Humber NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health in-patient services	East Riding Community Hospital Swinemoor Lane Beverley North Humberside HU17 0FA	RV9ER
Community health in-patient services	Withernsea Community Hospital Queens Street Withernsea Humberside HU19 2QB	RV913
Community health services for adults	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
Community health services for children, young people and families	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936

Summary of findings

End of life care	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
End of life care	Mac Milan Wolds Unit Bridlington & District Hospital 8 Bessingby Road Bridlington Humberside YO16 4QP	RV9X3
GP Out of Hours Service	East Riding Community Hospital Swinemoor Lane Beverley North Humberside HU17 0FA	RV9ER
GP Out of Hours Service	Goole Primary Care Centre Goole District Hospital Woodland Avenue Goole North Humberside DN14 6RX	RV9X1
GP Out of Hours Service	Hedon Primary Care Centre Rosedale, Preston Road Hedon Hull North Humberside HU12 8JU	RV9X6
Community Mental Health Teams	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
Community Crisis Treatment teams	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
Child and Adolescent Mental Health Services	Willerby Hill Beverley Road	RV936

Summary of findings

	Willerby Hull Humberside HU10 6ED	
Forensic Services	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
East Riding Addiction Services	Willerby Hill Beverley Road Willerby Hull Humberside HU10 6ED	RV936
Adult Mental Health admission services, s136 Place of safety	Buckrose Ward Bridlington & District Hospital 8 Bessingby Road Bridlington Humberside YO16 4QP	RV987
Adult Mental Health Rehabilitation Services	Hawthorne Court St Mary's Lane Beverley Humberside HU17 7AS	RV941
Inpatient and community older people mental health services	Maister Lodge Hauxwell Grove Hull Humberside HU8 0RB	RV938
Inpatient and community older people mental health Services	Mill View Castle Hill Hospital Castle Road Cottingham Humberside HU16 5JQ	RV942
Adult Mental Health admission wards, PICU , s136 Place of safety	Miranda House Gladstone Street Anlaby Road Hull Humberside	RV945

Summary of findings

	HU3 2RT	
Detox Ward substance misuse service	Miranda House Gladstone Street Anlaby Road Hull Humberside HU3 2RT	RV945
Adult admission ward	Newbridges Birkdale Way New Bridge Road Hull Humberside HU9 2BH	RV934
Adult mental health rehabilitation	St Andrew's Place 271 St Georges Road Hull Humberside HU3 3SW	RV980
Inpatient and community Learning Disability services	Townend Court 298 Cottingham Road Hull Humberside HU6 8QG	RV915
Adult mental health admission ward	Westlands Wheeler Street Anlaby Road Hull Humberside HU3 5QE	RV933
Child and Adolescent Mental Health Community Team	Westend 2062-2068 Hessle High Road Hull Humberside HU13 9NW	RV933

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.

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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Overall summary

Humber NHS Foundation Trust provides mental health, learning disability and community health services in the East Riding of Yorkshire and mental health, learning disability and some therapy services in the city of Hull, to nearly 600,000 people. It also provides some services to parts of North and North East Lincolnshire and North Yorkshire, as well as some specialist services to people from other parts of the country. The trust provides mental health forensic services to patients in the wider Yorkshire and Humber area.

Board members and senior managers were clear about strategic and key issues. Nonetheless their visibility, and the extent to which staff felt engaged and supported by them, varied considerably. Staff in some services considered themselves well-led but in the children and therapy teams, and older people's and CAMHS services, staff were less engaged with the trust's vision and strategy and least confident in its leadership.

We had concerns about the safety of some services provided by the trust and significant concerns in regards to the child and adolescent mental health services (CAMHS). These were linked to the capacity and demand pressures evident in some services and the impact that this had on staff working within these services. There was concern about the potential / actual impact on the quality of care experienced by patients who accessed these services. The trust risk register noted capacity and demand pressures within some services, and some action had been taken to address longer waiting times through appointment of temporary workers in community nursing services. This had been funded by commissioners and the budget for these posts was non-recurrent.

The capacity and demand pressures meant that there was too much work for staff to do and were particularly evident within the CAMHS, older people and community mental health team services. Although some action had been taken to mitigate the risks of high case loads and long waiting lists, controls were not in place to ensure effective monitoring of those patient referrals classed as routine and placed on a waiting list following telephone triage.

We identified restrictive practices in relation to the care provided to patients accommodated within the acute admissions ward but not detained by the Act (informal patients). These wards had locked doors to maintain security however not all informal patients were advised of their right to leave the ward. A system was in operation that required informal patients to sign confirmation of their agreement not to leave the ward for the first seven days of their admission.

There was inconsistency in reporting practice. Staff demonstrated varying ability and awareness of how to identify and consider serious incidents, incidents, near miss incidents and risks and what to do with that information. We were concerned there was inconsistency in how individual teams learnt from incidents and how information was shared following incidents across the organisation.

We found the care provided to people in the majority of services was evidence based and focussed on the needs of the patients. We saw some examples of very good collaborative work and innovative practice. However staff's ability to cope with the capacity and demand for services, had a negative impact on delivery of care and treatment;

Despite examples of person centred care, we found occasions where delivery of care was not focussed on the specific care needs of the individual patient. For example, staff at the Humber Centre routinely searched patients and asked them to open personal mail in their presence. This was in the absence of such instruction or documented reason, within the patient's individual care plan.

Whilst there was evidence of audits, and reference to NICE guidance, this was not consistent across the trust; there was limited evidence of outcomes being monitored to show how effective care was.

We were concerned about the effectiveness of communication between professionals. This problem was compounded by the use of various operating systems, both electronic and paper, to record and store patient information. Although summary information was available, we found delays in scanning paper records onto the electronic system, including records relevant to

Summary of findings

the safeguarding of children and attendance at minor injury units, at two out of fourteen clinics. We also identified potential risks for duplication and/or transcription errors when updating electronic records from paper records and potential risks of staff delivering care whilst in possession of out-of-date information. We brought these concerns to the attention of the trust at the time of the inspection visit.

Most of the facilities we visited were in a good state of repair and well maintained. The mental health seclusion suites at Derwent and Ullswater, were an exception as these were not in a good state of repair. We also identified ligature points within these suites that posed a risk to patients who were suicidal. The trust recognised that the seclusion suites did not meet the required standard. Capital funding to upgrade these facilities had been agreed in the current year capital funding programme.

The majority of people who use services told us they had positive experiences of care. Patients, families and carers felt well supported and involved with their treatment and staff displayed compassion, kindness and respect at all times.

We found staff to be hard working, caring and committed. Many staff spoke with passion about their work and were proud of what they did. However, some staff were not aware of the values or future direction of the organisation they worked for. In some services such as CAMHS and older people's services, staff felt disconnected from the wider organisation, including lack of direct consultation in strategic planning and development of services.

The majority of staff were up-to-date with mandatory training. However, whilst staff received training on the Mental Capacity Act as part of the mandatory training programme, their knowledge and application of this training was variable. Clinical supervision arrangements were in place across the organisation, however the quality of these was variable.

Across the trust, we found pockets of patient engagement, but this was not consistent or coordinated and the trust had not yet started using the friends and family test. The trust policy in respect of patient engagement was out to consultation at the time of this inspection.

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?

The trust had a new governance and reporting structure, which included arrangements for assessing, monitoring and reporting risk, but this was still to be embedded and a safety culture was not yet fully ingrained. The trust's ability to gather and analyse information about safety incidents, and feed these back to individual teams, was variable. It was not clear how the teams' work informed corporate decision making about safety.

In the community healthcare service, we found unscanned documents that staff had not had time to place on the electronic records system. These could have compromised patient safety.

