Humber NHS Foundation Trust

Services for older people

Quality Report

Willerby Hill,
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Hull
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Maister Lodge	RV938	Maister Lodge	HU8 0RB
Mill View Court	RV942	Mill View Court	HU16 5JQ
Maister Lodge Mill View Lodge	RV938 RV942	Older People's Intensive Home Care Teams	HU8 0RB HU16 5JQ
Townend Court	RV915	Older Peoples Community Mental Health Team	HU6 8QG
East Riding Community Hospital	RV9ER	East Riding Community Hospital	HU17 OFA
Willerby Hill	RV936	Rosedale Older People`s CHT Beverley Health Centre Older people community health team Dementia Service, Memory Clinic, Coltman Street	HU128JU HU177BZ HU3 2SG

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

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

Summary of findings

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

Summary of findings

Ratings

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

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

Humber NHS Foundation Trust provides assessment, treatment and care for people aged 65 years and older, who have a mental health problem of a functional (such as depression or anxiety) or organic (such as dementia) nature.

We found that there were appropriate safety and safeguarding procedures in place, which included a 'Blue Light' reporting system. All the staff knew about the safeguarding procedures and there were good links with the local safeguarding team. Staff reported incidents and we saw incident reporting forms on the Datix IT system.

Risk assessments were undertaken using GRiST (the Galatean Risk and Safety Tool) and the outcomes were used to inform all the care plans. The multidisciplinary teams worked well together and held weekly meetings.

The trust used a single point of access referral system. This meant that people were directed to the right service. However, there were long waiting lists and shortages of permanent staff. As a result, bank and agency staff were used, who were not always knowledgeable about the people using the services.

Carers and families were involved in care planning, and all the people using the service had received assessments of their physical health. There was also good communication between the intensive home care team and the community mental health teams for older people.

Staff had received training in communicating with people with dementia. This provided them with the skills and knowledge which helped ensure people received care and support that met their needs. The staff we spoke with were also aware of the national dementia strategy 'Living well with dementia' and NICE (National Institute for Clinical Excellence) guidelines on the care and treatment of people with dementia.

Staff were helpful and understanding, and treated people with respect. Recovery Star plans were person-centred and involved people's carers and families. People also had access to support from advocacy services, and the trust held support groups for carers.

Staff told us that they were unclear about the trust's vision and strategy, which left them worried about their future. They also told us that they did not receive regular clinical supervision.

Generally, arrangements for monitoring the Mental Health Act were in place and audits were carried out. People were also given their rights under the Mental Health Act, because some people using services may have difficulty retaining this information staff need to consider how often the information about their rights should be repeated.

Summary of findings

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

Are services safe?
There were systems in place to assess and monitor people's safety. Staff understood how to escalate and report incidents and safeguarding concerns and there were good links with the local safeguarding team. Staffing levels were maintained by the use of agency and bank staff.

Are services effective?
Staff worked in multi-disciplinary teams and there was good communication between the intensive home care team and the community mental health team for older people.

People using the service had assessments of their physical health. Risk assessments were also completed.

Staff had received specific training for working with older people however not all staff had received training in the Mental Capacity Act or deprivation of liberty (DoL).

Are services caring?
Staff were helpful and understanding, and treated people with respect. Recovery Star plans were person-centred and involved people's carers and families. Carers and family were involved in care planning.

People were given information in a format that met their needs and had access to advocacy services. The trust also held support groups for carers. We found that the ward and community teams worked well together on assessments at home and discharge planning.

Are services responsive to people's needs?
In patient services provided an environment that met people's needs and ward teams had good links with community and intensive treatment teams.

The trust used a single point of access referral system to direct people to the right service, however within community teams there were concerns about capacity to manage waiting lists for routine treatment and this was identified as a risk. Staff could not access investigation results in an effective manner on the current IT system. This caused delays in accessing information.

Are services well-led?
Staff were motivated and enthusiastic. Local leadership was good, however some staff were unclear about the trust's vision and strategy, which left them worried about their future. Some staff did not receive regular supervision session.

Summary of findings

Background to the service

Humber NHS Foundation Trust provides assessment, treatment and care for people aged 65 years and older, who have a mental health problem of a functional (such as depression or anxiety) or organic (such as dementia) nature.

Community mental health nurses and support workers visit people in their own homes, residential

or other care settings. The service also provides carer assessments, support and advice to family members and carers.

Inpatient services

- Maister Lodge. A 16 bed inpatient unit that provides services for older people who are experiencing predominantly organic mental health problems. The service is for the most acute and vulnerable stages of mental illness that are unable to be supported at home. A range of recovery focused interventions is offered to return people to their usual environments as soon as possible.
- Mill View Lodge. A nine bed unit that cares for men and women with functional mental disorders such as depression and those with memory impairment. The unit admits people from Hull and East Riding and offers occupational therapy, psychological interventions and physiotherapy and a range of recovery focused therapeutic interventions to return people to their usual environments as soon as possible.

