidents which involve the rapid tranquilisation of patients, there is no clear rationale for this in the patient records. There was no evidence that physical health monitoring had been undertaken after rapid tranquilisation had taken place

Medicine management

Inadequate

Are services safe?

The ward-based clinical pharmacy service was available during normal hours Monday to Friday. Limited pharmacist resource meant that attendance at ward multidisciplinary team meetings and consultant ward rounds was not always possible. Plans to increase clinical pharmacy staffing were included in the pharmacy medicines optimisation strategy, and a business case was being developed to address identified gaps in the provision of pharmacy services.

Pharmacy staff checked (reconciled) people's medicines on admission to some wards, however the process for reconciling and reviewing medicines was not robust. For example, we saw when problems had been identified by pharmacy staff this had not been effectively communicated to medical staff because no entry had been made in the patient's notes. We saw an example of a transcription error at Withernsea community hospital which resulted in a patient receiving a lower dose of medicine than intended for 23 days. In addition, we saw another intervention had been written in a hand-over book seven times over a period of 28 days; this had still not been resolved on the day of our inspection.

The trust was unable to comply with the recommendation that medicines reconciliation should be completed within 24 hours of admission (NICE 2015: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes). This had been identified as a risk and placed on the risk register. However, the principle pharmacist (clinical services) told us there was no rolling audit programme to monitor compliance with this standard.

Broad audit priorities had been identified for 2016/17, however plans were lacking in both scope and detail and there was no agreed audit schedule. The trust subscribed to POMH UK [Prescribing Observatory for Mental Health] to enable audit of prescribing practice against national standards and to benchmark their performance against other similar trusts.

Records of administered medicines were not always fully completed and we found a number of recording errors and omissions that had not been identified and appropriately reported and managed. The principle pharmacist (clinical services) told us the pharmacy team had not undertaken a delayed and missed dose audit since 2014.

Arrangements were in place to ensure medicines incidents were recorded, reported, and investigated through the trust governance arrangements. Trends and patterns were identified and discussed at the Medicines Safety Committee, and appropriate actions taken in response to these. The medicines safety officer reviewed all incidents on a daily basis. However, there was no mechanism in place to give assurance that national patient safety alerts had been actioned appropriately at ward level.

Direct notifications

There were 39 notifications received into CQC from 1 January 2015 to 8 March 2016 with Westlands submitting the most with eight.

In the same period there were also 15 child admissions to adult wards, eight of which occurred at Westlands, six at Millview and one at Willerby Hill. The patients were all 16-17 years of age. These admissions were all emergency admissions and the children were either discharged or moved to a CAMHS inpatient facility as soon as was practical. The trust was not commissioned to provide inpatient CAMHS services.

Safeguarding

Safeguarding alerts describe instances where the CQC are the first receiver of information about abuse or possible abuse, or where we may need to take immediate action to ensure that people are safe. Safeguarding concerns describe instances where the CQC are not the first receiver of information about abuse, and there is no immediate need for us to take regulatory action. For example, where the CQC are told about abuse, possible abuse or alleged abuse in a regulated setting; by a local safeguarding authority or the police. Between 1 January 2015 and 3 March 2016 there had been ten safeguarding concerns raised with the CQC regarding the trust. The latest concerns were from December 2015 and these concerns were closed.

Newbridges acute admission ward had the highest number of concerns raised with three. Two were raised on the same day, and the third was raised eight days after in February 2015. Two safeguarding concerns had been raised at trust level.

The trust had a Safeguarding Group which was a sub group of the quality and patient safety committee whose aim was to ensure safeguarding, leadership and expertise was provided across the organisation and to ensure processes were in place to provide accountability and assurance to the quality and patient safety committee. The director of

nursing, quality and patient experience was a co-chair of this meeting and the group met every six weeks. The chief operating officer sat on the East Riding safeguarding children board and the assistant director of nursing, safeguarding and patient safety provided a link into the safeguarding named nurse within the structure. The trust had produced a safeguarding annual report dated 2014-2016. The report summarised the trusts key activity for safeguarding adults and children across the location and included a ten point action plan and actions which had been taken in order to achieve these priorities

During inspection, we reviewed the safeguarding adult policy which was dated January 2016. This policy had been updated in line with the Care Act 2014. The policy included types of abuse and some signs of abuse, how to report abuse and action that will be taken however it did not provide any time scales for action or any indication of how lessons would be learned. There was a guide in relation to what training individuals were expected to complete in line with their role within the policy.

Staff had a good understanding and knowledge of safeguarding policies and procedures. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. Safeguarding training compliance for the trust was on or above the trust target of 75%. However, the exception was Maister Lodge, an older adult ward, where only 38% of staff were up to date with their safeguarding adults training and 65% were up to date with safeguarding children training. Despite this low level of staff uptake of safeguarding training, staff we spoke to had a good understanding of safeguarding procedure and what to do when faced with a safeguarding concern. Staff were able to describe situations that would lead to a safeguarding referral. Staff knew the internal lead for safeguarding as well as the local authority safeguarding hub

The trust had a safeguarding children policy dated July 2013. It had been amended in July 2014 and was due for review in March 2016, but had not been updated at the time of our inspection in April 2016.

Nineteen out of 55 staff in the inpatient learning disability services had not completed, or were not up to date with, safeguarding adults training. Despite this low compliance to safeguarding training, staff said they were clear about safeguarding and the procedures to follow including how to make referrals. The safeguarding policy said referrals should be made when abuse occurred or was alleged. It stated the rationale for not making a referral that met the criteria should be fully documented to show this had been considered. We saw evidence of referrals made by staff in accordance with this. They had documented details of contact with the safeguarding team along with their response and advice. However, there were instances where staff had not followed these procedures. Records showed one patient had told staff another patient had threatened them into giving up some of their belongings. This had not been referred to the safeguarding team and there was no information to show this had been considered. There were documented occasions of patients causing harm and minor injury to other patients. Although staff had taken action in response to these, there was no evidence of any safeguarding considerations. Another patient's relative alleged somebody (unrelated to the service) had recently taken money from the patient whilst on leave. Staff had not taken any action at the time the allegation was made to follow this up. This showed that staff had failed to identify and take appropriate action to respond to safeguarding concerns. This had exposed patients to risk of harm and abuse.

The safeguarding team described a new way of working which promoted openness, which enabled clinicians to approach safeguarding colleagues for advice and support. They described drop in sessions where adult and child practitioners were available to advise, using case studies to help learning. It was felt by the safeguarding leads in this area that clinicians were beginning to receive this message but that there was still had some way to go to embed this way of working.

Serious case reviews

The trust has had no serious case reviews in the last 12 months.

Track record on safety

We analysed data about safety incidents from three sources. Incidents reported by the trust to the national reporting and learning system (NRLS) and to the strategic executive information system (STEIS) and serious incidents reported by staff to the trust's own incident reporting system (SIRI). These three sources were not directly comparable because they used different definitions of

severity and type and not all incidents were reported to all sources. For example, the national reporting and learning system did not collect information about staff incidents, health and safety incidents or security incidents.

Providers were encouraged to report all patient safety incidents of any severity to the national reporting and learning system at least once a month. The most recent patient safety incident report (which covered 1 October 2014 – 31 March 2015) stated that for all mental health organisations, 50% of all incidents were submitted to the national reporting and learning system more than 26 days after the incident occurred. For Humber, 50% of incidents were submitted more than 34 days after the incident occurred which means that it was considered to be a consistent reporter.

The trust reported a total of 3,662 incidents to the national reporting and learning system between 12 January 2015 and 30 November 2015. When benchmarked the trust were in the middle 50% of reporters of incidents when compared with similar trusts. 73.1% of incidents (2,708) reported to national reporting and learning system resulted in no harm, 18% (665) of incidents were reported as resulting in low harm, 6.9% (254) in moderate harm, 0.5% (18) in severe harm and 0.4% (17) in death. The national reporting and learning system considered that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

Of the incidents reported to national reporting and learning system, 19% were related to 'Treatment, procedure', 11.5% to 'Disruptive, aggressive behaviour (included patient-to-patient)' and 10.8% to 'Self-harming behaviour'.

The strategic executive information system (STEIS) captured all serious incidents. Serious Incidents (as defined in the serious incident framework) can include but are not limited to patient safety incidents. Whilst almost all patient safety incidents that have been reported to the national reporting and learning system with correct use of the national reporting and learning system categories for death or official severe harm four would be likely to meet the definition within the serious incident framework, the serious incident definition must be directly applied when considering if reporting via the strategic executive information system is required.

In the period 6 November 2014 to 9 October 2015, the trust reported 40 serious incidents. Of these,

- 35 were incidents that were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public.
- two were incidents that were a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population.
- three were incidents that concerned a loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Staff survey

In the NHS staff survey of 2015, 20% of staff reported that they had witnessed potentially harmful errors, near misses or incidents in last month. This figure had increased by two percentage points from the 2014 survey. This figure was also two percentage points below the national average for combined mental health / learning disability and community trusts.

The survey showed that 94% of staff reported errors, near misses or incidents witnessed in the last month. This figure increased by three percentage points from the 2014 survey. This figure was two percentage points higher than the national average for combined mental health / learning disability and community trusts.

The trust reported a score of 3.54 in reporting staff confidence and security in reporting unsafe clinical practice. This figure has remained the same as the 2014 survey. This figure is 0.16 lower than the national average for combined mental health / learning disability community trusts

NHS safety thermometer

The mental health safety thermometer was designed to measure local improvement over time and should not be used to compare organisations, due to differences in patient mix and data collection methods. Safety thermometer data should also not be used for attribution of causation as the tool is patient focussed

The NHS safety thermometer measured a monthly snapshot of areas of harm including falls and pressure

ulcers. In the period January 2015 – January 2016, the trust reported 66 new pressure ulcers with the highest monthly number being 12 in March 2015 with a prevalence rate of 1.4%. The prevalence rate declined to 0.3% in November 2015.