During our inspection we found ligature risks in some seclusion rooms and found rails which were not collapsible. We brought this to the attention of the trust and appropriate action was taken.

Are services effective?

The trust achieved some good outcomes, for example in immunisation rates. In mental health the Recovery Star model was used meaning that people using services could map their progress.

However, data around benchmarking and key performance indicators was limited, particularly in community health services. There were no audits for community nursing in the trust's clinical annual audit plan for 2013/14, except for the trust's record-keeping audit. Therapy staff in the East Riding of Yorkshire told us they did not have time to conduct any audit activities.

Staff told us that they had to use several electronic health record systems, alongside paper records. This was time-consuming for staff, which caused frustration, and less time to provide direct clinical care. There was a potential risk for records to be duplicated or mismatches between the separate records. This could potentially lead too decision being made without an up to date information.

Not all staff in older people's services had received training in the MCA and DoLs. In relation to the Mental Capacity Act (MCA). We found that capacity and consent in relation to medication for physical ailments older people and learning disability mental health services was not recorded , particularly for people detained under the Mental Health Act.

Staffing levels, in areas such as school nursing, were not meeting national guidance.

Summary of findings

Within the Hull City access point for child and adolescent mental health services, staff told us they did not feel skilled enough, or that they were not supported enough, to be confident in making decisions about risk. There were also examples where staff had unsustainable levels of work, and we were not able to establish how the trust was supporting them to manage the work.

We found CQC were not notified consistently when children under the age of 18 were admitted to adult wards. There was a policy in place relating to the admission of young people in adult wards.

Are services caring?

Patients were very positive about the care that they received across mental health and community services. We observed that the way staff interacted with people was respectful, non-judgmental and compassionate.

Are services responsive to people's needs?

We saw that some innovative work had been carried out with the 'hard to reach' groups. For example, we saw that a programme within children's community services to engage the local traveller community, had worked well.

Many of the community teams in the mental health services had issues with demand and capacity with a rise in referrals. This meant that people were on waiting lists for long periods.

There were also long waiting lists for paediatric speech and language therapy services and pulmonary rehabilitation. Community health nurse teams were not meeting their four hour targets for urgent referrals, or the target for contacting or visiting new referrals.

In mental health services people were encouraged to write advanced directives about how they wanted to be cared for in the future. There were daily focus groups on the ward and staff responded to issues raised.

We found restrictive practices on mental health wards for both detained and informal people.

Community teams attended meetings to help people's transfer back to the community, while pharmacists ensured that people were aware of the side effects of their medicines. We found that the crisis team, in particular, were well organised and delivered clear pathways.

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Are services well-led?

Governance structures in place had been reviewed and identified changes that needed to be made. These changes led to the creation of new committees and revisions to existing ones.

The trust's services were mainly commissioned by two Clinical Commissioning Groups (CCGs) and the services provided to patients varied in each area, with people in Hull and the East Riding of Yorkshire receiving different services.

The Board and senior managers monitored risks that had been reported and had measures in place to manage them. However, there were inconsistencies in the way incidents were reported and learned from. This challenged the extent to which the Board were aware of risks about quality and safety.

We met some of the non-executive directors and found that they were knowledgeable and engaged with the work of the trust.

We found pockets of patient engagement across the trust but this was not consistent or coordinated. There was no feedback on lessons learned and the trust had not started to use the friends and family test. The current strategy was two years out of date and that a new strategy was in the consultation phase. Patient stories were heard at trust board meetings but the selection of these was described as "ad hoc."

Some staff at service level said they did not feel involved in the trust's vision and the values were not embedded within the services. During our inspection, we found that staff engagement was mixed, and depended on which service people worked in. Staff reported the children's services for both mental health and community services were not well-led.

The Mental Health Act Committee was led by a non-executive director and provided good governance arrangements in overseeing the Act, and the experience of people detained under the Act.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Team Leaders: Surrinder Kaur, Inspection Manager, Care Quality Commission (CQC, Mental Health) and Cathy Winn, Inspection Manager, CQC (Community Health Care).

The team included CQC inspectors and a variety of specialists including: Mental Health Act commissioners, psychiatrists, a specialist registrar, a student nurse, nurses including a specialist palliative care nurse and children's nurses, occupational therapists, psychologists, social workers, a community hospital manager, a therapies manager, a district nursing specialist practitioner, a respiratory nurse specialist, hospital managers, a GP and Experts by Experience who had used the service or were a carer of someone using a service.

Why we carried out this inspection

We inspected this trust as part of our comprehensive Wave 2 pilot mental health and community health services 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?

We carried out announced visits to the services of Humber NHS Foundation Trust between 20 and 23 May 2014, which included visits to some services outside of core hours. We carried out unannounced visits on 5 June 2014. Before visiting, we reviewed a range of information that we hold about the core service and asked other organisations to share what they knew. During the visits, we held focus groups with a range of staff who worked within the services, including nurses, health visitors, school nurses, doctors and therapists. We talked with people who use services as well as carers and/or family members. We observed how people were being cared for and reviewed their care or treatment records. We also distributed comment cards for people to complete if they wished.

Information about the provider

Humber NHS Foundation Trust provides services in the city of Hull and in the East Riding of Yorkshire, to nearly 600,000 people living in urban, rural and coastal areas. It also provides some services to parts of North and North East Lincolnshire and North Yorkshire, as well as some specialist services to people from other parts of the country. The trust provides forensic services to patients in the wider Yorkshire and Humber area, and community health services for the East Riding of Yorkshire. Some therapy services are also provided to the city of Hull.

The trust provides the following core services:

- Adult mental health admission wards.
- Psychiatric intensive care unit (PICU) and s136 Health Based Place of Safety suites.
- Crisis community teams.
- Long stay and forensic services.
- Older people's services.
- Learning disability services.
- Child and adolescent services.
- Substance misuse services.

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- Community health inpatient services.
- Community health services for adults.
- Community health services for children, young people and families.
- End of life care.
- GPs out of hours service.

Humber NHS Foundation Trust has 20 registered locations that provide mental health, learning disability and community health services. It also has three community health inpatient hospital sites: Bridlington Hospital, East Riding Community Hospital and Withernsea Hospital. In addition, the trust provides healthcare services for HMP Wolds, HMP Hull, HMP Wakefield and HMP Everthorpe, but these were not within the scope of this inspection. We have a separate method for inspecting offender healthcare, which includes joint visits with Her Majesty's Inspectorate of Prisons (HMIP). These reports can be found on the HMIP website.

Humber NHS Foundation Trust was granted foundation trust status on 1 February 2010. Community services for East Riding were brought into the trust from 1 April 2011. The organisation now provides services from more than 70 sites with an income of about £134 million and employs approximately 3000 staff.

Humber NHS Foundation Trust has been inspected on 13 occasions since registration at eight locations, including HMP Wolds. The reports of the inspections at the eight locations were published between December 2011 and August 2013. The eight locations were compliant at the start of this inspection.

Non-compliance with the Regulations had previously been found in three locations. We issued compliance actions for the trust's failure to ensure respect and involvement of people who use services, consent to care and treatment, care and welfare of people who used services, safeguarding people who used services from abuse, safety and suitability of premises, assessing and monitoring the quality of service provision and records. The trust took steps to respond to these positively.

Mental Health Act monitoring visits have also taken place to wards that have detained patients each year.

What people who use the provider's services say

People we spoke with from across the core services we inspected were positive about the care they received.

Fourteen locations had Patient-Led Assessments of the Care Environment (PLACE) assessments in 2013. The trust scored highest for cleanliness, when compared with other organisations, which put it in the top 25% of organisations that had PLACE assessments.

