Requires improvement

Humber NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Willerby Hill
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV936	Humber NHS Foundation Trust Willerby Hill	Recovery support (Hull West) Waterloo Centre	HU2 9AY
RV936	Humber NHS Foundation Trust Willerby Hill	Recovery support (Hull East) The Grange	HU8 0RB
RV936	Humber NHS Foundation Trust Willerby Hill	Recovery/ Psychological intervention (Hull) John Symons House	HU2 8TB
RV936	Humber NHS Foundation Trust Willerby Hill	Pocklington Adult Community Mental Health Pocklington Health Centre	YO42 2DF

Summary of findings

RV936	Humber NHS Foundation Trust Willerby Hill	Holderness Adult Community Mental Health. Rosedale Community Unit	HU12 8JU
RV936	Humber NHS Foundation Trust Willerby Hill	Haltemprice Adult Community Mental Health. Alanby Clinic	H10 6UE

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as requires improvement because:

- There were a number of staffing vacancies, and sickness rates among the teams were high, which put additional pressure on the workloads of other staff. Staff work-related stress assessments highlighted concerns about staff workloads.
- Team managers were not using caseload weighting tools. This meant there was no tool to measure the workload and weight of each care co-ordinator's caseload.
- Large waiting lists were not consistently managed. The average number of days a patient waited between assessment and treatment in each team varied from 21 days to 204 days. This meant that all six teams were above the trust target of 14 days.
- The number of staff who had completed mandatory training was below the trust target of 75 to 80% in most areas. The lowest team compliance was 22% and the highest team compliance was 48%.
- Senior managers were not visible within the teams and staff told us that they did not receive feedback regarding concerns they raised. Staff in the Hull area did not feel involved in changes taking place in the area's services.
- Key performance indicator reports were not reflective of the performance monitored at team level. The reports were not always reflective of the team's current position and did not always include data from social care staff. This meant that the teams did not always find the reports to be a helpful tool in improving performance.
- There were delays in transferring care records between services. This meant a patient's previous medical history was not always available to staff.
- Clinical audits were not taking place as the trust was reviewing these. Clinical audits check the effectiveness of patient care.

However:

- Patients had care plans and risk assessments that were person centred and met their needs. Staff worked closely with GPs to monitor the physical health care of patients, to ensure physical health care was prioritised.
- The provider had safeguarding policies and procedures and staff could identify what abuse looked like and acted on this accordingly. Staff reported all incidents through their electronic incident reporting system.
- Psychological therapies were offered in line with the National Institute of Health and Care Excellence guidelines. A full range of multidisciplinary professionals worked effectively together within the teams.
- Staff followed the Mental Health Act Code of Practice and understood the principles of the Mental Capacity Act.
- Patients and carers spoke positively about the care and treatment received in all of the services.
- The community teams all had adequate facilities to see patients, and could access interpreters and information in different languages where there was a need.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were a number of staffing vacancies, and sickness rates among the teams were high which put additional pressure on the other staff workloads.
- Caseload weighting tools were not being used; therefore, there was no tool to measure the workload and weight of each care co-ordinator's caseload.
- Waiting lists were not consistently monitored and managed for risk across the service. Not all teams maintained regular contact with patients on their waiting list.
- Mandatory training was not in line with the trust target of 75% in some areas. Specifically mandatory training in safeguarding, Mental Capacity Act, and equality and diversity.

However:

- Patients had risk assessment and management plans in place that managed their risks effectively.
- Staff followed the lone working procedures.
- Staff were aware of how to identify and report safeguarding concerns, and acted upon these immediately.
- Staff knew how to report incidents and what type of incidents should be reported in the electronic incident reporting system.

Are services effective?

Good

We rated effective as good because:

- Care plans were in place that were holistic; person centred and met the needs of the patients.
- The community mental health teams had access to psychological therapies in line with the National Institute for Health and Care Excellence.
- Support for patients with housing, benefits, and social needs was readily available.
- Care co-ordinators worked closely with GPs to monitor physical health care.
- There was a range of professionals available within the teams, including doctors, nurses, social workers, occupational therapist and psychologists.
- Supervision and annual work performance appraisals were completed in line with the trust's own policies.

Summary of findings

- Staff were aware of the principles of the Mental Capacity Act, and there were best interest assessors based within the teams who staff could approach for advice and guidance.

However:

- Patients' care records were transferred between services. There were delays in transferring care records from the inpatient wards to the community teams, which meant historical information was not always available.
- Clinical audits were not conducted as these were under review by the trust.

Are services caring?