In this period the trust reported 46 falls with harm. The highest monthly numbers reported were six each in January and March 2015 with prevalence rates of 0.8% and 0.7% respectively. In this period, the trust reported nine new catheter and urinary tract infection cases. The highest monthly number reported was three in May 2015 with a prevalence rate of 0.4%.

Intelligent Monitoring

The trust was flagged as a risk in relation to the number of deaths of patients detained under the Mental Health Act particularly, the number of suicides of patients detained under the Mental Health Act (all ages).

Reporting incidents and learning from when things go wrong

Reports to Prevent Future Deaths

There were no Reports to Prevent Deaths published between January 2015 and January 2016 relating to the trust.

Trusts are required to report serious incidents to the strategic executive information system. These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 40 serious incidents between 14 November 2014 and 9 December 2015. None of these were never events. Two of the incidents occurred in adult community services, these were all pressure ulcers (one grade three and one Grade four). Nineteen incidents were reported from

adult community mental health and nine were reported from adult In-patient mental health.

Duty of Candour

Duty of Candour is when providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment,giving them reasonable support, truthful information and a written apology.

Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents

The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident

The trust had a Duty of Candour policy which was dated December 2015. The policy worked to guide staff on the understanding of duty of candour and their responsibility in ensuring a culture of candour. The policy has had an equality and diversity impact assessment and the principles of the Mental Capacity Act were applied in the development of the policy. The policy had a clear flow chart diagram for staff to follow and there was template letters available for staff to use both pre and post investigation to ensure consistency when writing to individuals affected by these incidents. The organisational risk management group monitored compliance with duty of candour for moderate, severe and significant harm through weekly meetings. There was an audit tool within the policy which guided the care groups in reviewing the level of harm experienced by the patient.

In crisis services when we asked staff about their understanding of their duty of candour, staff knew of the trust policy and how to access it. Staff referred to the duty of candour as being open and honest with people when things go wrong. Staff did not receive specific training on the duty of candour but said this was included in their defensible documentation training. The datix system also prompted them to consider duty of candour. One member of staff was able to give an example of how they applied the duty of candour and described how they gave feedback to a former patient following an incident.

In older adults inpatient services Staff were aware of the need for openness and transparency if there was an incident. Staff encouraged patients and their carers to complain if there was something they were concerned about.

Anticipation and planning of risk

The board had identified strategic risks which could impact on business and had developed a board assurance framework. The trust provided their board assurance framework, detailing 14 key objectives. Also included is an action plan looking at four areas of weakness.

Inadequate

Are services safe?

Humber NHS Foundation trust is required to create and maintain plans to demonstrate how it would deal with a variety of emergency situations and how it would maintain services during a crisis. The emergency planning teamwas responsible for writing and updating all the emergency plans and for coordinating the trust's response in a time of crisis. If there should be an emergency situation, the emergency control room in the IT technology centre would beactivated and all actions and decisions will be coordinated from this area.

The trust would then link in with other health organisations, the local authorities and the emergency services through procedures that have been tested in order to deal with any crisis effectively and with minimum disruption to services and service users. All services and departments in the trust are required to produce business continuity plans which describe how their service or department would keep services running in the event of an emergency.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care

A number of electronic record systems were in use as well as paper records.

Risk assessments were captured on a system called Galatean Risk and Safety Tool (egrist). There was another recording system, Lorenzo that stored contacts and letters, systemone was also in use throughout the trust.

Staff coordinated paper records of patients care and clinical notes with electronic systems for recording risk assessments, incidents, admission information and patients personal contact details. All trust incidents were captured on the DATIX system.

The quality of records was variable. In forensic services all wards operated paper care records

The trust was moving to an electronic case note system, Lorenzo, with Darley House being the pilot ward commencing May 2016. Care records were stored securely in locked cupboards in staff offices. The files contained a contents list however, record keeping was disorganised in the paper files making it difficult to find information at times. Staff acknowledged the paper system was not ideal and hoped the move to an electronic system would make records easier to access.

The Galatean Risk and Safety Tool was completed electronically and a copy printed off and retained within the file. At the time of the inspection, the trust was experiencing some technical difficulties with the electronic record. As a result, staff were not using the Galatean Risk and Safety Tool to review risk. Staff in acute and psychiatric intensive care units told us they were using the patient's safety plan as a means of monitoring risk whilst the electronic Galatean Risk and Safety Tool was unavailable.

Some safety plans did not include all the risks on the Galatean Risk and Safety Tool. This was therefore not a robust method of assessing ongoing risk whilst the Galatean Risk and Safety Tool was unavailable for use.

In substance misuse services, there was a generic care plan for those patients the service transferred to the specialist drug service for prescribing interventions. This care plan only included goals directly relating to maintaining their substitute prescribing treatment. There was no inclusion of personalised, holistic or recovery orientated plans. There were care plans in 20 of the 28 records we looked at in substance misuse services, 11 of these were more than three months out of date

In wards for people with learning disabilities and autism all patients had a comprehensive assessment after admission which included a physical health examination. Ongoing physical health care was recorded and we saw care plans for specific health issues such as epilepsy, skin problems and weight loss. All patients had a completed 'hospital passport'. This is a document that assists people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

In community health services inpatients, patient care was personalised in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care. Comprehensive assessments were completed by each member of the multi-disciplinary team and progress was discussed within the daily multi-disciplinary team meetings and communicated in a timely manner with the patient and their families.

Within community health services for adults, we saw that staff carried out appropriate risk assessments at first contact in order to identify patient risk and ensure that care could be tailored to meet these needs. This included basic tissue viability, falls and nutritional assessments. However, within Neighbourhood Care Teams, the way a patient's care plan and risk assessments were reviewed varied between individuals. We observed that some staff would set up the

review as part of a care plan and others set up a task as a reminder to review the care plan or risk assessment. There seemed to be no consistency in the approach taken and meant that there was a risk that some assessments may not be updated appropriately.

Best practice in treatment and care

Throughout 2015, the trust had taken part in 26 clinical audits however, there was a gap in audit activity for 2016, including within community health care. There was a failure to establish a robust approach to audit with particular reference to the National Institute for Health and Care Excellence (NICE) guidelines which resulted in this issue being placed on the trust risk register.

We reviewed six prescription charts on Newbridges, Westlands and Avondale and in four of these they indicated use of rapid tranquilisation. The physical health monitoring of the patient had not been carried out in accordance with national guidance (NICE May 2015) or in accordance with the trust policy, which was due for review in February 2016.

The trust has participated in the 2014 national audit of schizophrenia. Notable findings for the trust included:

Performance in monitoring of physical health risk factors was average in the trust and is thus below the ideal target. Evidence of intervention for problems with blood pressure or alcohol misuse was significantly lacking.

Availability and uptake of psychological therapies was below average and thus well below what should be provided.

Many aspects of prescribing practice were average in the trust.

A rather low proportion of service users in the trust had investigations as to the reasons of not adhering to their medication or their alcohol and substance misuse.

The trust developed an action plan from the outcome of the national audit of schizophrenia results which saw them in the bottom 10%, some actions included:

- Agreement to recruit service users and carers to the bank to act as a reference group for clinical audit, research and evaluation of services.
- To identify user and carer groups held throughout the network
- The network to adopt the health improvement programmes (HIP) to ensure all patients' physical well being is monitored and assessed at time of care programme approach (CPA) review.
- To review health and well-being of carers via carer assessments
- Record in the case notes that psychological therapy has been offered, with reasons identified when offer is not accepted.
- Discuss with relevant Universities the development of specialised cognitive behavioural therapy for psychosis training

Whilst we were told this by the trust we did not see any evidence of this in practice.

Skilled staff to deliver care

All teams consisted of a range of disciplines including consultant psychiatrists, junior doctors, nurses, social workers, occupational therapists, psychologists, support workers and administration staff.

Specialist Training

Staff at Maister Lodge were ensuring that staff on the ward completed formal dementia training to better understand patients with dementia.

We saw that specialist staff within the community health adults services delivered training to other staff to increase their knowledge and competence in areas such as oxygen therapy and diabetes. An example of this was that once a month the diabetes team provided a teaching session to all staff for the administration of insulin and diabetes overview.

At Newbridges, mandatory training for all staff was being prioritised, so no other training was available to staff until mandatory training had reached the trust compliance level of 75%.

The lead nurse in the substance misuse services was the only non-medical prescriber in the partnership, however two other nurses had begun training for this.

Appraisals

Requires improvement

Are services effective?

In the NHS Staff Survey 2015, 79% of staff said they had been appraised in the last 12 months compared to a national average of 91%.This score had reduced by 14 percentage points 2014 to 2015. This was considered a negative finding.

We also found that in the NHS staff survey 2015, the trust scored 2.96 compared to 3.05 nationally for the quality of appraisals. The 2015 score was 0.09 points less than the national average for combined mental health/learning disability/community trusts and was considered to be a negative finding.

In the NHS staff survey 2015, the trust scored 3.66 with regards to the support staff received from their immediate managers. This was below the national average of 3.86 for combined mental health/learning disability/community trusts which was considered a negative finding. The score had reduced by 0.03 from 2014 to 2015.