We provided comments boxes at 16 locations across the trust during our inspection and received 32 responses from patients or their relatives. Almost all the responses related to community health services. Most of the responses we received were positive about care and treatment received. Three responses described negative experiences and concerns included the responsiveness of the service, waiting times and not feeling listened to.

Good practice

Mental Health

- Support from pharmacists was good across all wards, especially at Avondale, the assessment ward.
- The routine use of My Shared Pathway within mental health teams also meant that people who used services felt more involved in their care plans and able to contribute to their content.

Community

- The multidisciplinary working and involvement by the Macmillan nurse team in the Gold Standards Framework groups, and the multi-agency review of patient deaths to aid shared learning was identified as good practice,
- The trust supported nurse practitioners to train to become First Contact Practitioners (FCPs) in the out of

Summary of findings

hour's service. FCPs are highly skilled, experienced and degree educated nurse clinicians who, although forming part of the multidisciplinary team, effectively practice autonomously.

- A practitioner role was set up to prevent patients who were elderly or had serious illnesses, such as heart problems or diabetes, from being frequently admitted to the emergency department. They identified risk and relapse plans for patients with deterioration of health and identified named cover for the patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that the environment and ligature risk reduction in the seclusion rooms at Derwent, Ullswater and Green trees wards adhere to the Mental Health Code of Practice.
- The leave arrangements in place for informal patients at St Andrews Ward must take into account the least restrictive principle and their status in accordance with the Mental Health Code of Practice.
- The trust must address the leadership and staff engagement issues within the children's services.
- The trust must have an effective system in place to identify, assess and manage the risks of young people on its waiting lists.
- The trust must take action to ensure that all incidents that result in harm for a child or young person are reported internally, recorded and investigated and all external report recommendations fully implemented.
- The trust must take action to ensure that all its staff working within CAMHS adhere to Safeguarding Childrens' procedures and that all incidents that result in harm are referred onto the appropriate local authority Safeguarding team.
- Staff at St Andrew's Place must receive training in basic food hygiene

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that a system is in place so that CQC is notified promptly of every admission of a child or young person to an adult ward without undue delay.
- The trust should ensure that all staff have the required knowledge and receive training in assessment of people's mental capacity and deprivation and liberty.
- The trust should ensure that people's individual risk assessments are up to date on Ouse ward.
- The trust should ensure that individual restrictions are risk assessed and associated risks are documented and understood by people using services in the admission wards. This includes leave arrangements and access to garden areas.
- The trust should improve the processes and training for reporting and sharing incidents, accidents and near misses, to encourage learning and improvement.
- The trust should ensure that all records, electronic or paper based, are accurate, up-to-date, fit for purpose.
- The trust should make sure that all staff in learning disability services, including psychiatrists, receive adequate training on SystmOne until they are competent and know how to use it well.
- The trust should ensure that the policy relating to contraband items and which items are allowed on acute admission wards is fully understood.
- The trust must ensure that there are clear outcome measures across CAMHS teams and services and used in a systematic way.
- The 'Safe and Appropriate Care for Young People on Adult Mental Health Ward' policy should take account of Chapter 36 of the Mental Health Act Code of Practice.
- The trust should make sure that documentation relating to detained people with learning disabilities meets the requirements of the MHA Code of Practice.
- The trust should review staffing and caseloads, in particular:
  - for health visitors and school nurses to ensure that they are manageable, in accordance with national guidance.
  - neighbourhood care teams, to ensure there is a robust, embedded system to determine appropriate staffing and caseload size.
- The trust should make sure that there are enough staff when increased observations are required on Ullswater Ward
- The trust should ensure that staffing levels are kept under constant review on Ouse and Derwent ward so that people do not have their Section 17 leave cancelled.
- The trust should ensure that the GRiST (Galatean Risk and Safety Tool) assessment tool is adapted so that it is learning disability specific.
- The trust should follow the least restrictive principle of the Mental Health Code of Practice based on individual clinical risk assessment in relation to practices such as supervision of people opening their post searching people and rooms in the Humber Centre.
- The trust should consider how people in acute admission wards are involved in their care planning consistently across the acute admission wards.
- The trust should review noise levels of closing doors in corridors on Ullswater Ward and the impact this is having.
- The trust should continue to work with commissioners to ensure service specifications/agreements are in place for all services.
- The trust should continue to discuss and resolve the gaps in CAMHS provision, review the limited services available out of hours and during crises and waiting lists with commissioners of services.
- The trust should continue to reduce the waiting lists in the older people inpatient and community teams speech and language therapy services in Hull, podiatry services, pulmonary rehabilitation and in occupational therapy and psychological intervention teams
- The trust should ensure that agreed performance indicators are met in community health nursing.
- The trust should review access to therapy support within Withernsea Community Hospital.
- The trust should review the arrangements within community inpatient services, for obtaining medication outside the designated delivery times.
- The trust should complete and send in notifications of children and young people who have been admitted to an adult ward.
- The trust should make sure that all staff in the learning disability service know how to access managerial and clinical supervision and are clear about their line management responsibilities.

Summary of findings

- The trust should ensure that staff on Ouse ward receive regular supervision as per trust policy.
- The trust should ensure public engagement is considered from a trust-wide perspective to improve service delivery.
- The trust should improve the clinical audit programme to include community health care services.
- The trust should make sure that all staff are following the medicines procedures robustly within the GP OOH service and that medicines are stored at the correct temperatures.
- The trust should review access to prescribed controlled drugs for palliative care patients out-of-hours.
- The trust should ensure performance targets are in place for services and data is collected efficiently.
- The trust should ensure that mandatory training is completed and that the personal appraisal and development review (PADR) is consistent across the teams and meeting trust targets.
- The trust should work with partners to address the delays in getting specialist equipment to children and young people quickly.
- The trust should review and put formal arrangements in place for moving children to adult services.
- The trust should ensure that risk registers are updated consistently and that staff are aware of when to place an issue on the risk register and aware of the risks for their services.
- The trust should implement the action plan, which resulted from staff completing the Health and Safety Executive stress questionnaire.
- The trust should audit and review the time taken to provide equipment to patients receiving end of life care.
- The trust should improve records used to document end of life care so that national guidelines are followed and information is recorded in a consistent way by all staff.
- The trust should review processes on an ongoing basis for accessing specialist end of life care during out of hours and on weekends.

Humber NHS Foundation Trust

Detailed findings

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

The trust had a new governance and reporting structure, which included arrangements for assessing, monitoring and reporting risk, but this was still to be embedded and a safety culture was not yet fully ingrained. The trust's ability to gather and analyse information about safety incidents, and feed these back to individual teams, was variable. It was not clear how the teams' work informed corporate decision making about safety.

In the community healthcare service, we found unscanned documents that staff had not had time to place on the electronic records system. These could have compromised patient safety.

During our inspection we found ligature risks in some seclusion rooms and found rails which were not collapsible. We brought this to the attention of the trust and appropriate action was taken.

Our findings

Track record on safety

The trust reported there had been no never events (a serious event that is largely preventable) since April 2011. 64 serious incidents between April 2013 and March 2014 were reported. The majority of these related to the unexpected death or suicide of patients receiving care in the community. The trust had commissioned a review of these deaths and was drafting a suicide prevention strategy at the time of our visit.

The percentage of the trust's patients suffering falls with harm was above the England average at times during the period of April 2013 to April 2014. Overall the rate of new pressure ulcers at its community hospitals and district nursing, was relatively low and we saw systems were in place to risk assess, prevent and manage pressure ulcers.