Community older people's services

- Maister Lodge - Older peoples community health team (Hull) providing assessment, treatment and therapeutic interventions for people over 65 years it provides a 7 day service 9am to 5pm.
- Maister Lodge - Older peoples Intensive home care team (Hull) providing an alternative treatment option to inpatient admissions when someone has an increased mental health need. It provides a 7 day service 8am to 9pm.
- Mill View Lodge - Older peoples Intensive home care team (Hull) providing an alternative treatment option to inpatient admissions when someone has an increased mental health need. It provides a 7 day service 8am to 9pm.
- Rosedale Community Unit - Older peoples community mental health team (East Riding) providing assessment, treatment and therapeutic interventions for people over 65 years.
- Townend Court – Older people's community mental health (Hull) providing assessment, treatment and therapeutic interventions for people over 65 years. People are seen in their own homes, residential or other care settings by community mental health nurses and support nurses.
- East Riding Community Health Hospital – Older people's community mental health (East Riding) provides assessment, treatment and therapeutic interventions for people over 65 years who have a mental health problem such as depression or anxiety or dementia.
- Coltman Street – Dementia Memory Assessment Service offers early memory assessment and treatment service through the Hull memory clinic and community services in the East Riding and is an international centre for dementia research.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur and Cathy Winn, Inspection Managers, Care Quality Commission (CQC)

Summary of findings

The team included CQC inspectors and a variety of specialists: a consultant psychiatrist, registered care home managers, a senior nurse, senior registrar, a Mental Health Act commissioner, an Expert by Experience, and a specialist registrar.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use the 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?

We carried out an announced visit of older people's services from 20 to 22 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors and therapists. We talked with people who use services, their carers and/or family members. We also observed how people were cared for and reviewed their care or treatment records.

What people who use the provider's services say

Prior to the visit we spoke with people and received information from people about their experiences at Humber NHS Foundation Trust. We also left comments cards for people to complete to share their experiences.

People who used services were positive about the older people's services. They were happy with the service and felt involved in any decisions that were made related to their care and support. Everyone was confident that if they had any problems or complaints, they would be listened to and responded to appropriately. Overall, people we spoke with said they were well looked after.

Good practice

We found good practice around covert medication at Maister Lodge. The clinical staff showed a rigorous decision-making process, applying the MCA in relation to assessing capacity and also undertook a best interest's assessment, involving the family, considered the persons wishes and looked at least restrictive options.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should continue to reduce the waiting lists in the older people inpatient and community teams, and the waiting lists for therapist input.
- The trust should ensure that all staff have the required knowledge and receive training in the assessment of people's mental capacity and deprivation and liberty.

Humber NHS Foundation Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Maister Lodge – Inpatient ward	Maister Lodge
Older People Community Mental Health Team	Maister Lodge
Older People`s Intensive Home Care	Maister Lodge
Mill View Court –Inpatient ward	Mill View Court
Older People`s Intensive Home Care Team	Mill View Court
Older peoples community health team	Townend Court
Older People`s Intensive Home Care Team	East Riding Community Hospital
Older People`s Intensive Home Care Team Beverley Health Centre	Willerby Hill
Older people community health team Rosedale Health Centre	Willerby Hill
Dementia Service, Memory Clinic, Coltman Street	Willerby Hill
Oxford House Psychotherapy Services	Willerby Hill

Mental Health Act responsibilities

Admission of people to mental health wards

We saw that all the required section papers had been completed appropriately when an older person had been detained under the Mental Health Act (MHA) 1983. However, we noted that some people we spoke with were not aware of their status and their rights. Section 132 of the MHA requires hospital managers to take steps to ensure that all people subject to the MHA are given, and understand, information about how the Act applies to them. This information must be given as soon as possible after the start of the person's detention. Information must be given both verbally and in writing.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw many forms being used by the trust that had integrated questions about capacity to prompt staff to consider MCA/DoLs during a persons treatment and care from admission to discharge.

We found that staff were assessing appropriately people's mental capacity to consent for some decisions such as when sending a safeguarding alert, or when considering holding techniques, or for continuing healthcare assessment. We observed good practice in the application of MCA and Dols in relation to the administration of covert medication.

However we also saw that staff did not consider assessment of capacity or best interests in relation to physical treatment or medication for physical ailments not associated with mental disorder even when a person is already detained under the Mental Health Act.

We saw in files that that a standard DoLS authorisation under which the person was detained was allowed to expire by mistake. Whilst a urgent authorisation was arranged the trust did not give the service user a copy of the order, nor did we see evidence of the person being given their rights which are statutory duties. This reflected a failure to monitor the standard DoLS authorisation and a failure to recognise that responsibility lies with the managing authority (the hospital) to make the request for a renewal/extension.