Good

We rated caring as good because:

- We observed positive staff interactions during community visits, which were professional but also gave patients emotional support and reassurances.
- Staff were polite, respectful and knowledgeable about patients' needs.
- Patients and carers all praised the care and treatment they and their relatives received.
- Patients and carers told us that they were involved in their care planning and could have a copy of their care plan if wished.
- Carers told us that they felt involved with the person they were caring for.
- Advocacy services were available for those detained under the Mental Health Act and those who were not.
- Monthly patient surveys took place to gain patient feedback on the services.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- The average number of days waiting from assessment to treatment was significantly above the trust target of 14 days in five of the six areas. This meant that patients were not always able to access treatment in a timely manner.

However

- The allocated duty worker could see patients quickly when in a crisis.
- There was a clear operational procedure in place, which set out the admission criteria for each service.
- Staff used a variety of techniques to engage those patients who find it hard to engage with services.

Summary of findings

- The community mental health teams all had adequate facilities on site to see patients; this also included disabled access to the buildings.
- Complaints were managed in line with the trust's policy. There were low levels of complaints across the community services.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Managers above service manager level were not visible within the teams.
- Key performance indicators did not meet the needs of the service, as they were often not reflective of the performance at team level.
- Staff told us that they did not receive feedback from senior managers regarding concerns that were raised by the team leaders.
- The work-related stress assessments raised a number of concerns regarding staff workloads.
- The services in the Hull area did not feel engaged in the reconfiguration of services in that area.
- The qualified nursing staff did not feel that there were opportunities for career development due to the low number of higher bandings within the teams.

However:

- The trust's vision and values were understood by the teams.
- There was evidence of effective team working, and the teams were patient-centred and prioritised patient care and safety.
- There were regular team business meetings in which staff could provide feedback on services.

Summary of findings

Information about the service

Humber NHS Foundation Trust provides a range of community-based mental health services across Hull and East Riding. During our inspection, we visited six of the 10 community mental health teams. We had inspected these services once previously in 2014 and found them to be compliant with all fundamental standards. This inspection is the first time the community mental health services have been rated under the Health and Social Care 2008 regulations 2014.

The community mental health teams consist of staff from multiple healthcare disciplines providing mental health assessments, treatment, rehabilitation and support for people mainly aged 18 and over.

Services based in the Hull area are split into those for patients who experience psychosis such as hallucinations and those for non-psychosis such as depression or personality disorders. The Grange provides services for those patients with a psychotic illness in the east of Hull and the Waterloo Centre in the west of Hull. John Symons House provides services for those patients with a non-psychotic illness across all of the Hull area. Hull Clinical Commissioning Group commissions these services.

Services based in East Riding provide combined services for patients with both psychosis and non-psychosis. East Riding Clinical Commissioning Group commissions these services.

Our inspection team

The overall team that inspected the trust was led by:

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

Head of inspection: Jenny Wilkes, Care Quality Commission.

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

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected community-based mental health services for adults of working age consisted of one CQC inspector, a consultant psychiatrist specialising in community adult mental health, and two registered mental health nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

Summary of findings

- visited six community mental health teams and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service and seven carers
- collected feedback from patients using comment cards
- spoke with the managers or acting managers for each of the services
- spoke with 32 other staff members including doctors, nurses and social workers
- accompanied staff on seven visits to patients at home and observed how they cared for them
- attended two morning meetings and a dialectical behavioural therapy clinical supervision group
- attended three outpatient clinics
- looked at 17 care records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients and carers were positive about the services provided, and told us that the care and treatment that they received was very good.
- Patients and carers told us that they felt involved in their care planning and could have copies of their care plan if they wished.
- Patients told us that they could provide feedback about the services through a monthly survey.
- We reviewed eight comment cards about this core service. Five were positive, one negative, and two had mixed views.

Good practice

None found in this core service.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that caseloads are weighted within the services.
- The provider must ensure that it monitors patients on waiting lists effectively.
- The provider must ensure it reduces waiting times between assessment and treatment to meet the 14 day target
- The provider must consider how it will work with staff to address the issues raised in the work-related stress results.
- The provider must ensure that staff receive mandatory training.

Action the provider SHOULD take to improve

- The provider should consider how it will address the delay in the transition of clinical records between services.