Detailed findings

Learning from incidents and Improving safety standards

Staff reported incidents via a trust-wide electronic reporting system which had been in place since February 2014. However, not all staff teams reported incidents appropriately or understood what should be reported. Staff in some teams reported incidents and accidents frequently and routinely; whereas in other teams, staff only reported clinical incidents or specific types of incidents, such as pressure ulcers. In particular, teams did not always report incidents or near misses that were associated with staffing levels.

Serious untoward incidents were discussed at the service's governance meetings and a root cause analysis was undertaken to establish why the incident occurred and what could prevent the incident from happening in the future. However, managers did not always ensure that lessons learnt from this were communicated effectively so that staff across the organisation could learn from these adverse events.

Managers within the trust, told us of a plan to train dedicated staff to investigate incidents.

We were concerned about the trust's ability to synthesise and analyse information about safety incidents and to feed that back to individual clinical teams was not consistent. Some teams reported that they completed large amounts of information about safety to feed into the organisation but received very little back in relation to their own their team or their comparative performance. It was also not clear how information connected the work of teams and corporate decision making in relation to safety. The trust's own recent review of its governance arrangements by Deloitte, highlighted the underdevelopment of analysis of data being provided at all levels of the organisation, including the trust Board.

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

The trust policy on safeguarding was up to date and contained clear advice to staff about how to raise an alert and who to contact.

At two locations we inspected, (Hessle and Rosedale clinics) we found a large number of records (circa 250 at one location) relating to children and families, many of which were several months old, that had not been scanned onto the electronic information system. These documents included safeguarding records and referrals from the local minor injuries unit. Clinical staff were concerned about this and had reported it to senior managers. Although, when we checked a sample, we found summary information was available on the electronic system which reduced the risk to children, young people and their families, we remained concerned about the sustainability of the system and administrative resource to manage documents and ensure that records were updated in a timely way. We asked the trust to take urgent action regarding this matter and revisited as part of our unannounced inspection. We found that the trust had responded and most of the scanning had been undertaken, although we found there was a significant amount outstanding in one location.

Staff were aware of infection prevention and control guidelines. We observed good practices such as the correct application of hand washing and use of hand gel following care, staff following the 'bare below the elbow' guidance and staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care.

Staff confirmed they had access to sufficient supplies of suitable equipment although there had been delays in getting specialist equipment to children and young people. In most clinical areas, there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. However, within the doctors out of hours service we found staff were not robustly following the monitoring systems to ensure medicines were stored at safe temperatures.

In services we inspected, most clinical records showed that staff had undertaken risk assessments for individual patients and recorded this well. Most staff had received training in the management of actual and potential aggression (MAPA) and understood that physical intervention was only used after de-escalation techniques had been used to try and diffuse the situation. The use of restraint was recorded through the incident reporting process and in the patient's case records. Staff reported that seclusion was used at times, but only in the last resort when all other measures had failed.

We were concerned about the safety of some of the care environments. We found curtain rails that were not collapsible in the learning disabilities service at Townend Court. The trust responded promptly to investigate and manage this during our site visit. We found the seclusion rooms at Derwent, Green Trees and Ullswater required

improvement as they had ligature potential risks. Following our inspection, the trust informed us that the upgrading of the seclusion facilities had been identified as a high priority in the trust's capital programme for this year and that patients were constantly observed when they were in seclusion to minimise the potential risk.

Throughout our inspections at locations within the trust, we saw that the hinges used on all ward doors were not of the continuous type, which meant that the gap between the top of the door and the jam down to the top hinge on each door offered a commonly used potential ligature attachment point.

Assessing and monitoring safety and risk

There were arrangements to assess, monitor and report risk with a new governance and reporting structure in place, which was still to become established. A safety culture was not yet fully embedded in the trust.

The trust sent 'Blue Light' information alerts in response to concerns raised by incident reporting, complaints, commissioners, CQC visits and changes to information requirements from the Department of health. Blue Light information alerts highlighted actions to be taken, but it was unclear how the trust gained assurance that actions had been completed and embedded within the services.

Understanding and management of foreseeable risks

The trust's risk register, which linked directly to the board assurance framework, was a working document and informed improvement plans across the trust. However, the quality of service improvement plans varied between services; as did the extent to which they were implemented.

A clinical governance system was in place to escalate risks to senior management, however, this was not always being used effectively by local staff. This meant that the community teams were not always aware of identified risk and strategies could not be implemented to reduce further risk to patients.

Local services reported they identified high, medium and low risks for inclusion on the trust's risk register and that risks were monitored through local business meetings, with an overarching review by the trust governance committee, however we did not see this happening consistently either at team or directorate level.

Following concerns about the efficacy of the trust's governance arrangements, the trust commissioned a review of its governance arrangements by Deloitte. The report highlighted the under development of analysis of data being provided at all levels of the organisation including the trust board, whilst an action plan was implemented to introduce an integrated governance system. We were concerned about the trust's ability to synthesise and analyse information about safety incidents and the feed that back to individual clinical teams was patchy. Some teams told us that they completed large amounts of information about safety to feed into the organisation, but received very little back in relation to their own their team or their comparative performance.

It was also not clear how information connected the work of teams and corporate decision making in relation to safety.

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

The trust achieved some good outcomes, for example in immunisation rates. In mental health the Recovery Star model was used meaning that people using services could map their progress.

However, data around benchmarking and key performance indicators was limited, particularly in community health services. There were no audits for community nursing in the trust's clinical annual audit plan for 2013/14, except for the trust's record-keeping audit. Therapy staff in the East Riding of Yorkshire told us they did not have time to conduct any audit activities.

Staff told us that they had to use several electronic health record systems, alongside paper records. This was time-consuming for staff, which caused frustration, and less time to provide direct clinical care. There was a potential risk for records to be duplicated or mismatches between the separate records. This could potentially lead too decision being made without an up to date information.

Not all staff in older people's services had received training in the MCA and DoLs. In relation to the Mental Capacity Act (MCA). We found that capacity and consent in relation to medication for physical ailments older people and learning disability mental health services was not recorded , particularly for people detained under the Mental Health Act.

Staffing levels, in areas such as school nursing, were not meeting Royal College of Nursing guidance.

Our findings

Assessment and delivery of care and treatment

Staff had access to guidance and patients mostly received care according to national guidelines. Templates and care plans on SystmOne were validated and linked to evidence bases such as the Marsden Manual (a practice based tool by The Royal Marsden Hospital Manual of Clinical Nursing Procedures). Patients were assessed using recognised assessment tools, for example the Malnutrition Universal Screening Tool (MUST). We saw that staff in services provided care and treatment in line with some National Institute of Health and Care Excellence (NICE) guidelines but not all, such as enuresis care.

In school nursing, a significant number of children had received the HPV vaccine making the trust one of the best performers in this benchmark nationally. There had been national recognition of work done in therapies around postural management.

Some services were involved with research. For example, the older people's mental health services had a professor who carried out research with the local university. The speech and language therapy service was working with The Communication Trust to have a therapist in 16 schools one day a week, engaging children and teaching assistants to develop speech and language strategies and techniques in schools.

The trust had phased out the use of the Liverpool Care Pathway for the Dying Patient (LCP), in line with national guidance and staff confirmed this was no longer used. The trust had developed an end of life care pathway to replace the LCP, but this had not yet been implemented and the staff we spoke with were not clear on when this was due to be implemented.

Outcomes for people using services

In mental health services we found that a programme of audits was undertaken and the trust participated in national audits, for example in relation to prescribing. Internal audits were also carried out for example in record keeping and where required training was rolled out to staff to bring about improvement. In older people's services audits were conducted and the outcomes discussed during supervision and in team meetings with staff.