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

There were systems in place to assess and monitor people's safety. Staff understood how to escalate and report incidents and safeguarding concerns and there were good links with the local safeguarding team. Staffing levels were maintained by the use of agency and bank staff.

Our findings

Maister Lodge

Track record on safety

Prior to January 2014there were 218 incidents reported on the trust's incident register, and between January 2014 and May 2014 staff reported approximately 18 incidents. These were varied and included staff shortages, and incidents on the wards related to patient's behaviour.

Information received prior to the inspection showed that the trust had not reported any 'Never Events' since April 2011. Never Events are classified as such because they are so serious, they should never have happened.

The trust board monitored the number of safeguarding referrals and investigations in older people's services and made recommendations. These were cascaded to managers in the service to discuss with staff and learn from the outcomes.

Learning from incidents and improving safety standards

Staff members told us all incidents were recorded on the trust's internal Datix IT system. All staff were aware of a 'Blue Light' system that was used across the trust. This system sent emails to all staff, which helped ensure they knew about the incidents and included guidance related to how any similar incidents could be avoided. Learning from incidents meant people who used services would be protected from any similar incidents in the future.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that there were appropriate safety and safeguarding procedures in place, which included a 'Blue Light' reporting system. All staff members were aware of safeguarding procedures. There were good links with the local safeguarding team

Assessing and monitoring safety and risk

Environmental risk audits were carried out and management plans put in place. The trust board received the results of environmental risks and priorities to be addressed from each service area.

We saw that GRiST (Galatean Risk and Safety Tool) risk assessments had been undertaken and the outcomes used to inform all care plans. There was evidence of good multidisciplinary team working and meetings held on a weekly basis which looked at risks.

Understanding and management of foreseeable risks

There were acknowledged shortages or permanent staff and therefore bank and agency staff were used to ensure there were the correct numbers of staff. The trust acknowledged there was a staffing shortage and were recruiting staff.

Mill View Court

Track record on safety

Between January 2014 and May 2014 staff reported 13 incidents. We saw evidence that action had been taken and the incidents were reported and monitored by the governance committee.

Staff members had been trained to enter all reported incidents directly onto the trust's intranet system which helped ensure an audit trail could be viewed when required. The safety thermometer showed that there had been no falls causing injury or pressure ulcers, catheter urinary tract infections or venous thromboembolisms.

The number of serious incidents are low,Between January 2011 and January 2014 there were two serious incidents (SUIs) relating to patient deaths.

Are services safe?

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

Learning from incidents and Improving safety standards

A 'Blue Light' reporting system was in place to share learning from incidents. Staff signed to show that they had read the emails received notifying them about incidents. Staff told us that learning from incidents was shared in supervision meetings and at performance reviews. The manager said that they also had long handover periods so that staff on different shifts could meet and discuss issues.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found there were appropriate safety and safeguarding procedures in place. All staff members aware of safeguarding procedures. There were good links with local safeguarding team.

Assessing and monitoring safety and risk

An environment risk assessment was undertaken on every shift and there was also a weekly fire-alarm test. A full environmental risk assessment was conducted on an annual basis and included a check for any possible ligature points. During our inspection, we did not observe any obvious ligature points.

We observed a resuscitation box in the clinic room and saw evidence that it was checked daily.

Understanding and management of foreseeable risks

Although we observed a high use of both bank and agency staff, there was evidence that staffing levels on all shifts were maintained at a level that allowed safe and appropriate care to be provided. Normally two qualified nurses and two care assistants were on duty caring for nine people. There was also an additional newly qualified nurse who was supernumerary. Staffing levels had recently been reviewed for all units and the outcome showed there was a requirement for an additional Band 6 nurse and 2 Band 5 nurses. We checked the rosters for a two month period and found that most shifts were worked by agency and bank nurses who were familiar with the ward because they worked there regularly.

All ward staff members carried personal alarms which helped ensure their safety was maintained at all times.

Community services

Track record on safety

The safety thermometer in relation to older people services did not identify any significant issues relating to pressure ulcers, catheter urinary tract infections, venous thromboembolism or falls. The number of incidents reported are low. The Maister intensive home care team reported one incident between January 2014 and May 2014.

Learning from incidents and improving safety standards

We found there were appropriate safety and safeguarding procedures in place, which included a 'Blue Light' reporting system. All staff members aware of safeguarding procedures. There were good links with local safeguarding team.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The training matrix showed staff were up-to-date with safeguarding training. We spoke with several staff on duty and they all had a good knowledge of safeguarding procedures, particularly related to the reporting of any observed or suspected forms of abuse. A whistleblowing policy was in place across all the units and staff we spoke with were aware of it and said they would use it if they thought necessary.

Assessing and monitoring safety and risk

A lone worker policy was in operation at all locations across the trust and all staff we spoke to were aware of the procedures to be followed. Regular risk assessments were held and these in turn informed decisions about those people who should not be attended by a lone worker. This meant staff were kept safe when providing care and support to people using services.