As at 29 February 2016, a total of 1,723 (70%) permanent non-medical staff had received an appraisal and 740 (30%) permanent non-medical staff have not had an appraisal. The core service with the lowest appraisal rate was community health services inpatients with 34%. The core service with the highest compliance was the substance misuse service at 100%.

Performance

Poor performance for staff was dealt with through the trusts policy, we reviewed staff files where disciplinary action had been taken and they had been undertaken according to trusts human resources policies.

Revalidation

The trust provided their general medicines council (GMC) revalidation information broken down by team. All teams had 100% compliance with this measure.

Multi-disciplinary and inter-agency team work

We spoke to commissioners of services and also received feedback from other stakeholders, which showed they had developed an open and honest relationship with the trust.

All core services had regular multi-disciplinary team meetings usually weekly or more often when the patient's need dictated this.

There were good multi-disciplinary working in the crisis teams. Staff met daily to review people who used the service.

The forensic services employed two part time speech and language therapists and a part time speech and language assistant. The therapists spent the majority of their time working with patients on Ullswater ward regarding communication, capacity, consent and patient pathways. Staff felt that this therapy was very positive for the patient group and fed into the patient's treatment plan in multidisciplinary team meetings.

In community health services for end of life care, there was evidence of multi-disciplinary working across all teams. Consent to care and treatment was obtained in line with legislation and guidance, including the mental capacity act 2005.

On acute services multi-disciplinary team meetings took place weekly on all the wards. This gave professionals involved in patient care the opportunity to discuss the treatment being provided and any possible changes. We were unable to observe any multi-disciplinary meetings. However, we did see documentation that was completed at these meetings. These showed that the meetings were well attended by a range of professionals.

Discharge and referral pathways in urgent care services showed effective multidisciplinary working practices.

Adherence to the Mental Health Act and the Mental Health Act code of practice

Training in the Mental Health Act was not mandatory for staff at the trust. However the Mental Health Act states that certain staff should have regard for it. Data provided indicated very low numbers of staff completed Mental Health Act training. However we were unable to report the compliance percentage as the number of eligible staff was not recorded. There were however, 400 qualified mental health and learning disability staff employed by the trust. Training in the revised Mental Health Act code of practice had not been delivered. In total only 99 staff were trained in the Mental Health Act, figures were

Community health services Urgent Care 1

Wards for older people with mental health problems 1

Community health services for children, young people and families 1

Requires improvement

Are services effective?

Other 1

Forensic inpatents/secure wards 4

Mental health crisis services and health-based places of safety 6

Community health services for adults 7

Specialist community mental health services for children and young people 7

Community mental health services for people with a learning disability or autism 9

Community-based mental health services for adults of working age 19

Community-based health services for older people 20

Acute wards for adults of working age and psychiatric intensive care 23

The trust had a blue light' briefing system in place which was used to communicate any changes to practice require immediately by staff including updates to the Mental Health Act.

In older adults inpatient services detention paperwork was orderly up to date and stored appropriately. There were good checklists and proformas provided by the trust to ensure the correct papers were available on the ward for each detention episode. Detention papers showed that there had been appropriate medical and administrative scrutiny to ensure that where patients were detained under the Mental Health Act, each detention was supported by a full set of well completed detention papers. The section 17 leave forms were well completed with clear conditions.

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

There were 13 Mental Health Act Reviewer visits between 1 March 2015 and 1 March 2016, all of which were unannounced visits.

In total over 13 visits there were 50 issues found at locations across the trust. The highest category for issues was purpose, respect, participation, least restriction with 25 issues, equating to 50% of the total. Other issues included consent, leave of absence, admission and control.

The psychiatric intensive care unit at Miranda house had the most issues in a single visit with seven and Lilac Ward (Learning Disability) at Townend had the lowest number of issues in a single visit at two.

At Lilac ward we found that assessments of capacity to consent to treatment were not completed for two detained patients in accordance with code of practice (CoP) guidance and one patient detained under section 3 did not appear to have had a nearest relative identified within the meaning of the Act.

At Miranda house we found that:

- the patients' files showed that patients were given information regarding their rights on arrival on the psychiatric intensive care unit but did not provide evidence that this had been repeated.
- Assessments of capacity to consent to treatment were not being completed for the majority of patients in accordance with code of practice guidance.
- No evidence that patients were being given information about the treatment being prescribed to them, where practicable.
- One patient detained under section 3 did not appear to have had a nearest relative identified within the meaning of the Act.
- Patients' discharges from psychiatric intensive care unit were being delayed because beds were not available for them in less restrictive environments.
- Staff were not aware of a trust policy on the possession and use of mobile phones and mobile devices.
- The staff we spoke with were unable to tell us whether the trust had any policies which guided the use of restrictive interventions in regard to the low stimulus room

We found that the trust had sent comprehensive action plans to address these issues.

During our visit to acute mental health wards we saw evidence that all detained patients had access to an

independent mental health advocate (IMHA). An automatic referral to the independent mental health advocate was made by the central Mental Health Act administration office in the trust. Most of the detained patients we spoke to confirmed that they had seen and spoken to an independent mental health advocate. We also saw that patients had regular access to advocacy across forensic inpatient and secure ward services.

Good practice in applying the Mental Capacity Act

Mental Capacity Act was part of mandatory training, however we found that the overall compliance rate for Mental Capacity Act training across the trust was 50%, far below the 75% trust target.

The highest achievers were community mental health services for people with a learning disability or autism at 84% and community-based health services for older people at 66% and the lowest were community health services urgent care at 17% and mental health crisis services and health-based places of safety with 21%.

In older adults, inpatient services, staff ensured health decisions were made based on mental capacity or in the best interest of the person. We observed staff seeking informed consent prior to giving care, for example, when moving people. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible.

Fifty per cent of the staff on the older people's wards had received recent training on the Mental Capacity Act including the five statutory principles. This broke down further to 84% of staff of Mill View Lodge were formally trained and up-to-date; whereas only 26% of staff on Maister Lodge were formally trained.

Within community health adult services, the overall compliance rate for Mental Capacity Act training in the service was 56%; worse than the trust's target of 75%.

Deprivation of Liberty Safeguards

The trust provided information around the Deprivation of Liberty Safeguards applications they had made in the last six months. The trust data does not provide an exact date range but application dates run from 3 June 2015 to 25 February 2016.

There were 31 Mental Health Deprivation of Liberty Safeguards applications made. 18 (58%) out of 31 applications were classed as 'urgent'. These broke down as wards for older people with mental health problems 20, wards for people with learning disability or autism six, community health inpatient services four and learning disabilities one.

The CQC records show that we received nine Deprivation of Liberty Safeguarding notifications from the trust between the same period (3 June 2015 to 28 October 2015). The details are Townend Court four, Maister Lodge three, Willerby Hill one, Millview one.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

During the inspection, we saw many examples of positive interaction between staff and patients across all services we visited. We saw that patients were treated with kindness, dignity, respect and support and that staff were committed to their roles and compassionate about the patients they were responsible for.

We were able to see that staff knew their patients well across all services and were able to communicate effectively with those with communication difficulties.

When visiting the mental health services wards for learning disabilities or autism we saw that staff spoke in a kind, respectful way and tailored their communication styles to meet the needs of each patient. Two patients had limited verbal communication and were receptive to sensory stimulation. We saw staff use touch, such as holding the patient's hand, in an appropriate manner whilst communicating. We observed that one staff member used signing to communicate with one patient who responded in turn with signs and was smiling and laughing throughout the exchange.

During our visit to the end of life team we visited a patient who was very frightened about being alone at night. Reassurance was given and following careful investigation, it was established that this stemmed from comment made by a doctor in hospital which was interpreted by the patient as them being expected to die in their sleep. The nurse immediately arranged a night sitting service to support the patient and to help the patients' family get some rest.

However, patients we spoke to who were currently accessing the mental health acute inpatients wards told us that staff were often too busy to respond quickly when patients asked to speak to them. We did observe staff telling patients to wait or speak to another member of staff whilst we were on the wards. Twelve of the patients we spoke to told us that they didn't think there were always enough staff on duty. This was also reflected on two of the comments cards we received. Patients told us that this meant they did not get to spend enough one to one time with staff.

Patients did not have keys to their bedroom doors. This meant that patients had to request access to their rooms by staff. Patients told us staff were not always available to respond to requests to open bedroom doors. Patients informed us that at times ward activities and escorted leave were cancelled due to staff shortages. They told us they found this frustrating. Patients also said that there was almost nothing to do at weekends, as activities were only arranged during Monday-Friday.

In the health based place of safety unit we saw that the safety, dignity, and confidentiality of people detained under Section 136 was compromised. Staff from the emergency services brought people who were detained under Section 136 to the health based place of safety either by ambulance or by police car. Emergency staff brought people through the main door of the reception area at Miranda House. The entrance door outside the reception area was rarely used. People were brought into a public area before entering the health based place of safety. The door into the health based place of safety led directly into the reception area. This meant that privacy; dignity and confidentiality were compromised and put the person detained under Section 136 and others at risk. Staff observed people detained in the health based place of safety at all times to mitigate the identified risks in the room. This meant that staff observed people using the toilet facilities, which compromised their dignity.

The friends and family test was launched in April 2013. It asked people who use services whether they would recommend the services they have used and gave the opportunity to feedback on their experiences of care and treatment.

For community health services, the percentage of respondents who would recommend the trust as a place to receive treatment, was above the England average during the five -month period from July to November 2015, with August and November 2015 reaching 99%. This fell to

below the England average in December 2015. However, the response rate was lower in each month (around a third) of the England average and therefore casts doubts on whether the figures are representative of the patient's views on the whole.