However there was limited data around benchmarking or key performance indicators within community health services. The trust's clinical annual audit plan for 2013/14

detailed no audits for community nursing with the exception of the trust's record-keeping audit. Therapy staff in the East Riding of Yorkshire told us they did not have time to conduct any audit activities.

We found the community hospital wards monitored key indicators such as pressure ulcers as part of the safety thermometer. Although there were peaks across the year, the overall numbers for pressure ulcer prevalence, falls and venous thrombo-embolism was low.

Some community health teams monitored outcomes for people. For example, the falls team had identified increased patient confidence and decreased fear of falling. School nursing had undertaken a number of case studies to highlight 'soft data' outcomes and the National Child Measurement Screening Programme implementation had resulted in 98% of children being appropriately screened and assessed in line with the national programme. We saw that targets were met for the Healthy Child Programme in line with commissioning arrangements through health visiting and school nursing services.

Children, young people, families and carers told us that the child and adolescent mental health services service helped them. We saw some thorough risk assessments and a range of assessment tools were used to inform clinical decision making. There was limited evidence that best practice guidelines informed interventions and some evidence that NICE guidelines were not being followed. There was no evidence of a systematic approach to the use of outcome measures. However, we were told that the trust were developing such systems as part of the new service delivery model.

In mental health services the Recovery Star model was used so that people could monitor their progress and influence their care plans. Participation in audits of NICE guidelines was evident particularly those led nationally. The substance misuse services used a number of outcome measures to ensure that effectiveness was assessed.

Whilst a small number of people told us they did not feel they were making progress, the majority of people said they were making positive progress and were very happy with the care and treatment they were receiving.

Staff, equipment and facilities

There were enough staff to ensure that patients were safe and received the right level of care in most areas. However, we had concerns about the staffing levels and caseload particularly within health visiting, school nursing, community nursing and therapy staff. Staff told us they felt the capacity within services were being stretched by increased referral rates, and this was not reflected in an increase in staffing levels. The trust had identified on their corporate risk register, that the increased demand and complexity of patient care within the neighbourhood care service was affecting the delivery of timely, effective, safe care. They had also identified the lack of agreed service specifications was exacerbating these concerns.

Caseload figures for health visitors provided by the managers were not consistent with those provided by clinical staff. We identified some health visitors had caseloads in excess of 400. This was above that recommended by the Community Practitioners and Health Visitors Association (CPHVA) which say that caseloads for health visitors should be an absolute maximum of 400 with an average caseload being 250. We were aware that the trust was in the process of recruiting new health visitors as part of the national programme to reduce caseload sizes.

In school nursing, we saw that one specialist practitioner (school nurses are required to undertake further study and qualifications) was covering 4 secondary schools and associated primary schools; most covered two secondary schools. Management of this service told us there was a high number of Looked After Children (LAC) within the service. Whilst they were supported by a number of staff nurses, Royal College of Nursing (RCN) guidance specifies there should be one school nurse to one secondary school. This was compounded by the school nursing service operating to a lapsed service agreement. The age that school nurses are responsible for children has now risen to 18. This meant that the service was responsible for more children and young adults than was being reflected in their service agreement or staffing plan (though we were aware a caseload management tool was in use). There had been a restructuring of school nursing implemented in September 2013 which saw some nurses now working term time only and reduction in school nursing hours.

A number of staff we spoke with told us they regularly felt under pressure to work over their hours to get their work completed, whilst others said they completed work at home. The last national staff survey put the trust in the bottom 20% for work pressure felt by staff.

Community health care staff confirmed that the acuity of patients was increasing and staffing had not increased in

line with this. Staffing levels varied across the teams and localities but there was no systematic approach to determining appropriate staffing and caseload size, particularly for community nurses. The trust had recognised and recorded on the risk register that increased demand and complexity of patient care within the neighbourhood care services, affected the delivery of timely, effective and safe care. Staff had an increased numbers of visits and the trust had worked with commissioners to secure temporary funding for 20 community nursing posts. This had improved the staffing across the nursing teams, but was a slow process. It was unclear if the additional funding would continue.

Therapist staff such as physiotherapists, occupational therapists and podiatrists told us they were routinely understaffed and as a result could not meet capacity and demand. Performance data showed the number of face to face contacts for the physiotherapy and occupational therapy teams had increased over the year. Waiting lists had also increased with more than 80 patients waiting to be seen. In mental health services there were also waiting lists for therapy staff.

The trust had identified that there had not been adequate levels of medical input to ensure patient safety, particularly at East Riding Community Hospital. There has been an increase in the bed base of the ward, an increase in the acute presentation and the early transfer of patients from the acute trust. Temporary arrangements had been put in place to provide medical cover at both East Riding Community Hospital and Withernsea Community Hospital. At East Riding Community Hospital a Senior House Officer was employed and arrangements were in place for daily telephone supervision a Consultant. A tender had been advertised to contract permanent medical cover for the wards to replace the current temporary arrangements.

Facilities were generally fit for purpose. Most staff confirmed they had access to sufficient supplies of suitable equipment. However, staff told us that there could be delays in getting specialist equipment to children and young people in a timely way, especially when a patient had additional needs. We were told the waiting time for equipment was generally between three and six months. For patients receiving end of life care, we saw that equipment for patients in their own home was not always received promptly.

Whilst the trust reported that Local Authority and trust staff were on separate IT systems, all patients were on the MH system, all staff could see both systems and there was a single integrated paper record that all staff could access and write in. In practice the IT systems often hampered clinical staff and resulted in duplication of effort and a risk of transcription errors. Staff told us that they had to use several electronic health record systems, alongside paper records. This was time-consuming for staff, which caused frustration, and also meant that they had less time to provide direct clinical care. In addition, there was a clear risk for records to be duplicated or for there to be mismatches between the separate records.

In community services, the electronic patient record system did not always support staff to keep accurate and complete records. Poor connectivity to an internet signal across the geographical area covered, limited the impact of attempted solutions and an alternative was being sought. In addition, the IT systems in use across the community health services and community mental health teams were not interlinked. We were informed that the trust were working on a solution to create a patch to link both systems together.

The community mental health teams had been awarded the Home Treatment Accreditation Scheme (HTAS) award from the Royal College of Psychiatrists (RCP). The award is given to services which have been assessed as meeting set quality standards. This meant the teams sought opportunities to have the quality of their service reviewed by others. Equally in the long stay services, the wards had all been awarded the, Accreditation for In-Patient Mental Health Services (AIMS) award from the Royal College of Psychiatrists (RCP), some of which were rated, 'Excellent'.

However within some community mental health services, such as CAMHS and Older People, capacity and demand had affected the caseloads of staff and their ability to meet this demand.

In the older people's mental health services we found the community mental health team was on the same site as wards and this meant that there was continuity in provision and good planning for assessment and discharge. Physical health checks were being undertaken.

Are services effective?

The mental health services had implemented a recovery based model of care on all the wards to assist people in their recovery. We found good evidence to show that overall people had care plans that reflected their individual needs.

Multidisciplinary working

We found effective multidisciplinary (MDT) team working practices were in place across community health services. Patients were placed at the centre of their care and teams generally worked well together. This included examples of provision of joint appointments for people who use services with a range of staff involved with their care for the convenience of the person.

Teams linked with external specialities such as the palliative care service, hospices, GP's falls services and the fire service. We saw good practice, for example, the Physio Hull service's multidisciplinary team included local consultants in orthopedics, rheumatology, neurosurgery and pain, and therapy staff including physiotherapists, osteopaths and podiatrists. They were part of the clinical networks and had partnerships with the local authority and voluntary services.