We observed GRi:ST risk assessments had been undertaken and the outcomes used to inform all care plans. There was evidence of good multidisciplinary team working and meetings held on a weekly basis to review risks.

Understanding and management of foreseeable risks

Staff were very supportive of each other which helped to reduce caseloads across the unit and so prevent any risk to older people. Staff meetings were held weekly to discuss the current needs of the people using services which helped ensure people continued to receive good quality care and support.

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

Staff worked in multi-disciplinary teams and there was good communication between the intensive home care team and the community mental health team for older people.

People using the service had assessments of their physical health. Risk assessments were also completed.

Staff had received specific training for working with older people however not all staff had received training in the Mental Capacity Act or deprivation of liberty (DoL).

Our findings

Maister Lodge

Assessment and delivery of care and treatment

A comprehensive plan of care and support had been written up for all people who used services. People's families and carers were involved in the process and assessments to identify risk to people's health and welfare were up-to-date.Findings her>

Outcomes for people using services

Staff members had received training in communication techniques with people with dementia which provided an alternative where people were unable to verbally communicate. Staff members we spoke with were aware of the national dementia strategy 'Living Well With Dementia' and NICE guidelines related to the care and treatment of people with dementia, it was unclear how outcomes were measured.Staff, equipment and facilities

Multi-disciplinary working

There was evidence of ongoing communication between the Intensive Home Care team and the community mental health teams for older people. We observed good joint working between all professionals on the ward particularly during staff handovers which helped ensure a continuity of care for people who used the services.

Multidisciplinary meetings were held at Maister Lodge. We sat in on these meetings. Staff members described the meetings as worthwhile and provided the opportunity to discuss any issues that had been identified over the previous month. We saw minutes of a recent themed review of older people's services.

The older people's ward was on the same site as the older people's community mental health team. This helped ensure that any transition between services for the older person would be 'seamless' and so maintain a continuity of care. We observed all recorded information related to any proposed, or ongoing transition had been retained in older people's care plans.

A psychologist provided supervision to staff on the ward and provided support the time of transition of servicesFindings here>

Mental Health Act (MHA)

We saw that all the required section papers had been completed appropriately when an older person had been detained under the Mental Health Act (MHA) 1983. However, we noted that some people we spoke with were not aware of their status and their rights. Section 132 of the MHA requires hospital managers to take steps to ensure that all people subject to the MHA are given, and understand, information about how the Act applies to them. This information must be given as soon as possible after the start of the person's detention. Information must be given both verbally and in writing, and repeated where people do not understand or circumstances changed.

Mill View Lodge

Assessment and delivery of care and treatment

All information related to people's care and treatment was recorded on the trust's internal IT system called Lorenzo. Information we observed was up-to-date. This meant staff could access relevant information related to a person's care needs in a speedy and efficient manner. Any treatment a person had received was recorded appropriately including the outcomes following the treatment.

The ward had adopted the recovery model for older people services and we saw care plans that showed the approach had been applied successfully. Paper case records also showed evidence of physical health checks being undertaken at the time of admission.

Staff, equipment and facilities

At the time of the inspection, the manager told us that there were two qualified staff vacancies on the ward. The matron had assessed what the staffing requirements were, based on the RCN and Sainsbury's models, for the future; as a result this had identified a need for 1x Band 6 and 2x Band 5 nurses. The manager said that they had used a high number of temporary staff, but attempted to use the same

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.

staff where possible. We were told that bank and agency staff worked an induction shift to introduce them to the ward. Agency and bank staff were primarily used to support people who required 1-1 observation.

Most staff members had undergone mandatory training. We were told that further training was being planned which was aimed at any gaps we observed in the training matrix. This meant staff should have the skills and knowledge to provide care on an individual basis to ensure people's needs were met.

However, we were told by several staff members that supervision meetings were not held at regular intervals. This meant staff members were not provided with a regular opportunity to discuss any concerns they may have had in a formal setting.

Multidisciplinary working

Multidisciplinary team meetings were held on a weekly basis and considered the needs of each person who used services. One particular theme was a discussion related to the capacity of all people to make decisions related to their care and treatment.

A pharmacist visited the ward regularly to meet people using services, check prescriptions and medication administration. Additionally, the ward team included or had ready access to other healthcare workers from different disciplines. This included psychiatrists, physiotherapists, and a psychologist who visited once a week, a dietician and a speech and language therapist. This showed an effective approach to multidisciplinary working at Mill View Court

A consultant attended the ward every day and, if required, we were told another consultant was on call. Other additional staff included a registrar, a dietician, and physiotherapists as required. A psychologist was also available one afternoon a week to provide reflective practice sessions with staff members but also did sessional work with people using services. At the time of our inspection, there was no occupational therapist support for people who used services which meant nurses provided sessional activities. Staff described a pharmacist's input as good, and the ward was working towards a system for people who used services to self-administer their own medication with appropriate risk assessment processes in place.