For mental health services, the trust scored above the England average throughout the six-month period. The response rate had been equal or higher in each of the six months in the period and therefore provided a more representative view of the trust than the community scores.

There were some variations in the data with September having the highest percent (6%) that would not recommend the trust whilst October 2015 had 0% of patients who would not recommend the trust.

The staff friends and family test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asked staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work.

The trust had a lower staff response rate than the England average (9% compared to 11.4%) during quarter 2 of 2015 (1 July – 31 September).

The percentage of staff who would recommend the trust as a place to receive care was 12% lower than the England average with 67% compared to 79%.

In addition, staff who would not recommend the trust as a place to receive care was slightly higher than the England average with 8% compared to 7%.

A similar trend was found for staff who would recommend the trust as a place to work as was found for staff who would recommend the trust as a place to receive care.

The figures for this showed a lower percentage of staff who would recommend Humber NHS Foundation trust as a place to work at 52% compared to the national average of 62% and a higher number who would not recommend the trust as a place to work when compared to the England average at 26% compared to the national average of 19%.

In the community based mental health services for adults of working age a monthly patient survey took place to gather patient feedback on the services. The feedback we saw from January and February 2016 was very positive. Information from the survey was fed back to the services through their key performance indicators. Action plans were in place to address any concerns raised within the responses and also to address some identified problems with the uptake of patients completing the survey. Overall responses from the patient survey were good, which reflected the information we were given from families, patients and carers.

Patient led assessment of the care environment (PLACE) assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

In relation to privacy, dignity and wellbeing, the 2015 patient led assessment of the care environment score for Humber NHS Foundation trust was 89% which is just above the England average of 86%. St Andrew's Place, Maister Lodge and Newbridges were the only locations to score below the England average.

There were seven individual comments raised with the CQC via share your experience web form between 8 March 2015 and 7 March 2016. All were negative comments about the trusts mental health services and three were whistleblowers.

The CQC community mental health survey 2015 surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. The survey involved 55 NHS trusts in England and had 13,292 respondents, a response rate of 29%.

The trust performed similarly to other trusts in the CQC community mental health survey. At the start of 2015, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 247 people (29%) which were exactly in line with the England average.

Involvement of people using services

During inspection, most patients and carers we spoke to told us that they were involved in their care and were given the opportunity to make suggestions regarding the services they were accessing. However we found that documented evidence regarding patient's involvement in their care was not always available.

Good

Are services caring?

In the substance misuse service, care plan documentation and patients told us that they were not fully involved in their care plans. Most patients were unaware of what was on their care plan but felt involved in their treatment. This was because care plans were not regularly reviewed with the patients during their appointments. Reviews mostly took place during the multidisciplinary team meetings in the patient's absence. The care plan itself was not updated with new goals and interventions.

The trust performed similarly to other trusts in the CQC community mental health patient experience survey for questions relating to 'have you been told who is in charge of organising your care and services' 'being able to contact this person if concerned about their care' and 'that this person organises the care and services they need well'

The trust scored higher (better) than other trusts for those who had a formal meeting to discuss how their care is working and 'being involved as much as they wanted to be in this discussion'

During our visit to the forensic inpatient and secure ward we saw evidence that the patient involvement and empowerment meeting had occurred monthly between September 2015 and February 2016 and involved senior management, ward managers and staff. Staff invited patients from each ward to attend and to discuss matters arising on the wards and to provide feedback on their care.

The trust encouraged patients to be involved in the recruitment of staff, and one patient we spoke to had done this and found it to be a positive experience.

The board encouraged departments across the trust to share patient experiences at board level. Staff had facilitated a patient on Swale ward to attend the board meeting and present their own patient journey. A local journalist had picked up on this and blogged on social media during the board meeting. The patient felt very positive about this and had enjoyed sharing his story. Patients also attended a regional service user meeting and were due to attend a regional patient involvement conference.

On the wards for people with learning disabilities or autism we saw an example of one patient who had a certificate on display from March 2016 commending them for their contribution for interviewing psychologists and speech and language therapists who had recently applied to work at the service. And the patient told us they had enjoyed being involved with recruitment of staff.

In community mental health services for children and young people patients were involved in the development and updating of the service website. This had included emergency contact information, access to online counselling and self-help tools and applications which young people could access and use on their phones to provide extra support.

Across community health services, we saw that staff gave a full explanation of the care and treatment the patient was receiving when discussing matters with them in clinic and at home. The majority of care plans we saw were patient focused and involved families and carers where appropriate.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

Our findings

Access and discharge

The trust's proportion of admissions to acute wards gate kept by the crisis resolution home treatment team (CRHT) was well above the England average for all 12 quarters reported – ranging from 0.4 % - 3.7% above the England average. April - June 2013 (Q1 13/14) was the lowest point in the period with 98.3%, although they exceeded the national 95% target in all quarters.

We found that in a number of services the trust was not meeting their targets from referral to assessment and/ or assessment to treatment.

In substance misuse services, patients were required to travel to different locations to access treatment as their needs changed. The specialist drug services were based in Hull outside of the East Riding area. When patients were accessing the community drug and alcohol teams based in Goole, Bridlington or a drop in at East Riding they were at times referred back to specialist drug services if they relapsed, required medication changes or risks increased. Patients told us this compromised their treatment as traveling on a daily basis was time consuming and added a financial pressure. The partnership had a three week target to access specialist drug services from referral. Data from the national drug treatment monitoring system showed that 5.2% of opiate patients waited over the three week target. Patients told us that they also waited up to six weeks when they were transferred internally between teams. The pathway across the treatment programme resulted in long waits and a high percentage of patients dropping out of treatment.

In the community mental health service for people with learning disability and autism the trust had a target of 18 weeks from referral to be allocated a case worker. Very few of the learning disability services were able to meet this target and some services had waiting times in excess of 90 weeks.

In community based mental health services for adults of working age the waiting list from assessment to treatment was significantly above the trust target of 14 days. In the figures provided to us by the trust for February 2016 the average waiting time to access the John Symons service was in excess of 200 days.

In community health services for children, young people and families we found waiting lists to access paediatric therapy services. Children were waiting over 18 weeks for Speech and language we were told that the longest waiting time had been 36 weeks from referral. The service did, however, have an action plan in place which included ongoing recruitment, more efficient ways of working and the use of agency staff. Data showed there was an ongoing reduction in the length of waiting times.

In community services for adults, some services, such as speech and language therapy and pulmonary rehabilitation, had lengthy waiting times in excess of 18 weeks. We also saw that Neighbourhood Care Teams were not meeting performance targets for triage.

The services with the highest assessment to treatment times were learning disabilities (community mental health services) with an average of 42 days and CAMHS (specialist community mental health services for children and young people) with an average of 36 days.

The average bed occupancy rate was 83% across all wards between 1 September 2015 and 29 February 2016. 11 out of 22 wards had bed occupancy over 85%. These were in the following four core services: forensic inpatient 84%, long stay/rehabilitation mental health 94%, mental health acute ward for adults 86% and community health inpatient services 85%. Whilst on inspection we reviewed these figures and we found that these figures were excluding leave beds, and when these were taken into consideration the figures were significantly higher.

Although there is no optimum bed occupancy rate for hospital beds, the Royal College of Psychiatrists looking

Requires improvement

Are services responsive to people's needs?

ahead, future developments of UK mental health services 2010 and "do the right thing" how to judge a good ward 2011 states that very high bed occupancy mitigates against quality and safety of in-patient care. Bed utilisation is at its most efficient when bed occupancy is at 85%. This means that patients can be admitted in a timely fashion to a local bed,retain the connections with their social support network and take leave without the risk that they cannot return to their ward should they need a longer period of in-patient care. Delays in admission to hospital can result in patients becoming more distressed and unwell, and likely to need more long-term care.

The trust had been flagged as a risk for bed occupancy ratio, looking at the average daily number of available and occupied consultant-led beds open overnight.

We found that there was a pressure on the use of beds within the mental health acute inpatient wards and psychiatric intensive care unit. The average bed occupancy rate between April 2015-March 2016 was 97%. We were told that staff felt under pressure to admit patients into leave beds and there had been occasions when patients who had been away on leave had been unable to return to the ward as their bed had been allocated to a new patient. We saw how this then impacted on the long stay rehabilitation units for adults of working age. We were told how pressures on acute admission wards had led to inappropriate admissions within both rehabilitation units. Patients were admitted with no clinical rational or rehabilitation needs, we were told that although these admissions were temporary they unsettled existing patients as staff had to concentrate on the patients who were most vulnerable. There was no dedicated individual or team to oversee bed management within the trust. This was being covered by the mental health crisis team two days a week and three charge nurses from the mental health acute wards one day per week each. This was in addition to their usual duties

The psychiatric intensive care unit was closed to female admissions or transfers. This was due to a male patient in long term segregation in the female sleeping area. This meant that if a female patient needed a place on psychiatric intensive care unit they would need to be referred out of area.

In mental health services for children and young people the service website included access to an online counselling service called 'Kooth' which provided vulnerable young people who had emotional or mental health problems with support. The service was aimed at 11-25 year olds and was confidential. There was also a self-help section called 'moodjuice' which was designed to help individuals think about emotional problems and work towards solving them.

Overall, the average length of stay for current patients was 305 days across the trust, compared to an average of 304 days in the previous 12 months.

The figures below show discharged patients average stay across the 12 month period (1 March 2015 to 29 February 2016) and current patients (as at 29 February 2016).