Staff told us they were supported by a range of professionals within a multidisciplinary team (MDT) framework to provide care and treatment to people

Mental Health Act (MHA)

We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. We noted that the trust had systems in place to monitor the legality of the detention and had good processes for administrative and medical scrutiny of detention papers.

We found evidence that hospital managers discharged their duty and held full panel meetings when individuals appealed against their detention and at the time of renewal of detention.

Copies of detention documents were available and contained all required information including the views of the patient and their nearest relative as appropriate.

In care records we reviewed, relating to the detention, care and treatment of detained patients, the principles of the Mental Health Act had been followed and adhered to.

We were also told that the trust was managing its responsibility in monitoring the number of patients on Community Treatment Orders (CTOs). We were told that Guardianship was very rarely used.

We noted that section 17 leave for detained patients was being managed in line with the MHA Code of Practice. However, we noted that on Derwent ward staffing problems had resulted in patients not taking their escorted leave as often as they would wish. We were also told that very few activities took place on that ward. There was not a system in place to routinely update Section 17 leave documentation.

We observed that certificates of treatment authorisation for consenting and non consenting detained people held with the medicines cards. We found staff acting as statutory consultees did not make a record of their consultation with the visiting Second Opinion Appointed Doctor (SOAD) in the patients' records.

We were told that section 136 health based place of service was well coordinated and met the needs of patients and their representatives. However information from our meeting with the Approved Mental Health Practitioners (AMHP) for Hull and East Riding appeared to contradict this. Issues were raised there about AMHP cover at weekends which had resulted in some patients experiencing delays in their assessment and allocation to the inpatient services

We found evidence that detained patients were being provided with information on their rights under the Mental Health Act which were available in different formats. We found that detained patients were being provided with independent mental health advocacy (IMHA) services by two different organisations. Staff told us that where a patient lacked capacity to understand the information they would routinely refer the patient to an IMHA service. We noted that in most care records there was evidence of the patient's involvement in their care, with the exception of the psychiatric intensive care unit (PICU) and Avondale ward. Advanced decisions about how people wished to be looked after when unwell were discussed and encouraged particularly in the acute and rehabilitation wards.

We found that blanket rules and over restrictive practices were embedded in the daily routine of the wards

Are services effective?

MCA/DoLS

We saw the use of the Deprivation of Liberty Safeguards and best interests assessments under the Mental Capacity Act 2005.

We looked at people's records in the learning disabilities and older people's service. Even though records seen indicated it was likely that they lacked capacity, we were unable to find that an assessment of their mental capacity or best interests authority had been considered for the prescribing of physical medication (e.g. diabetes) not covered by Part IV of the Mental Health Act.

The trust's management of violence and aggressive behaviours policy (ratified 7 April 2014 by the trust's governance committee) failed to provide the only statutory definition of what restraint is in healthcare (physical or otherwise) as given in the Mental Capacity Act; or the statutory criteria that staff must meet to restrain an informal patient who lacks capacity. It provided other definitions from Codes of Practice and NICE, all of which have less legal authority than statute.

Assessment of capacity form, the standard assessment of capacity and best interests form used by the trust and Social Care Agencies in Hull and the East Riding of Yorkshire: Mental Capacity Act 2005) had tick boxes Yes or No for whether a person understood or retained, used /weighed or communicated but it did not provide any space beside these to explain what a person could not do if the No box is ticked, this form was mainly completed by clinicians.. Under the Act, the burden of proof falls on the assessor to prove that a person lacks capacity and simply ticking a box does not provide that level of evidence.

Are services caring?

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

Summary of findings

Patients were very positive about the care that they received across mental health and community services. We observed that the way staff interacted with people was respectful, non-judgmental and compassionate.

Our findings

Kindness, dignity and respect

Within mental health services, children, young people, families and carers told us that services were respectful and listened to them. We met with committed staff who were passionate about providing good, child, young person or family centred services. We saw evidence of compassion and respect in all of the case records we reviewed. In acute wards people using services were positive about the care they received. They were provided with welcome packs on admission. Most staff were positive and clear about their role and purpose. Community teams supported people to participate in social and community activities to maintain and develop their networks to support their recovery

Within community health services, staff treated people who use services with dignity, compassion and respect. Service users and their relatives spoke positively about their care and treatment. Staff kept service users and their relatives involved in their care and supported their emotional needs. There was limited information about bereavement and counselling services to support patients or their relatives. However, the trust was in the process addressing this.

People using services involvement

Within mental health services staff in crisis teams provided support to people's carers and family members which included offering carer assessments to identify their specific needs'. People's family members, friends and advocates were involved in the person's care as appropriate and according to the person's wishes. In older peoples services we found that information was being provided in different formats. Carers were involved in care planning and maintenance of independence promoted. Interpreters were provided to assist communication. People told us they were treated as individuals with respect by staff well trained in substance misuse.

Care plans were individualised and holistic although there was variation into the level of input people had in their care plans.

In acute admission wards we found people had holistic care plans although there was little evidence of meaningful involvement. The Recovery Star model was routinely used and people were attending Care Programme Approach (CPA) meetings. Physical health assessments were undertaken and physical health care plans were in place.

The crisis teams had a clear care pathway which focussed on assisting people in their recovery. The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice.

Within community health services, staff had the appropriate skills and knowledge to seek consent from patients or their representatives. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. Records we looked at showed that verbal or written consent had been obtained and that planned care was delivered with their agreement.

Staff respected the person's' right to make choices about their care. We observed staff speaking with people clearly in a way they could understand. Staff discussed options relating to areas such as equipment or medication to allow patients to make an informed decision. The patients and relatives we spoke with told us the staff kept them up to date and involved in their care.

Emotional support for care and treatment

Within community health services we observed staff providing reassurance and comfort to patients. The relatives we spoke with told us the staff were reassuring and supportive. Patients could access the multi-faith chaplaincy services for spiritual support. Staff providing palliative care, told us they provided emotional and bereavement support for patients and their relatives,

Are services caring?

including home visits to relatives following bereavement. However, there was no specialist bereavement or emotional support service within the trust. Staff told us patients or relatives that needed specialist psychological or emotional support were referred to services provided by local hospices or the acute trust. Patients could also be referred to CRUSE bereavement sessions across the East Riding.The trust's palliative care clinical network was in the process of developing bereavement booklets.

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

We saw that some innovative work had been carried out with the 'hard to reach' groups. For example, we saw that a programme within children's community services to engage the local traveller community, had worked well.

Many of the community teams in the mental health services had issues with demand and capacity with a rise in referrals. This meant that people were on waiting lists for long periods.

There were also long waiting lists for paediatric speech and language therapy services and pulmonary rehabilitation. Community health nurse teams were not meeting their four hour targets for urgent referrals, or the target for contacting or visiting new referrals.

In mental health services people were encouraged to write advanced directives about how they wanted to be cared for in the future. There were daily focus groups on the ward and staff responded to issues raised.

We found restrictive practices on mental health wards for both detained and informal people.

Community teams attended meetings to help people's transfer back to the community, while pharmacists ensured that people were aware of the side effects of their medicines. We found that the crisis team, in particular, were well organised and delivered clear pathways.

Our findings

Planning and delivering services

The trust provided care over a large geographical area and a number of Clinical Commissioning Groups (CCGs) commissioned the provision of care. This meant that there was a variance in what the trust provided to patients. This was particularly evident between Hull and East Riding of Yorkshire. For example, the stroke service in Hull was a multidisciplinary team approach and there was a much more limited service in the East Riding. Within mental health services, people receiving support from the Hull crisis team could be visited at home up to four times a day whereas some people receiving support from the East Riding team were only visited once a day even if they required more frequent visits.