Mental Health Act (MHA)

The Mental Health Act was administrated well and audits were undertaken. People were read their rights. People were informed of their rights, however staff would need to consider how often this information was reinforced based on peoples capacity to understand and retain information.

Mental Capacity Act

We saw many forms were used by the trust that had integrated questions about people's mental capacity, to demonstrate that due consideration was given to MCA/ DoLs from admission to discharge. The multidisciplinary team weekly review form included specific standard prompts and the initial inpatient assessment form, asked if the person had mental capacity to consent to admission. It also recorded whether the person had a lasting power of attorney.

We found what could be considered best practice around covert medication. Even though people were detained under the MHA, if covert medication was being given, the clinical staff were applying the MCA in relation to assessing capacity. They also undertook a best interest assessment involving the family, considered the person's wishes and looked at least restrictive options. This approach showed a rigorous decision-making process

However we also found staff did not consider assessment of capacity or best interests in relation to physical treatment or medication for physical ailments such as diabetes, not associated with mental disorder even when a person is already detained under the Mental Health Act.

We saw in one set of case records that a standard DoLS authorisation under which the person was detained was allowed to expire by mistake. Whilst an urgent authorisation was arranged the trust did not give the service user a copy of the order, nor did we see evidence of the person being given their rights There was no record who the representative was, how to contact them and if and when they had visited. These are all required if a person is detained under DoLS and are statutory duties. This reflected a failure to monitor the standard DoLS authorisation and a failure to recognise that responsibility lies with the managing authority (the hospital) to make the request for a renewal/extension.

We saw in case records that a standard assessment of mental capacity and best interests form was jointly used by the trust and social care agencies in Hull and the East

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.

Riding of Yorkshire. The form was mainly completed by trust clinicians, and had tick boxes 'Yes' or 'No' to record whether a person understood and retained information, but it did not provide space to record and explain further what the person could not do if the 'No' box was ticked. Ticking a box did not provide the level of detail needed to fully demonstrate why the person lacked mental capacity and the information was not recorded elsewhere

We found that the trust's 'management of violence and aggressive behaviours policy' (April 2014) failed to provide the only statutory definition of what restraint is in healthcare (physical or otherwise) as given in the MCA or the statutory criteria that staff must meet to restrain an informal patient who lacks capacity.

Training in the Mental Capacity Act and Dols was not mandatory and We were informed that some staff had not received training in Mental Capacity and Dols.

Community services

Assessment and delivery of care and treatment

Families were involved in the planning for people's care. Occupational therapists were also available to provide assessments and activities. All assessments and treatment were provided by staff who were aware of their roles and responsibilities which meant people received care that met their needs. We noted physical health checks had been completed for all people who used services

GRiST (Galatean Risk Screening Tool) assessments were completed and Addenbrookes Cognitive Examinations (ACE) had been conducted. GRiST integrates structured clinical evidence with empirical evidence, thus combining the best approaches to mental health risk assessment. The ACE is a screening tool used for detecting cognitive defects. Case notes seen included a record of all assessments and were clear and concise. Monthly clinical audits demonstrated that appropriate notes had been taken and recorded in care plans which were used to inform future care and treatment.

Consideration had been given to the spiritual needs of the older person at the time of the initial assessment. This meant people's preferences had been listened to and their choices respected.

Outcomes for people using services

We saw evidence of frequent participation in audits at the memory clinic. The memory clinic was in the process of seeking memory service accreditation to demonstrate it was meeting quality standards. The memory clinic also measured patient outcomes and fed this back to staff.

The trust hosted the centre for applied research into dementia care and research links were close with the local university through the Associate Director R&D and Clinical Innovation / Consultant Clinical Psychologist post. The latter having been awarded NHS Quality Champion and innovator of the year by the NHS Leadership Academy.

Staff, equipment and facilities

The trust's electronic Lorenzo system allowed the tracking of individual older people's records. All information we saw was up to date. Accident and incident report forms were available on the Datix IT system. Assessments and treatment were delivered appropriately by staff who were aware of their roles and responsibilities.

Multidisciplinary working

Multidisciplinary team meetings were held on a weekly basis and on the day of our inspection we sat in and observed discussions during one of the meetings. We observed and staff reported that there was good multi disciplinary working between doctors, nurses, therapy staff and social workers. We saw safeguarding alerts had been recorded which indicated a good working relationship was in place with the local safeguarding teams.

Qualified nurses attended regular meetings with consultant psychiatrists at which new referrals were discussed. Discussions also took place related to the needs of older people who were on their caseloads at that time. This helped ensure that people`s needs were regularly being reviewed which meant they received care and treatment that met their needs.

Mental Capacity Act

Audits of records took place and it was found that capacity was not being documented in the memory clinic.

Are services caring?

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

Summary of findings

Staff were helpful and understanding, and treated people with respect. Recovery Star plans were person-centred and involved people's carers and families. Carers and family were involved in care planning.