Acute wards for adults of working age and psychiatric intensive care unit – 25 days

Community health end of life – 9 days

Community health inpatient services – 19 days

Forensic/secure wards – 858 days

Long stay rehabilitation mental health wards for working age adults – 107 days

Wards for older people with mental health problems – 54 days

Wards for people with learning disabilities or autism – 60 days

The trust reported that there were no out of area placements during the period 1 September 2015 and 29 February 2016.

During our inspection we saw that there were a total of 119 readmissions within 30 days reported by the trust between 1September 2015 and 29 February 2016 across 22 wards. Acute wards for adults of working age and psychiatric intensive care units had the most with 104 (87% of readmissions reported).

In the substance misuse service we found that readmissions within six months of discharge was 14% above the national average of 10.7%. In the new service contract aftercare would be provided for all substance misuse whilst the previous contracts only provided aftercare to those who were alcohol users. Discharged patients would then have the opportunity to attend day groups and support to help prevent readmission and relapse.

Requires improvement

Are services responsive to people's needs?

There was a 3% rate of delayed discharges on average across Between 1 September 2015 and 29 February 2016. Beverley Community Ward with 15% was the ward with the highest proportion of delayed discharges.

There were 141 patients with delayed transfers of care between January 2015 to December 2015. Overall, over the year, the number of delayed patients had fallen by 53%.

The trust's total number of delayed patients peaked in January and February, April and May and September, but had been at a steady level in other months. .

Public funding was the main reason for delayed patients between January 2015 to May 2015. In the second half of the year, this appears to be less of an issue, and awaiting care packages in patients' own homes was the most prominent reason for delay over three months.

Although public funding has been the highest number throughout the period, it remained at a similar level over the year. The month with the highest peak during the year (October 2015) was due to peaks in both awaiting care home placements and awaiting completion of assessment.

The number of days delayed over 2015 fell steadily, although there were spikes in May and again in September. Over the year in total, the number of delayed days fell by 55%.

The number that were the responsibility of the NHS fell steadily over 2015. The figure of 37 recorded in December 2015 represents an 86% reduction compared to January 2015.

The number of delayed days that was the responsibility of either the NHS or social care but reduced significantly over the year. However, the number that was the responsibility of both increased significantly.

There were a total of 4173 delayed days over 2015. The reasons with the highest number were as follows: 1152 (28%) were due to public funds, 815 (19.5%) were due to awaiting care packages in patients' own homes, 724 (17%) were due to awaiting residential home placement/ availability

The trust was flagged as an elevated risk for the proportion of care spells where patients were discharged without a recorded crisis plan.

The trust recorded 95% of patients on the care programme approach who were followed up within seven days after discharge in quarter 3 2015/16. This was below the England average of 97%. The trust was above the England average in the previous three quarters, before falling sharply in the latest quarter.

The facilities promote recovery, comfort, dignity and confidentiality

The trust provided the patient led assessment care environment scores in forensic services for 2015. The Humber Centre received a score of 99% for cleanliness, 94% for food, 91.16% for privacy, dignity and wellbeing and 92% for condition and maintenance. Greentrees ward incorporating South West Lodge received a score of 99% for cleanliness, 93% for food, 93% for privacy, dignity and wellbeing and 90% for condition and maintenance. The scores appeared higher than expected given the condition of some wards we had visited. However, the patient led assessment care environment scores gave an average view across all seven wards and some were in better condition than others were.

A range of activities were provided across the inpatients wards and most patients on these wards had access to outside space. However in the forensic inpatient and secure wards both patients and staff reported that there were not enough activities on the wards and that staffing levels could not meet the demands of the service. The service did not monitor if activities needed to be cancelled or how many patients were engaged in meaningful activity throughout the day. On Greentrees ward there was a vacancy for an activity worker which had influenced the level of activity offered to patients.. Staff told us that the ward was quiet during the inspection as most patients retired to bed in the afternoon.

We found that some telephones were in shared spaces but staff told us that they could be provided with facilities to make private calls.

The services provided each patient with an informative and comprehensive welcome pack to help familiarise them with way the services ran.

All community health inpatient wards were bright and well organised, staff and patients spoke positively about the facilities and environment.

Meeting the needs of all people who use the service

Requires improvement

Are services responsive to people's needs?

Wards and community bases were accessible to people with disabilities and facilities for wheelchair users such as bathroom and toilets were available. Some rooms at inpatient settings had been specifically adapted for those with a physical disability.

All services described being able to accommodate different spiritual needs, support for different faith needs could be accessed when required. In mental health acute wards and psychiatric intensive care units all patients had access to spiritual support but not all wards had a faith room which meant some patients needed to use section 17 leave to access local faith services.

The Humber Centre (forensic inpatient and secure wards) had a multi-faith room containing religious texts and items. A priest was available each week and could provide one to one discussions or meet groups. Staff told us if this arrangement was not sufficient patients could ask for further support and this with be considered in their initial assessment. Staff gave an example of a patient who was pagan and specific reading materials had been sought for him.

All services had access to interpreters when needed and could access information leaflets in different languages. In the mental health crisis team some team members were able to speak Polish enabling them to support the growing Polish community directly without the use of interpreters.

We were told across all inpatient facilities that dietary requirements could be accommodated this included meeting religious and ethical specifications.

In community mental health services for children and young people we saw how both the Hull and East Riding service had introduced a gender identity pathway as they had identified this as a growing population.

In substance misuse services specific advice and support was being provided to people who used image and performance enhancing drugs such as steroids and tanning agents. These clinics were provided within two different locations. Staff had also delivered training to local gym staff relating to steroid use.

A dementia strategy was in place, which identified the trust's aims and objectives in the care of people who have a dementia and their families and carers. This applied to all adults accessing community services. East Riding Community Hospital had designed facilities incorporating dementia friendly initiatives. Staff within community health adult service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This national scheme teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

The trust provided details of joint working arrangements, which were in place between the community team for learning disabilities and community health services such as district nursing and falls teams. This allowed community staff to access specialist support.

Listening to and learning from concerns and complaints

The trust received 177 complaints between January 2015 and March 2016. Of the total complaints 44% have been upheld (either fully or partially). No complaints were referred to the ombudsmen during this period. With the exception of 'attitude of staff; 'other' and 'policy and commercial decisions' all of the remaining categories received an increased number of complaints in 2014/2015 compared to 2013/2014

Mental health community adults received the highest number of complaints with 43, (24%), 12 of these were fully upheld and six were partially upheld.

Wards for people with learning disabilities and mental health long stay rehabilitation received one complaint each, only one of these was upheld.

We found that in all services most patients knew how to make a complaint and felt able to speak to staff about their concerns. We saw information regarding how to make a complaint displayed around trust premises and easy read information formats were available. Patient Advice and Liaison Services leaflets were available to all patients and included in most service information packs.

During inspection we observed a staff member on a ward for patients with learning disability or autism supporting a patient who wished to discuss a situation they were unhappy with. At all stages of the discussion the staff member asked the patient for their views and how they wanted to deal with the situation. The staff member with

Requires improvement

Are services responsive to people's needs?

the patients' permission and at their request agreed to take forward the concern as a formal complaint. This showed staff were responsive to patient's complaints and made efforts to find solutions.

The trust received 159 compliments during the last 12 months (March 2015 – February 2016). Community services received 110 (69%) compliments and mental health services received 49 (31%) compliments during the 12 month period.

Community adult services received the highest number of compliments with 74 (47% of trust overall).

Requires improvement

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

The trust had a strategy for 2015-2016 which established its vision of the trust's operational structure and how this structure would take the organisation forward in the near future.

The trusts vision was underpinned by five values.

The Vision was:

'We aim to be recognised as a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with a problem solving approach.'

The trust described their values as:

Putting the needs of others first

- We place our patients and their carers at the heart of everything we do
- We listen to what the people who use our services tell us – and we act on it
- We accept that this requires acting with courage at times

Acting with compassion and care at all times

- We treat patient and carers with dignity, respect and compassion at all times
- We deliver our services to the highest standards of safety and in safe environments

Continuously seeking improvement

- We focus on learning and developing an open culture
- We aim to provide the best services we can and constantly look at how we can improve them

Aspiring to excellence and be the best that we can be

- We believe in the need to innovate and develop new models of care based on evidence, research and best practice
- We are a teaching trust and seek to improve standards of care and clinical effectiveness

Value each other and develop teamwork

- We believe in multi-disciplinary work, bringing together the right people, with the right skills, to care for our patients
- We work across boundaries to deliver seamless service provision on behalf of our patients and their carers
- We recognise, reward and celebrate success'

Although the trusts vision and values were available on display for individuals to see in all trust services, the staff we spoke with could not identify these values and could not recall being involved in the development of them. There was a disconnect between staff working in services and the trust board. This impacted on how individuals felt about their influence within the trust and how valued they felt by those in leadership positions.

The trust had a strategy which began in April 2015 and was running until June 2016. This included changes which were made to the trusts operational structure, implementation of care groups and a new executive team. Although this strategy had begun to be implemented, the staff working in services told us they did not feel they were involved in the decisions regarding this new strategy and did not feel an inclusive consultation had occurred. The consultation period was still ongoing at the time of inspection but staff reported feeling that transformational changes were happening to them rather than feeling involved in the process.

We saw a good understanding of the strategy amongst the support service team and the care group management team. However, the service level staff did

not have a clear vision of the corporate restructure and uncertainty regarding individual's jobs existing in the new structure were causing anxiety and stress to those affected. This was evidenced through interviews with individual staff and focus groups.

The trust had set out a clear consultation timeline which provided opportunity to monitor and review the progress on delivering the strategy however at time of inspection this timeline was still in its infancy therefore we were unable to determine the outcome and impact of this plan.