There was a lack of agreed service specifications for some teams, including occupational therapy and speech and language therapy team (SALT). These had been outstanding for 2 and 5 years respectively. This resulted in staff being unaware of what service they should be delivering. The lack of agreed service specifications was on the trust's risk register and they were meeting with commissioners.

The trust were committed to developing services within the community and to integrated teams, for example Neighbourhood teams were trying to integrate mental health and physical health communities to serve the needs of people that had needs in both areas.

Right care at the right time

Within the community based teams in mental health services, there were concerns's about staff's capacity to meet demand. The rise in referrals meant that people were on waiting lists and in older people and CAMHS services, people could be on the waiting list for many months.

Children, young people, families and carers told us that services were very good once a worker was allocated to them. We were told that individual workers could be flexible and very understanding of their needs. However, because of the problems accessing the service there were long waits before interventions started. Parents told us about the gaps in the service out-of-hours and during crises. The trust noted the capacity and demand issues on their risk register and had dialogue with the commissioners about them.

In mental health services people were encouraged to write advanced directives about their future management. Daily focus groups took place to discuss the ward and staff were responsive to issues. Community teams attended meetings in order to facilitate transition back to the community. The pharmacists ensured people were aware of the side effects of medication they were taking.

Are services responsive to people's needs?

In the Humber Centre, we found examples where blanket policies and restrictive practices were used for all and were not related to individual patients' care plans and risk assessments. Routine searches were undertaken and people were told to open their post in front of staff.

In acute adult mental health admission wards we found restrictive practice being followed in relation to informal patients. We were shown a policy which required them to sign confirmation of their agreement not to leave the ward for the first seven days of their admission. We were told this policy has been in use for some years, but it was not something of which the trust was aware at board level. The trust responded swiftly to our feedback to rectify this.

Within community nursing, performance reports for Beverley, Bridlington, Driffield and North Holderness areas showed teams were below the 100% target for the proportion of preventable or urgent referrals seen within four hours, contacting new referrals and following up visits to patients.

There had been an increase in the number of referrals to the out of hours team. The service manager told us that calls were triaged using clinical decision making to decide if the visit could wait until the next day. They also said the service worked closely with GP out of hour's service and visits could be passed to them if needed. No data was available regarding missed or delayed calls.

A definition of 'house bound' had been agreed with commissioners and attendance at wound clinics had increased from 12% to 30%. This meant that patients who could attend clinics were being encouraged to whilst those that could not were seen at home. This meant house visits were conducted according to patient need.

Single point of access (SPOC) teams were set up but did not cover weekends or include all teams for example, the stroke service. This meant there could be a delay in responding.

Performance data showed the face to face contacts for the physiotherapy and occupational therapy had increased over the year. In Driffield, first time contacts had increased from 14 patients in April 2013 to 35 in March 2014 and follow up patients seen had increased from 60 to 90 in the same period. This led to longer waiting lists.

Speech and language therapy had long waiting lists in Hull. We saw that the service had identified concerns in waiting lists and that the situation was being monitored and addressed with some waiting times reducing. However, in May 2014, the longest wait at two clinics was over 40 weeks and 84 children were waiting over 18 weeks to be treated. This failure to meet referral to treatment times for therapies was identified as a risk and was on the trust's risk register.

Referral to treatment times for podiatry in Hull and the East Riding of Yorkshire pulmonary rehabilitation service was 28 weeks and 19 weeks respectively against targets of 18 and 10 weeks.

Waiting lists in community mental health teams were high, for example waiting times for assessment could be up to nine months in older people's services and similarly for young people. Capacity and demand was recognised by staff members as a problem. Paperwork and travelling were factors in limiting time spent with patients in the community. Evidence of good working links between wards and community services was apparent.

Bed occupancy across the trust was 73%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. However there were instances in mental health services of people going directly to the treatment wards because beds were fully occupied on the admission wards. This impacted on the treatment wards which could become more unsettled.

Care pathway

The trust had phased out the use of the Liverpool Care Pathway for the Dying Patient (LCP), in line with national guidance and staff confirmed this was no longer used. The trust had developed an end of life care pathway to replace the LCP, but this had not yet been implemented and the staff we spoke with were not clear on when this was due to be implemented.

We found that for some services in children's services there were no formal transition arrangements in place. We were told that in some therapy services that when children transitioned to adult services they were given a discharge report outlining their future therapy needs.

The crisis teams had a clear care pathway to enable people to access the service. They also linked well with the acute wards to identify people they could support to facilitate their early discharge from hospital.

Are services responsive to people's needs?

Learning from concerns and complaints

The trust's complaints process had recently changed and now all complaints (formal and informal) were reported to the trust's complaints department. Staff were aware to listen to people's complaints and apologise where mistakes had been made. The Operational Risk Management Group has been established to identify risks to the trust, arising out of incidents, near misses, claims and complaints

There had been 169 formal complaints made to the trust in the period April 2013 to March 2014. Sixty-four (38%) were upheld with 10 still being investigated and one was considered by the Parliamentary and Health Service Ombudsman (PHSO).

There were inconsistencies in practice amongst the different teams in regards to high level learning in relation to concerns and feedback. Some teams gave examples of service improvement following patient feedback; other teams were unable to give any examples where patient's views had been utilised to inform service design.

In older people's mental health services, there was no visible signage telling people how they could make a complaint.

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

Governance structures in place had been reviewed and identified changes that needed to be made. These changes led to the creation of new committees and revisions to existing ones.

The trust's services were mainly commissioned by two Clinical Commissioning Groups (CCGs) and the services provided to patients varied in each area, with people in Hull and the East Riding of Yorkshire receiving different services.

The Board and senior managers monitored risks that had been reported and had measures in place to manage them. However, there were inconsistencies in the way incidents were reported and learned from. This challenged the extent to which the Board were aware of risks about quality and safety.

Our findings

Vision and strategy

Interviews with members of the Board and review of Board and committee papers confirmed that Board members and senior managers were clearly sighted on complaints, quality issues and general performance across the Trust. However, it was not always clear what systems were to be used for providing assurance to the board that actions were completed.

Staff gave mixed responses when asked about the vision and strategy of the service. Some staff told us that they were unaware of a vision or the direction of travel of the service. Other staff were unable to articulate the vision for the trust or the service in which they worked.

The trust did not have a suicide prevention strategy and this has been outstanding since 2012. A document was in early draft.

A new risk strategy had been presented and ratified by the Board in September 2013. The trust were moving to an integrated governance model and when we spoke with staff they were unclear when the new model was to be implemented.

Responsible governance

The trust had commissioned an external review of their governance structures which found that governance was not seen as a fully integrated and holistic working concept within the trust. We were told that an integrated governance structure to improve the robustness of governance was being implemented. We found this was being introduced and was not yet fully embedded.

The non-executive directors were able to describe to us the information flows and how they challenged what they did not understand. We found that these directors were a strong group who understood their role and exercised their duties effectively.

The trust did not have a robust clinical audit programme for community health services to provide evidence of service changes and re-audit.

Leadership and culture

The culture within the service was mixed. Some staff told us they felt unsupported by some local and senior management within the service and that their concerns were not always taken seriously or acted upon. This was particularly evident in children's and therapy services. Other staff we spoke with told us they felt adequately supported by their manager and team.

We found in acute mental health services that leadership at ward level and board level was visible. There was good multidisciplinary working. Staff received regular supervision and their performance development reviews were completed. Staff felt that they were able to raise concerns**.** In the crisis teams staff told us that they felt well supported by their managers and were proud to work for the service. Staff told us that there was a visible presence in

Are services well-led?

the teams from the manager. All staff we spoke with told us the teams had a positive learning, transparent culture and they were committed and motivated to continually improve and develop the services.