People were given information in a format that met their needs and had access to advocacy services. The trust also held support groups for carers. We found that the ward and community teams worked well together on assessments at home and discharge planning.

Our findings

Maister Lodge

Kindness, dignity and respect

People's care plans had been written in a person-centred manner. This meant people received care that met their needs and wishes. We observed staff members treated people in a patient and unhurried way and were dedicated to providing good quality care. People were treated in a respectful, kind and dignified manner. We received several comments from people using services and their families telling us that staff were very kind, helpful and understanding.

People using services involvement

We found that ward staff involved people's carers and family members when planning people's care, however there was little engagement of people using services in ward or other activities.

Quality circle meetings were held on a monthly basis. Quality circles are an opportunity for people to discuss their experiences and make suggestions to improve the quality of the service. We saw that after a meeting people who had been involved were given feedback on the actions taken.

Emotional support for care and treatment

During our inspection we spent time in communal areas and noted people who used services were cared for in a respectful manner for example staff knocked on doors before entering service user bedrooms. Good interaction was observed at all times between people and staff members. The privacy and dignity of all people was respected which showed respect for people`s wishes and preferences.

Mill View Lodge

Kindness, dignity and respect

During our inspection, we observed older people being treated in a kind, respectful and dignified manner. We observed a good interaction between staff and people who used services. Staff were patient when providing care to people for example, One staff member continually attended to one person who was quite agitated. The staff member asked the older person to sit down. However, the person preferred to keep walking and the staff member respected their wishes but accompanied them, while holding their hand and keeping them safe in the garden area.

People using services involvement

People who used services had their care reviewed during regular meetings with the home treatment teams who normally provided support to people when they were discharged from hospital. We were told most people were discharged 'quickly and safely'. However, there were at times delays in discharge when the ward found it difficult to find the most suitable residential environment.

Emotional support for care and treatment

The 'Recovery Star' care plans we saw focused on the wishes of the person who used services. We could see there had been family involvement when writing up the care plans. Care plans were detailed and showed evidence of recovery star discussions, outcomes from multidisciplinary team meetings, risk assessments and MHA monitoring.

The Recovery Star tool was used to optimise individual recovery and gain the information to create recovery-focused care plans. We found positive feedback and compliments from families related to the care a member of their family had been received. Care staff spoken with were passionate about providing care and actively supported each other whenever necessary. This meant people who used services received care when they needed it.

Mental Health Act

Independent mental health advocates visited Mill View Court on a regular basis, and were in attendance on the day of our inspection. This meant older people continued to have decisions made in their best interests that met their

Are services caring?

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

needs. Those older people who were not detained under the Mental Health Act (1983) also had access to an advocacy service. This helped ensure they continued to have their voices heard.

Community services

Kindness, dignity and respect

Staff members we spoke with had knowledge of the individual needs of all people they were caring for. Staff had a good understanding of people's personal and religious choices, which helped ensure their cultural and emotional needs were being met. People who maybe anxious about attending hospital or where it was important that they remained in a familiar and comfortable environment, could have their mental health assessments conducted at home.

People using services involvement

All people using services and when possible their families, were involved in the formation of their care plans. This meant they were able to make informed decisions related to their care and treatment. People using services received information in different formats so that they could be understood. People were supported to remain independent as much as possible and encouraged to participate in any social and community activities. This helped ensure people were kept aware of what was happening in and around their local community

We were told about, and saw evidence of carer support groups that were facilitated by the trust. We observed feedback from both people using services and family members/carers following meetings which showed they were involved in any decisions related to their care and support.

Quality circle meetings were held in various locations and attended by staff members, carers and people using services. We were told these provided the opportunity to discuss any issues or concerns that were identified as important.

Emotional support for care and treatment

We spoke with three family members who received services from the trust. One told us, "We are more than happy – we get well cared for." All three family members told us staff were always respectful and treated them with dignity. Carers' assessments were undertaken so that emotional support was provided and people were signposted to advisory and advocacy services.

We noted several comments in the service user's communication book which were positive for example we read, "Staff are very helpful and understanding" and another comment read, "The first time I have visited this clinic and I am very impressed with everything."

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

In patient services provided an environment that met people's needs and ward teams had good links with community and intensive treatment teams.

The trust used a single point of access referral system to direct people to the right service, however within community teams there were concerns about capacity to manage waiting lists for routine treatment and this was identified as a risk,for example. the trust provided information on older people's waiting times in the community mental health teams. In May 2014, Holtemprice Beverly & North bank team had 105 people waiting for assessment and 40 people waiting for treatment,

Staff could not access investigation results in an effective manner on the current IT system. This caused delays in accessing information.

Our findings

Maister Lodge

Planning and delivering services

All people referred to the unit were admitted via the single point of access screening system. This approach aimed to identify which service would best meet the needs of the individual older person. This reflected a person centred approach to providing care and support for the older person.