Humber NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Recovery support (Hull West) Waterloo Centre	Humber NHS Foundation Trust Willerby Hill
Recovery support (Hull East) The Grange	Humber NHS Foundation Trust Willerby Hill
Recovery/ Psychological intervention (Hull) John Symons House	Humber NHS Foundation Trust Willerby Hill
Pocklington Adult Community Mental Health Pocklington Health Centre	Humber NHS Foundation Trust Willerby Hill
Holderness Adult Community Mental Health. Rosedale Community Unit	Humber NHS Foundation Trust Willerby Hill
Haltemprice Adult Community Mental Health. Alanby Clinic	Humber NHS Foundation Trust Willerby Hill

Mental Health Act responsibilities

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

- Mental Health Act training was not mandatory within the trust therefore there was a low compliance in this training.

Detailed findings

- Despite this, staff that we interviewed were knowledgeable about the Mental Health Act, including the requirement for those patients who are subject to a community treatment order.
- Patients on community treatment orders had their rights read on a monthly basis alongside an assessment of their capacity to consent to treatment they received.
- The legislation department provided support and advice for all questions about the Mental Health Act. They also provided all the administration for the MHA paperwork.
- Paper work for those subject to a community treatment order was stored safely and securely in the patients' records. We found that paperwork for community treatment orders were completed correctly.
- Independent mental health advocacy services were available for patients should they wish to use this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a low percentage of staff across the community mental health teams that had completed the Mental Capacity Act training.

There was a policy in place for the Mental Capacity Act, which staff were aware of. There were a number of best interest assessors within the services, who could offer support and guidance in relation to the Mental Capacity Act.

Staff were aware of the principles of the Mental Capacity Act and this was evidenced within the patient care records. Patients were supported to make decisions about their care and treatments.

Capacity assessments took place on an individual needs basis. Patients were presumed to have capacity to make their own decisions unless concerns were raised and agreed through formal processes.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

All the community mental health teams had facilities to see patients on site. The environments were clean, safe and fit for purpose. Some of the interview rooms were smaller and held only 2-3 people but other larger interview rooms were available. With the exception of Rosedale community unit all community mental health teams had alarms in the interview rooms or personal alarms could be used. Rosedale staff told us that should there be a risk to staff from a patient visiting the unit, an interview room that would be in a more prominent and populated area would be used. However, staff told us they mainly saw patients in their own homes.

Each community mental health team had a reception area at the entrance and staff and visitors were asked to sign in and out of the building for security and for fire purposes. Health and safety risk assessments were completed for each building that showed that all risks were being managed effectively. Where there were noted to be actions, these had been appropriately managed and had either been completed or were in the process of being completed.

Staff adhered to infection control procedures including handwashing. Handwashing posters were visible around sinks.

Clinical rooms were clean and tidy. Sharps boxes that were open had been clearly labelled and dated. Examination couches where present were clean and in good condition. Procedures were in place for managing medical devices. Staff reported that these worked well and that they did not have to wait for replacement equipment or for out-of-date equipment to be calibrated.

Safe staffing

The provider estimated the number of staff required for each community mental health team through the numbers on each teams caseload. Current establishments in post whole time equivalents (WTE) were:

Pocklington Health Centre – community mental health team East Riding

- Team manager – 0.6
- Band 5 nurse – 1.0
- Band 6 nurse – 2.0
- Clinical lead nurse - 0.5
- Band 8a psychologist - 0.2
- Band 5 occupational therapist – 0.3
- Band 6 occupational therapist – 0.4
- Social worker – 2.0
- Care officer – 2.0
- Care worker – 0.7

Rosedale Community Unit – community mental health team East Riding

- Team manager – 1.0
- Band 5 nurse – 4.0
- Band 6 nurse – 1.8
- Clinical lead nurse – 1.0
- Band 6 occupational therapist – 1.0
- Band 8a psychologist – 1.2
- Band 3 support staff – 1.0
- Social worker – 2.0
- Care officer – 3.0
- Care worker – 0.9

Alanby Clinic – community mental health team East Riding

- Team manager – 1.0
- Band 5 nurse – 3.0
- Band 6 nurse – 2.0
- Clinical lead – 0.5
- Band 6 occupational therapist – 1.0
- Band 8a psychologist – 0.9
- Social worker – 2.0
- Care officer – 3.0

Requires improvement

Are services safe?