Good governance

A new care group structure was designed and implemented in April 2015, each care group had a management team which was known as the triumvirate. Each triumvirate reported up to the support services and down into clinical services. The care groups included community and older people, children and learning disability, adult mental health and specialist services .This structure had been implemented to move the organisation forward and focus services on providing exceptional clinical care. The care groups were supported by support services and the following directorates had been developed:

- medical directorate
- nursing and quality directorate
- finance directorate

There was also a human resources and corporate affairs function.

A governance framework was in place within the trust which had a clear reporting structure. The trust board of directors were accountable for the running of the trust and had oversight of governance and quality issues through the executive management team and the mental health legislation committee. The quality and patient safety committee reported to the executive management team.

The following groups reported to the quality and patient safety committee:

- organisational risk management group
- health care associated infection group
- safeguarding group
- clinical audit and effectiveness group
- patient and carer experience group
- medical devices group
- integrated audit and governance group
- care group clinical forum
- deteriorating patient and resuscitation group
- drug and therapeutic committee

However, there were gaps within these processes, which meant that key elements of governance were not supported in such a way, which enabled robust systems. These included completion of mandatory training, appraisals, supervision, safe staffing, clinical audit, learning from incidents and national guidance on issues relating to the Mental Health Act.

There was also a lack of high level mental health knowledge within the board team with the exception of the medical director and the deputy director of nursing. Assurances for issues relating to mental health were provided by a non-executive director who did not have a strong mental health background. Staff informed us they felt able to pass information to board through the care group structure however did not feel they received the information they required and feedback from support services in the same way. This view was reflected by clinical staff working in services and by those in leadership positions. This had impacted on staff morale and a feeling of not been valued by the support services team.

The training compliance for trustwide services was 61% set against a trust target of 75%. Community mental health services for people with a learning disability or autism was the core service with the highest percentage of trained staff with an overall training rate of 74%. Wards for older people with mental health problems had the lowest aggregated rate of training of 45%. Through interviews and focus groups held during inspection we found that individuals struggled to be released from clinical areas to complete mandatory training it was felt this was due to staffing numbers and those on shift needing to remain within the clinical environment.

Staff appraisal targets were set at 85%, however the figures returned to us by the trust showed a 72% compliance of permanent non-medical staff who had received an

appraisal. The area with the highest appraisal rate was substance misuse services at 100%. The area with the lowest appraisal rates was community health services inpatients at 34%.

There was a safer staffing dashboard which was broken down into wards and inpatient units. This dashboard was published on the Humber NHS Foundation trust website so the public could access information regarding how the hospital was being managed. The public could also access trust board meeting papers on this page which enabled the public to see discussions about the figures shown on the dashboard. During inspection we spoke to staff that sat within the human resources and diversity directorate and at the time of inspection the trust were recruiting to approximately 240 posts. The trust were running a' golden hello' pilot where they gave a £500 incentive for new appointments and another £500 if the individual was still in post after 12 months. They were also looking at using social media as a way to advertise posts. Through interviews and focus groups held during inspection there was a reported theme of the teams within the human resource directorate been under pressure with limited staffing in post to respond to the work demands. There were staff vacancies within the structure and posts had not been recruited to. There was a reported lack of direction around staff training and a concern that decisions were not been made which would enable progress in the training strategy. Staff described not feeling valued, not being part of the wider trust and spoke of low morale.

The trust board of directors included a chief executive and five executive directors who were responsible for strategic leadership. A chairman and six non-executive directors also make up part of the board. They were not employed by the trust and their role was to provide advice and challenge to the executives.

Following the inspection, we attended a board meeting on the 04 May 2016. We reviewed minutes from these meetings dating back to December 2015 and interviewed members of the trust board. We found that although the trust had forecast a £1.2 m deficit from the £138m budget, this was not seen to be a significant deficit. The minutes from board meetings indicated that there were some financial pressures discussed, but these were not considered of significant concern. However the board time out timetable showed regular discussions at board level. Issues regarding staffing and the use of bank and agency staff, waiting lists, mandatory training compliance, recruitment and the length of time taken to move through the recruitment process were all discussed at these meetings.

Each care group had a cost improvement plan in place and this was managed at corporate level. Some workshops were held across care groups so they could identify cost improvements and to encourage a bottom up approach. There was evidence that the board had taken part in a development day in December 2015 and there was evidence of patient stories been shared during these meetings looking at areas such as end of life care and learning disabilities.

In October 2015, the integrated audit and governance committee was set up; the membership for this group was a non-executive committee and was in place to review trust systems of governance, risk management and internal control. This group met on a quarterly basis and held an additional meeting at year end to review annual submissions. The committee reported to the trust board and had no executive powers. There was a monthly audit and NICE group which was chaired by the deputy director of nursing and patient experience. This group oversaw the implementation of the annual clinical audit plan and tracked the progress of this plan. A number of priorities had been identified for future clinical audits and a clinical audit and effectiveness strategy for 2016–19 was in place. However we found that there was a gap in audit activity for 2016. Failure to establish a robust approach to audit with particular reference to The National Institute for Health and Care Excellence (NICE) guidelines, resulted in this being placed on the trust risk register.

The trust had an organisational risk management group which was responsible for monitoring and reviewing serious and significant organisational risks. The group commissioned incident investigations and co-ordinated a trust response. The group were also responsible for maintaining the corporate risk register and ensuring processes, strategies and policies relating to risk management were regularly reviewed and implemented within the trust. The meetings were held weekly and co-chaired by the medical director and the director of nursing, quality and patient experience. Although incidents and learning from incidents were discussed at this group and an organisational learning report was in place not all staff

working in services were able to tell us how they learned from incidents outside of the service they worked in. Therefore learning from incidents trust wide was not embedded across all services.

The trust serious incident and significant event policy was reviewed during the inspection; the policy was in date and reviewed to ensure compliance with the NHS England serious incident framework (March 2015). This also introduced a significant events analysis process. Amendments made to the policy in March 2016 took into account aspects of duty of candour in relation to serious incidents. The policy was comprehensive and showed clear lines of responsibility and accountability. Template letters and tools were included in the appendix to ensure consistency. However during inspection we reviewed eight serious incident investigations. These investigations varied in quality with some showing completed investigations, action plans and outcome letters and others not.

During inspection we looked at eight complaint files, two of these files were complaints made by patients detained under the Mental Health Act 1983 (MHA) and one of the files was a complaint made by a patient with a learning disability. We found that all these complaints had been supported, investigated and reported in line with the complaints policy. Action plans following the complaint investigation were in place. Through interviews we found the team working within the complaints department although under resourced, were committed and passionate about their role. However there had been little input from the chief executive into complaints and this impacted on how valued individuals who worked within this department felt within their role.

There were significant issues relating to the Mental Health Act. Particularly use of seclusion and segregation, Mental Health Act training, restrictive practices and the skills and knowledge of mental health of those in senior leadership roles.

Mental Health Act training was not mandatory for all staff within the trust and the figures provided to us by the trust showed a total of 99 individuals were up to date with Mental Health Act training out of a possible total of 400 qualified mental health and learning disability staff.

At time of inspection we were told by the trust that no patients were been nursed in long term segregation however we found that two patients were been nursed in long term segregation. The trust did have a seclusion and long term segregation policy this policy had been reviewed and implemented in March 2016 to reflect changes in the Mental Health Act code of practice. Which all providers had to have compliance with by October 2015.

We found examples of restrictive practices been used in the forensic and acute services. For example the opening of patient mail and decisions being made based on one individuals behaviour. Patients told us that this meant they did not get to spend enough one to one time with staff. In acute services patients did not have keys to their bedroom doors. This meant that patients had to request access to their rooms by staff. Patients told us staff were not always available to respond to requests to open bedroom doors It was not clear that staff understood this to be restrictive practice but rather just the culture with no external or internal challenge.

Managers and staff were keen to reduce restrictive practice and had begun to have monthly meetings. The purpose of these was to review and understand episodes of restraint and seclusion, monitor trends and patterns, review data from the risk department and receive updates from staff on the wards. A workshop had been held for patients in February to discuss areas of restrictive practice and identify next steps. On Ullswater and Greentrees wards recent changes included open smoking times and patients having control over their own finances. On Swale ward patients now had access to the TV remote as oppose to having to ask staff for it and were able to use the microwave in the patient kitchen. On Darley House, staff used observation and relational security to monitor any patient who had restricted access to certain areas. Managers reported there was some way to go with embedding the use of relational security and removing restrictive practice, but they felt a change in culture was occurring.

During inspection we talked with Mental Health Act hospital managers about their role and experience of working within the hospital. There was a concern expressed by hospital managers that they only ever undertook renewals and not appeals by patients. It was unclear if this information had been discussed with patients by nurses during their detention.

Mental Capacity Act mandatory training figures showed a total of 50% compliancy which is below the trust target.

Requires improvement

Are services well-led?

The community health services urgent care team totalled 17 % compliant with the community mental health services for people with learning disability or autism showing 84% compliance.

The trust had a Safeguarding Group which was a sub group of the quality and patient safety committee whose aim was to ensure safeguarding, leadership and expertise was provided across the organisation and to ensure processes were in place to provide accountability and assurance to the quality and patient safety committee. The Director of Nursing, Quality and Patient Experience is the chair of this meeting and the group met every six weeks. The Director of Nursing, Quality and Patient Experience also sat on the East Riding Safeguarding Children Board and the Assistant Director of Nursing, Safeguarding and Patient Safety provided a link into the safeguarding Named Nurse within the structure. The trust had produced a safeguarding annual report dated 2014-2016. The report summarised the trusts key activity for safeguarding adults and children across the location and included a ten-point action plan and actions, which had been taken in order to achieve these priorities.