The matron for the unit said that the general manager was supportive when a need for additional staffing was indicated and here was a plan to reduce the bed numbers.

We did note gender specific areas had been provided which helped ensure the privacy and dignity of people using services was respected.

Right care at the right time

There was good liaison within multi-disciplinary community teams.

The trust informed us that the Local Authority and trust staff are on separate IT systems , all patients are on the MH system, all staff can see both systems and there is a single integrated paper record that all staff can access and write in. The trust uses a number of electronic systems, Community staff use SystmOne. Staff told us they were not able to access important information in a quick and efficient manner for example blood results on the trust's intranet system. The information technology department were working on the issue to try and resolve the problem which could take up to six months to implement. This utilised staff time and caused delays in obtaining important clinical information to make decisions in a timely manner.

Care pathway

The trust had developed clear pathways to support people in their homes, to come into hospital for a minimum period and outpatient clinics which generally seemed to be working.

Learning from concerns and complaint

All incidents and concerns were recorded on the trust's intranet system. Complaints were managed by the Patient Advice and Liaison Service (PALs) and recorded at the trust headquarters. No written records were kept at the location the complaint related to, which may have helped with the auditing process and lessons learnt. We did not see information or notices informing people how to complain. Quality Circles were used to discuss learning and improvement.

Mill View Lodge

Planning and delivering services

We observed the ward had a good range of rooms available for therapies and activities. All bedrooms were single and all had en-suite bathrooms. The ward was compliant with the requirement for same sex accommodation and we also saw a separate lounge was available for female service users. We were told the ward team had a good working relationship with the intensive treatment team and with the community mental health teams

Right care at the right time

Mill View Lodge accommodated an intensive home care treatment team for older people who met with ward staff on a weekly basis to facilitate discharges.

Learning from concerns and complaint

All incidents and concerns were recorded on the trust's intranet system. Complaints were managed by the Patient Advice and Liaison Service (PALs) and recorded at the trust headquarters. Quality circle meetings held with people who used services helped ensure people's complaints and

Are services responsive to people's needs?

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

comments were listened to and addressed with the aim of improving the quality of care and treatment provided to people using servicesWe did not see information or notices informing people how to complain.

Community services

Planning and delivering services

The planning and delivery of older people's services was focused on the needs and choices of the older person that had been identified at the time of assessment. All referrals for services were directed through a trust wide single point of access system. Those referrals received by the older people's community mental health team were triaged. If allocated as an urgent referral the person would be seen within a week.

Crisis referrals are seen within 4 hours and urgent within 1 week. People who were assessed as non-urgent were placed on a waiting list which we were told, and observed through a pathway tracking exercise, could last up to nine months, and at times longer. The waiting list for referrals could have posed a risk for some people awaiting services. The trust provided information on older people's waiting times in the community mental health teams. In May 2014, Holtemprice Beverly & North bank team had 105 people waiting for assessment and 40 people waiting for treatment. Similarly there were waiting lists for psychology services.

The trust had identified waiting lists and capacity constraints on its risk register which was reviewed by the trust board. The trust has acknowledged that it could not provide full assurance and an action plan was in place. Dialogue had been established with the commissioners of services and waiting list information provided on a weekly basis and monitored monthly. The trust had recruited additional temporary staff to assist in reducing the waiting lists. Following our feedback at the inspection, the trust told us a caseload management tool was being identified to assist staff in making decisions and a detailed policy of managing risks within waiting lists was being produced.

Right care at the right time

During our inspection we visited several services which included, Rosedale Older People`s CHT, East Riding Community Hospital and Townend Court.

Staff told us they were concerned about the lengthy waiting times across the trust. A considerable proportion of calls taken by the older people's team were from people using services and/or their families who were on the waiting list for assessment/treatment. This period of waiting had the potential for some older people to deteriorate, both mentally and physically, which may in turn escalate their level of need. We were told that the triage system was aimed at prioritising people depending on their level of need. Consequently those older people with a high level of need were seen first.

We were told that at Coltman Street Memory Clinic bank staff were not used and there were no nursing staff vacancies. However a reduction in consultant time had impacted on the team and waiting times.

Following our visit the trust acknowledged there were waiting times and capacity issues within the older people's community teams and had placed the issue on their risk register. The trust had put in place a data cleansing exercise to establish the size of the problem in order to take remedial action. Following our inspection they told us that they were producing a waiting list policy which identified actions clinical staff should take to manage ongoing risk to those on waiting lists.

The trust had introduced neighbourhood teams which would deliver mental health and physical health services in an integrated way.

Several staff members said delays in providing services to older people were often caused by inadequate referral information received from GP surgeries, they were not able to inform us how this was then addressed with the GP surgeries. This would negatively impact on the continuity of care for older people using services. Staff working in the community expressed concerns with the time spent completing paperwork and travelling in between calls. This impacted on the time spent with people using services.