Similarly in substance misuse services, staff told us they felt that the service was well-led and staff morale was high. The leadership and governance of both services at a local level and the wider trust assured the delivery of good quality care. Staff were complimentary about their line manager and open relationships have been formed. Staff were aware of and understood the trusts vision and strategy and there were good governance processes in place.

In all the admission wards had been awarded the Accreditation for Inpatient Mental Health Wards (AIMS) accreditation from the Royal College of Psychiatrist. This showed that the service was committed to improving its performance. The service had robust governance structures in place which were fully embedded on the wards. The ward held regular staff meetings that had an agenda which was focussed on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services. Staff achievements within the trust were recognised and celebrated.

In some older people services, staff told us they felt undervalued and did not feel involved in the service design. Staff raised concerns and were disheartened by lack of response from management. Staff were unaware of strategic direction and were unsure of what the future held because of lack of communication from the Board. Uncertainty expressed by staff related to future direction and structure of community mental health services for older people.

The trust was part way through a process which would see CAMHS provided through a different model of service delivery. Staff did not feel they had been consulted and listened to or their concerns appropriately acknowledged. Staff told us that they were discouraged from raising concerns and that there was not one senior person at the helm, steering CAMHS through difficult times. Staff in CAHMS struggled to meet the increasing demands of the service and there was no workload management system in place to support them.

We fedback these concerns to the trust at the inspection. They told us they were taking measures to identify a workload management system to help risk assessment. They were also in dialogue with the commissioners of services to discuss waiting lists.

In community services for children, young people and families, some staff told us they felt unsupported by some local and senior management within the service and that their concerns were not always taken seriously or acted upon. A number of staff we spoke with told us they regularly felt under pressure to work over their hours to get their work completed, whilst others said they completed work at home. A comparatively recent restructure in some of the children's services had left staff feeling disengaged and unsupported by senior management and in some cases alienated. Some members of staff told us that they lived in fear of management and were concerned about repercussions when speaking out.

In the NHS Staff Survey 2013, the trust was in the worst 20% nationally for six of the 28 key findings. This included relating to staff motivation, effective team working and support from immediate managers and work pressure felt by staff.

The trust scored within the best 20% of mental health trusts nationally on key findings relating to staff receiving regular annual job-relevant training, learning and development and the availability of hand washing materials.

Members of the trust's Health and Wellbeing group proposed they focused on managing and reducing stress and improve staff well-being. A high level action plan had been developed which included the Health and Wellbeing bus travelling around the trust during the week commencing 20 January 2014 to promote staff health and wellbeing; however in some services we found staff were not aware of the work of the Health and Wellbeing board.

Staff sickness rates at the trust have been similar to the England average for mental health and learning disability trusts over the two years between January 2012 and December 2013, although most recently since July 2013 they have been higher than the average. The trust's average for the most recent year of data (January to December 2013) was 0.5% higher than the average for the region

Are services well-led?

across all NHS organisations. The trust was aware their top reason for sickness absence was stress. The trust had conducted surveys and had referred staff to occupational health.

Engagement

We found pockets of patient engagement across the trust but this was not consistent or coordinated. There was no feedback across the trust regarding lessons learned. The friends and family test had not yet been implemented. The patient experience lead told us the current strategy was out of date by 2 years and a new strategy was in the consultation phase. Patient stories were heard at trust board meetings but the selection of these was described as "ad hoc."

Senior managers we spoke with had an understanding of the service issues however there was a disconnect between the perception of senior managers, who felt that they were providing clear management and leadership, and that of staff in some services. Some staff felt unclear and unsupported and they felt disengaged and not listened to about their concerns about the service delivery. This was particularly evident across children's services.

The community health care provision was integrated into the trust in 2011. Whilst some staff viewed this as a positive move, other teams felt undervalued and reported working in silos.

We saw that in some areas of the service, innovative work had been carried out to increase the engagement in health services of 'hard to reach' groups. For example, we saw a programme of engagement for the local traveller community which had been run with positive results in terms of engagement.

Performance Improvement

The trust had a quality monitoring system in place which aimed to give an overview of the trust. This included a reporting system of actions. In February 2014 the trust reported that it was meeting 11 of its 14 reported quality indicators. However they were not meeting their quality indicators for: Standards regarding Seclusion in the Mental Health Act; improving the diagnosis, care and treatment for people with dementia and improving the care treatment for people with long term and chronic health conditions.

The trust's mandatory training compliance was reported as 75.5% for February 2014, which was a decrease of 2.5% compared to January 2014. The target was 75%. The reason for the reduction in the overall training compliance was due to the drop in compliance with Information Governance (IG) Training.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. The registered person must have regard to the information contained in the records referred to in regulation 20 **The way the Regulation was not being met:** There was a backlog of records that had been identified as requiring scanning on to the electronic record at Hessle Health Centre and Rosedale Care Centre. The operation of the systems was not effective and there was a risk that people may receive unsafe or inappropriate care. Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision 10 (1)(b) and (2)(b)(iii)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered must have suitable arrangements in place in order to ensure that staff are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training professional development, supervision and appraisal: **The way the Regulation was not being met:**

This section is primarily information for the provider

Compliance actions

- Staff in a number of the children's services felt unsupported by some local and senior management within the service and their concerns were not always taken seriously or acted upon.
- Staff at St Andrews Place assisted people to prepare meals however; they had not received training in basic food hygiene.

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers 23 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person must ensure that service users are protected against the risks associated with unsafe or unsuitable premises by means of: (a) suitable design and layout **The way the Regulation was not being met:** • There were protruding shelves in the seclusion rooms at Green Trees and Derwent ward which posed a ligature risk and was not in line with the most recent guidance concerning such environments. • There were ligature risks on some doors at St Andrews Place and Green Trees. • There were no toilet facilities near to the seclusion room on Swale ward. • On Ullswater ward.the door frame of seclusion room one required repair. • Willow ward had metal edges above on the entrance to the room and around the window. There were also exposed plug sockets in the adjoining de-escalation room. There was no policy or procedure in place regarding infection control when passing urine bottles through the hatch which was also used for passing through food and drink. These factors put people at increased risk when in seclusion. Regulation 15 (1a) HSCA 2008 (Regulated Activities) Regulations 2010 • Suitability of premises

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of: (b) the planning and delivery of care and, where appropriate, treatment in such a way as to- (i) meet the service users' individual needs and (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. **The way the Regulation was not being met:** At St. Andrews Place, we found a, 'leave care plan' for an informal person which specified that, 'Leave to be recorded on a section 17 leave form' and that, 'All leave to be agreed by MDT'. The goal of the care plan was documented as being for the person not to abscond from the ward. The person was informal therefore was free to leave the ward without permission whenever as they chose to do so. The care plan was not compliant with the Code of Practice as it did not reflect the person's lawful right to leave the ward at any time. This could result in the de facto detention of the person. Regulation 9 (1b) HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to: -regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these regulations and

This section is primarily information for the provider

Compliance actions

- identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the

regulated activity.

The way the Regulation was not being met:

- Not all incidents that resulted in harm for a child or young person were reported internally, recorded and investigated Not all external report recommendations were fully implemented.
- The Safeguarding Childrens' procedures had not been adhered to. Referrals had not been made to the appropriate local authority Safeguarding team following incidents.
- The waiting list was not being adequately monitored for risk.
- Contact point staff did not have effective training and procedures, to support triage.
- Lateral checks on young people being referred were not in place.

Regulation 10 (1) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010