There was a safeguarding adult policy, which was dated January 2016. This policy had been updated in line with the Care Act 2014. The policy included types of abuse and some signs of abuse, how to report abuse and action that will be taken however it did not provide any time scales for action or any indication of how lessons would be learned.

The trust had a number of clinical records systems in place and paper based records were also being used in some services. Systemone was used within community hospitals and physical healthcare. Lorenzo was focused on Mental Health and Learning Disabilities. The systems were not all joined up which meant work was often duplicated on multiple systems. There was a plan to move towards the patient portal which would draw together information from Systemone and Lorenzo however there was not a specific roll out or implementation date. The trust were approximately three months behind with their roll out plan for ensuring all services are using an electronic clinical record. There were reported IT connectivity problems in some areas. When staff were seeing patients in urgent conditions clinicians could not always get access to a whole patient record this impacted on clinician's knowledge of the patient and knowledge regarding clinical risk. It also meant documentation within the patient records could not always happen in a timely way. The trust was working with other public services to improve availability of wi-fi.

Chief information officers were in post who took the lead on staff engagement within the care groups. Officers were able to identify what the issues were within specific services in relation to Information Technology (IT). They also looked at how systems could be adapted to address the issues.

The trust information systems did not allow for the reporting of accurate information on the performance of services. Information requested by the Care Quality Commission prior to inspection did not match up to information we were given during inspection. The data was conflicting and this then required further investigation. During interviews we were told on a number of occasions the figures that had been received by the trust off the electronic staff records (ESR) system and these did not accurately reflect the true picture of activity in relation to mandatory training. There was also low confidence reported from clinicians in the use of Lorenzo. The trust were running two workshops on business intelligence to think about what information the trust should be measuring to ensure good quality data was available to provide assurance to themselves and commissioners.

Although relationships between the trust and commissioners had improved over the last 2 years, there was a feeling that further work was needed to strengthen the collection of accurate, timely, good quality data. Other issues identified by commissioners related to staffing and staff morale. Commissioners felt relationships had improved since the formation of the care groups and also felt that board had become more 'business focused' with an improved contracting process in place. Relationships between commissioners and local services were positive but some concern was expressed regarding the demand on young people's mental health services and the capacity within these teams to meet the demand. This was seen to be having a direct impact on staff morale.

Other stakeholders working with the trust felt there were challenges to engagement with the executive team however this had improved over the last six months. The feedback from patients and the public had been in main

positive, however some concern was expressed regarding access to community crisis teams and patients feeling they had been discharged too early which had impacted on re-presenting in an emergency.

The board had identified strategic risks which could impact on business and had developed a board assurance framework. The trust provided their board assurance framework, detailing 14 key objectives. Also included was an action plan looking at four areas of weakness.

1. The board assurance framework included board level action plans but the majority of these actions appeared to be without a date for completion or out of date, as reference was made to events that should have already taken place. The trust should have updated the board assurance framework and either removed completed actions or made it clear that they are 'previously completed actions' to highlight that they are not out of date. Also, completion dates should be included for all actions, wherever possible. The trust felt these concerns would be mitigated as part of the ongoing improvements and changes planned for the board assurance framework document. The trust aim to revise the board assurance framework in line with new trust strategic objectives; a consultation is currently taking place within the trust to develop these.

2. The board assurance framework does not include the scoring matrix within the document itself, which may have enabled improved discussion at the board around the risks and ensured that the scores were recorded appropriately. The inclusion of the scoring matrix within the board assurance framework document should be considered. The trust felt that this would be of benefit to board members and help with risk scoring.

3. There were currently no risks identified for the following trust goal: To work in partnership with other organisations and local authorities to develop seamless service provision. It would be expected that the trust has strategic level risks that would sit under each goal/objective. This goal should have been reviewed to determine whether any associated risks should be included in the board assurance framework .The trust agreed that going forward the trust would endeavour to have risks assigned to each of its new strategic goals.

4. Five risks on the board assurance framework had no links to the risk register recorded. board assurance framework risk 3.1 made reference to risks 263 and 269 on the risk register, however, risk 269 did not appear on the March 2015 Risk Register that was tabled at the integrated audit governance committee and when it was included on the February 2015 document presented to the board. There were no links to the board assurance framework noted and it was not included in the list of closed/updated risks. From discussion with staff it was found that this was due to two risks (263 and 269) being merged into one. In addition, risk 4.4 on the board assurance framework lacked any information under the "gaps in assurance" column but it did include a board level action plan. All columns of the board assurance framework should have included relevant, accurate information and there should be appropriate links between the board assurance framework and risk register. The merging of risks 263 and 269 should be reported to the next integrated audit governance committee and board meetings. The trust expressed that going forward, the trust would endeavour to have the information noted in all columns of the board assurance framework and clearly state 'none identified' if this was found to be the case. The board has been asked to consider and has discussed adding risks to the board assurance framework in relation to capacity and external enquiries/regulations. Once they have been added to the corporate risk register and wording has been approved, they will then be added to the board assurance framework, this was identified on the board assurance framework board level action plan.

The trust provided a risk register from December 2015 which detailed a total of 26 risks scoring 12 or higher. Also provided was a separate risk register which lists nine local risks by care group.

The trust were flagged as a risk for the proportion of Mental Health Act (MHA) and hospital inpatient episodes closed by the provider.

The trust have produced two documents in relation to equality and diversity, the annual report and an action plan. The annual report is split down into three areas, patient care objectives 2014/2015, staff objectives 2014/2015 and leadership objectives 2014/2015. Objectives included, to review the procurement and provision of translation services including British sign language, to

consider whether the age of patients on their ability to access services, to implement the requirements of the race equality standard and to include equality information on future governor nomination forms

Trust figures for mandatory equality and diversity training was below the trust target of 75% totalling 44% across the organisation. Wards for older people with mental health problems were 15% compliant with community health services for children, young people and families having a 61% rate of compliance.

Fit and Proper Persons Test

The fit and proper person's requirement (FPPR) is one of the new regulations that applied to all NHS trusts, NHS foundation trusts, and special health authorities from 27 November 2014. Regulation 5 of the fit and proper person's requirement says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualification, skills, and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).

We reviewed the personnel records of five executive directors and three non-executive directors. All were found to be compliant with the requirements of the regulation. All had a disclosure and barring scheme check including those employed prior to implementation of the fit and proper person's requirement. There was an annual declaration of ongoing compliance and annual review of the disqualified directors and insolvency service register.

The trust had a documented process for the fit and proper person's requirement, however this was undated. This included clear procedures and checks for new applicants and was consistent with the requirements of the fit and proper person requirement.

Leadership and culture

During inspection we held focus groups with a range of staff groups. Staff spoke passionately about the work they did and mainly felt supported within their local teams. However staff morale was low, there had been large transformational changes and changes to key figures within the organisation. Staff expressed feeling disconnected from the support services and could not always tell us who key individuals in leadership positions were. Staff felt they had not been consulted in an inclusive way during the changes and some staff did not know if they would still have a job once the new structure had been fully implemented. Staff reported vacancies had not been recruited into for long periods of time and this had left them feeling stretched and unable to provide care beyond basic tasks. Although individuals described felling valued amongst peers they did not feel valued by the organisation.

In the 2015 NHS Staff Survey, the trust had 24 key findings that fell below the average for combined mental health and learning disabilities trusts. These related to;

- staff recommendation of the organisation as a place to work or receive treatment
- staff satisfaction with the quality of work and patient care they are able to deliver
- staff motivation at work
- recognition and value of staff by managers and the organisation
- percentage of staff reporting good communication between senior management and staff.
- % able to contribute towards improvements at work
- staff satisfaction with the level of responsibility and involvement
- effective team working
- support from immediate managers
- percentage of staff appraised in last 12 months
- quality of appraisals
- quality of non-mandatory training, learning or development
- staff satisfaction with resourcing and support
- percentage of staff working extra hours

Requires improvement

Are services well-led?

- percentage of staff suffering work related stress in last 12 months
- % feeling pressure in last 3 months to attend work when feeling unwell
- organisation and management interest in and action on health and wellbeing
- % experiencing physical violence from patients, relatives or the public in last 12 months
- % experiencing physical violence from staff in last 12 months
- percentage of staff /colleagues reporting most recent experience of violence
- fairness and effectiveness of procedures for reporting error, near misses and incidents
- staff confidence and security in reporting unsafe clinical practice

The trust had three key findings that exceeded the average for combined mental health and learning disabilities trusts;

- percentage of staff believing the organisation provides equal opportunities for career progression/promotion
- percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- % of staff reporting errors, near misses or incidents witnessed in the last month

The score for staff recommending the organisation as a place to work or receive treatment had not significantly changed from 2014 to 2015. The 2015 score was lower than the national average for combined mental health and learning disabilities trusts and was marked as a negative outlier.

The percentage of staff suffering work related stress in the last 12 months had decreased by 4% from 2014 to 2015. The 2015 score was 6% higher than the national average for combined mental health and learning disabilities trusts and was marked as being a negative outlier.