We were told the duty practitioner and the crisis team were available to offer advice, and to provide interventions or intensive home treatment if required. Interpreters were on call if there were any problems with communication which showed diverse needs were catered for equally.

Learning from concerns and complaint

All incidents and concerns were recorded on the trust's intranet system. Complaints were managed by the Patient Advice and Liaison Service (PALs) and recorded at the trust's headquarters. Quality circle meetings held with

Are services responsive to people's needs?

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

people who used services helped ensure people's complaints and comments were listened to and addressed with the aim of improving the quality of care and treatment provided to people using services.

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

Staff were motivated and enthusiastic. Local leadership was good, however some staff were unclear about the trust's vision and strategy, which left them worried about their future. Some staff did not receive regular supervision session.

Our findings

Maister Lodge

Vision and strategy

During our inspection, we sat in on several focus group meetings with staff from across older people's services and with different roles and responsibilities within the trust. Staff told us that strategies had been implemented by the board in the past and then changed a while later. We were told this was partly due to several changes of staff at board level whose vision for the trust may have differed from previous board members. There had been no clear statement of vision or guiding values passed down from board level which some staff said left them feeling 'anxious' about their future within the trust.

Responsible Governance

The trust has a programme of audits that it undertakes to monitor standards, for example. 'Essence of Care' standards in the area of pressure ulcers and food and nutrition within the older people's inpatient services. These were undertaken by the matrons and the outcomes discussed at the clinical governance committee and reported to the board.

Engagement

Senior staff at a local level, were focused on delivering a good quality, caring and compassionate level of care to all people using services. Staff members stated they had not received regular supervision with their line manager however an open-door policy was utilised at a local level whereby staff members could talk to their immediate manager to resolve any outstanding issues. which would have provided them with the opportunity to raise any concerns they regarded as important. Supervision would have helped ensure that staff were involved and actively encouraged to participate in organising effective care that met the needs of all people using services.

We were told by the trust that they were aware of where there were staff shortages and they were actively recruiting for more staff. Staff spoken with said that the process appeared to be drawn out and it took a long time to get new staff employed.

Performance improvement

The trust told us that they were in discussions with commissioners for additional investment so that they could improve the early diagnosis in dementia.

Mental Health Act Monitoring

Staff provided detained people with their rights and did not always take into account whether they had properly understood. Some older people did not know about their legal status, but there was a signed form saying they understood.

Mill View Lodge

Vision and Strategy

The ward consultant and the ward manager were clear that their vision for the ward was to integrate the ward with the intensive homecare team to facilitate discharge and give warning about potential admissions. They were hoping to get social services involved to work with both teams. They said that there was difficulty in accessing senior management support for this initiative, despite this working well with the crisis services in adult services.

Responsible governance

Supervision and personal development structures were in place for all staff members. The ward used a 'Blue Light' system for raising alerts related to any incidents that may have occurred within the trust. Staff were allowed protected time when lessons were learned from any such incidents. We were told regular meetings were held with the general manager following which information was cascaded down to charge nurses and other staff members via ward matrons.

Leadership and culture

The deputy manager had been in post since February 2014 as the temporary manager for the ward, she said her post as deputy had recently been back filled so she was able to manage the ward more effectively. The manager was a trust trainer in the recovery model and had introduced this to older people's services.

We saw evidence of good team work and effective management of the team. The manager described the process of how information was cascade to the teams. She

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said that the general manager held regular meetings with matrons who in turn met with charge nurses. This was then shared at meetings where the manager provided the opportunity for staff members to raise any concerns they may have.

Community services

Vision and strategy

Staff spoken with were uncertain about the future direction and structure of community mental health services. They said that they had not been involved in or consulted about developments in the service. We were told that in the past, governance arrangements had been put in place which were aimed at supporting the delivery of the trust's vision and strategic objectives. However, we were informed by staff that further board changes were to be made in the near future which had left many staff 'uncertain about their future.'

Leadership and culture

At location level, there was a clear understanding of roles and responsibilities and staff were aware of this. However, staff perceived a lack of communication from board level, some staff described feeling under-valued. Front line staff we spoke with commented that any concerns they expressed were not listened to by senior management which left them feeling dis-engaged and without a voice.

Staff members at different levels, said that despite staff shortages in several locations, they were

satisfied in the care they provided and carried out their roles to the best of their ability at all times. However, there was a clear climate of negativity within community services. Staff told us they felt stressed and anxious over what the future held. Several staff members told us about an initiative they had developed to expand their services out into the community. However, although the idea was forwarded to the trust headquarters, the initiative was not pursued any further which left staff disappointed.

Staff were aware that the trust were trying to recruit the best staff but were frustrated in the delay in them taking up the post.

Performance improvement

The "Meridian" system was in place enabling real time feedback from people who used services. This information was fed back to the community team and used in the quality circle meetings.