- The percentage of staff believing the organisation provides equal opportunities for career progression or promotion had decreased by 1% 2014 to 2015. The 2015 score was 3% higher than the national average for combined mental health and learning disabilities trusts and was marked as a positive outlier.
- The percentage of staff reporting good communication between senior management and staff had remained the same from 2014 to 2015. The 2015 score was 10% lower than the national average for combined mental health and learning disabilities trusts and was marked as being a negative outlier.
- The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months had decreased by 1% from 2014 to 2015.The 2015 score was the national average for combined mental health and learning disabilities trusts and was marked as being within average range.
- In the 2015 GMC national training survey general psychiatry was the only post speciality with published results. Results for general psychiatry were within the middle quartile.

There were three qualified whistleblower reports received by CQC since April 2013. Further detail has not been included to ensure confidentiality. We asked the trust to investigate one of these reports and we carried out two responsive inspections to follow up on the others.

The trust had a duty of candour policy which was dated December 2015. The policy worked to guide staff on the understanding of duty of candour and their responsibilities to ensure a culture of candour. The policy has had an equality and diversity impact assessment and the principles of the Mental Capacity Act were applied in the development of the policy. The policy had a clear flow chart diagram for staff to follow and there were template letters available for staff to use both pre and post investigation to ensure consistency when writing to individuals affected by these incidents. The organisational risk management group monitored compliance with duty of candour for moderate, severe and significant harm through weekly meetings. There was an audit tool within the policy which guided the care groups in reviewing the level of harm experienced by the patient.

The trust advised that all clinical staff should have supervision every four to six weeks, although they did not currently have a compliance rate. The average rates of supervision across 116 teams was 84% between March 2015 and March 2016. The worst performing team was the community health inpatient services at 33%. The rest of the teams were achieving over 70%.

Requires improvement

Are services well-led?

There were 18 instances where staff have been either suspended or placed under supervision since August 2014. Community health services for adults had the highest number of staff either suspended or under supervision with nine. We reviewed these files and found that the trust had adhered to their own policy.

Services at Whitby Hospital had recently transferred to the trust (April 2016) and staff told us they had been communicated to well and kept informed of developments affecting the service. Performance information for this ward was not yet available through the trust.

Engaging with the public and with people who use services

A strategy for public engagement had been agreed; this was absent at the previous inspection. However, this had not yet been implemented at service level.

The Humber NHS Foundation trust website has a 'your views' page which includes information on becoming a trust member and how to become an elected trust governor. The page also provides links to the 'Humber people, getting involved, having a say, make a difference' newsletter.

The trust had a number of service user groups running. We attended one of these groups prior to our inspection. We received mixed feedback about the services, however overall they thought that staff were caring.

Quality improvement, innovation and sustainability

Humber memory service and Hull memory clinic offer patients the opportunity to take part in research programmes which supports the services with compliance for the memory service national accreditation scheme. The clinic have recently been involved in the recruitment of patients and research commissioned by the Department of Health to evaluate different models of memory assessment services in terms of health related quality of life of the patient, carers and carer burden.

The Hull and East Riding Crisis resolution home treatment teams have achieved home treatment accreditation scheme (HTAS) accreditation. This accreditation was ratified by the Royal College of Psychiatrists special committee for professional practice and ethics on 15th January 2014 and covers a three year period.

The Home Treatment Accreditation Scheme (HTAS)aims to work with teams to assure and improve the quality ofcrisis resolution and home treatmentservices for people withacute mental illness and their carers. It engages staff in a comprehensive process of review, through which good practice and high quality care are recognised, and teams are supported to identify and address areas for improvement. Two teams had been accredited these were East Riding Crisis Resolution Home Treatment Team and the Hull Crisis Resolution and Home Treatment Team

At the time of the inspection, only one ward was fully accredited through the Royal College of Psychiatrists' accreditation for inpatient mental health services programme. Accreditation for inpatient mental health services programme is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Avondale was accredited until February 2019. Mill View court, Newbridges, Westlands and the psychiatric intensive care unit all had their accreditation for inpatient mental health services programme deferred.

The quality network for perinatal mental health services works with specialist perinatal mental health teams to improve the quality of mental health care for new mothers. They supported members to evaluate their performance across a range of standards, reflect on their findings through a peer review process and share best practice and approaches to service improvement through an active network.

Participating services were able to benchmark their practice against similar services and demonstrate the quality of care they provide. The perinatal Hull and East Riding Specialist perinatal mental health liaison team were part of this network.

The pain service offered Tai Chi clinics to patients to provide an alternative method of controlling pain and improving mobility. We observed a clinic session and saw positive feedback from patients about the benefits of the treatment.

The community falls service was working in conjunction with the local fire service and health providers to offer joint a rapid response falls assessments service at risk of falls.

Requires improvement

Are services well-led?

This was designed to offer clinical support to patients who had been injured in a fall and increase confidence in patients to avoid a fear of falling reducing confidence, independence and social contact.

The stroke service was working with the Royal Philharmonic Orchestra in the 'Strokestra' initiative. This allowed stroke survivors and their carers to take part in participatory music activities alongside professional musicians, while being supported by clinical staff. The aim was to allow patients to work towards physical, emotional, social, cognitive and communicative recovery goals. A live public concert had been arranged for patients to perform their music.

The Macmillan clinical nurse specialist team were contributing to the International RAPID pharmacovigilance in hospice and palliative care clinical practice audit. They were the only nurse led team in the world who were involved in this. This program is an international, multi-site, post-marketing study of the real world net clinical effects of medications used in hospice and palliative care.

The band 7 Macmillan clinical nurse specialist team staff delivered the palliative care degree module. This module was delivered as part of a unique collaboration with a social care provider.

In December 2015, the Macmillan clinical nurse specialist team started a unique monthly collaboration with the "Living with Cancer" service from the local acute trust. This service provided information, advice and follow up appointments for patients and their carers who are at the end of their active treatment at one of the trusts community inpatient units. Long-term condition patients were also able to attend the breathlessness management, nutritional advice, and activity and exercise sessions irrespective of diagnosis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and Equipment** • The premises were not clean, suitable for the intended purpose or well maintained. The environment on Derwent ward, Ouse ward, Greentrees ward, and Darley House ward was in a poor state of repair. The seclusion room on Derwent ward was dirty. The shower rooms on Derwent and Ouse wards contained rust and lacked ventilation. • The environment and maintenance of Derwent ward, Ouse ward, Greentrees ward, and Darley House ward were below standard • **The environment of the health-based place of safety at Miranda House was not suitable for the purpose for which it was being used.** • **On Beech ward the provider did not comply with guidance on mixed sex accommodation.** This was a breach of Regulation 15 (1) (a) (c) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance** • **The trust did not have effective governance in place, including the assurance and auditing of systems and processes, to asses, monitor and drive improvement in the quality and safety of the services provided.** • **In forensic and secure services staff did not maintain an accurate, complete and contemporaneous record**

This section is primarily information for the provider

Requirement notices

in respect of each patient. Staff did not always document when they had administered medication to patients. Mental Health Act documentation was not always up to date or fit for purpose.

- The rapid tranquilisation policy was dated for review in February 2016 at the time of inspection in April 2016
- There were multiple electronic and paper notes systems running within the trust
- Staff did not feel engaged with the trusts vision and values
- The care and treatment pathway in substance misuse services meant patients were required to travel to different locations as their needs changed.
- In substance misuse services there were high waiting times and high unplanned exits resulting from the pathway.

This was a breach of Regulation 17 (1) (2) (a)(c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing

- The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they could meet people's care and treatment needs. The wards were often short staffed and vacancy levels were high.
- Staff did not receive appropriate training and supervision as was necessary to enable them to carry out the duties they were employed to perform. Staff attendance at mandatory training was below the 75% trust requirements and had been so for the preceding 12 months. Some staff were not receiving regular clinical and managerial supervision in line with the trust policy

This section is primarily information for the provider

Requirement notices

- Only 99 staff were trained in the Mental Health Act.

This was a breach of Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Person-centred care** How the regulation was not being met: • In substance misuse services staff from all teams did not fully assess or monitor a person's physical health. • In substance misuse services care plans were not up to date, personalised, holistic or recovery focused. • In substance misuse services staff did not deliver recovery focussed psychosocial interventions. • The trust did not ensure the care and treatment of patients always met their needs.Staff did not provide patients with sufficient access to meaningful activities to aid their recovery. This was a breach of regulation 9 (3) (a) and regulation 9 (3) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment** Care and treatment must be provided in a safe way for service users.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- In forensic and secure services the registered provider had not assessed all risks relating to the health and safety of service users receiving care or treatment.
- In forensic and secure services patients' records showed all known risks had not been assessed. Risks plans were not always reviewed and updated as required.
- in inpatient learning disabilities all areas of the environment had not been fully assessed to ensure risks were identified and mitigated.

This was a breach of Regulation 12 (1) (2) (a) (b)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Safeguarding service users from abuse and improper treatment

Service must be protected from abuse and improper treatment.

How the regulation was not being met:

- In inpatient learning disability services systems and processes did not operate effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.
- In inpatient learning disability incidents that met the threshold for safeguarding consideration were not always referred to, or discussed with, the safeguarding team as necessary.

This section is primarily information for the provider

Requirement notices

- In inpatient learning disability interventions where service users were controlled or restrained were not subject to review to ensure these were necessary to prevent, or a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint.

This was a breach of Regulation 13 (1) (3) (4) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and treatment** **Effective governance arrangements were not in place in respect of the use of rapid tranquilisation and on occasions rapid tranquilisation was used inappropriately by staff.** **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 are in seclusion;** **This was a breach of regulation 12 (2) (a) (b) (c) (d) (e) (f) and (g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (Regulated activities) Regulations 2014:** **Safeguarding service users from abuse and improper treatment**

This section is primarily information for the provider

Enforcement actions

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

This was a breach of regulation 13 (1)