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

- Home link worker – 0.8

John Symons House – Recovery and psychological intervention team (Hull)

- Team leader – 1.0
- Band 5 nurse – 2.4
- Band 6 nurse – 1.8
- Band 3 nurse – 1.0
- Band 6 occupational therapist – 0.6
- Band 4 allied health professional – 1.2
- Support time recovery worker – 0.8
- Social workers – 3.0
- Care officer – 1.6

Waterloo Centre – Recovery and support (Hull West)

- Team leader – 0.8
- Band 5 nurse – 5.0
- Band 6 nurse – 2.0
- Clinical lead – 0.8
- Band 6 occupational therapist – 1.0
- Band 4 occupational therapy assistant – 0.5
- Band 8a psychologist – 1.0
- Band 3 support worker- 2.0
- Social workers – 3.5
- Care officers – 5.9

The Grange – Recovery and support (Hull East)

- Team leader – 1.0
- Band 5 nurse – 3.3
- Band 6 nurse – 3.4
- Band 6 occupational therapist – 1.0
- Band 3 support worker – 2.0
- Social worker – 2.0
- Care officers – 3.4

There were vacancies at four of the teams we visited. These included 2.3 whole time equivalent vacancies for band seven and eight psychology posts and 3.8 whole time equivalent vacancies across band five nurse and allied health professional posts. The team with the highest number of vacancies was John Symmons House. There were five vacancies in the team including a 0.8 whole time equivalent clinical lead nurse.

The number of vacancies whole time equivalent in each team were:

Pocklington Health Centre

- Band 5 nurse – 1.0
- Band 7 psychologist – 0.3
- Band 3 support worker – 1.0

Rosedale Community Unit – No current vacancies

Alanby Clinic – No current vacancies

John Symons House

- Band 5 nurse – 1.0
- Band 7 clinical lead nurse – 0.8
- Band 7 occupational therapist – 1.0
- Band 7 psychologist– 1.0
- Band 8b psychologist – 0.4
- Social worker –1.0

Waterloo Centre

- Care officer – 1.0

The Grange

- Band 5 nurse – 1.0
- Band 3 allied health professional – 0.8
- Band 8a psychologist – 0.6
- Social worker – 1.0

Services that were based in East Riding had social workers, care workers and care officers that were employed by the local authority, and worked in partnership with Humber NHS Trust under section 75 of the NHS Act 2006. For services that were based in Hull, the social workers and care officers had transferred over their employment to Humber NHS Trust.

Requires improvement

Are services safe?

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

The staff we spoke with in the community services told us a number of staff had taken maternity leave and in some of the services there were human resources issues that meant staff were not in work. This, combined with the vacancies and sickness levels, placed additional strain on staffing resources and ability to manage caseloads and those patients on the waiting list. Caseloads of those staff not in work were shared out amongst existing staff.

The trust has told us that the average caseload is 23.5 cases per care co-ordinator. Caseloads were assessed during supervision on a four to six weekly basis. However, team managers told us that they had not used the caseload-weighting tool to assess the difficulty of individual caseloads.

Team managers told us that there were a number of factors leading to increased weighting of caseloads for care co-ordinators. In the Hull area where the teams were spilt into recovery services for psychosis and non-psychosis, those services for psychosis held a greater number of patients requiring intramuscular depot medication. This increased the workload for the staff. At the Waterloo Centre they estimated that they had 80 patients all requiring this form of medication.

Within the East Riding area, the Local Authority staff had taken on case management for those patients who met the criteria for assessment care support assessments for direct payments. This meant that it reduced their capacity to take on purely CMHT patients.

For both Hull and East Riding, a number of patients due to the risks they posed required a visit with two staff present.

Patients currently awaiting allocation of a care co-ordinator were:

- Rosedale Community Unit – 51
- Alanby Clinic – 35
- Pocklington Health Centre – 0
- John Symons House – 131
- Waterloo Centre – 29
- The Grange – 17

The community mental health teams in some areas were looking creatively to manage their waiting lists. For example, the non-psychosis service ran a 12-week intervention group that covered topics such as life skills, healthy living and sleep hygiene. The service wrote to patients who had been placed on their waiting list, following their initial assessment with the single point of access, to invite them to join this. Following the group, the patients' needs were assessed along with their need to remain on the waiting list .

Other community mental health teams were writing to patients who had been on their waiting list for some time to reassess their needs. Rosedale Community Unit were piloting working alongside improving access to psychological therapies and were reviewing those patients on the waiting list who would benefit from psychological intervention. Improving access to psychological therapies services saw those patients for an agreed number of sessions. Following this, they were reassessed by the community mental health teams to see whether they continued to require community mental health team input.

Doctors were easily accessible through the week in most areas. In Pocklington, Rosedale, and Alanby consultants were shared across the East Riding community mental health teams. Staff told us that if there was a crisis with a patient or they wanted to discuss a patient they were able to contact the doctor without significant delay.

The current mandatory training compliance for the community mental health services for adults of working age is 48%. The Grange had the lowest percentage of trained staff with an overall training rate of 22%. Rosedale Community Unit had the highest percentage of trained staff with an overall rate of 48%. The trust target for staff training overall is 75%. All services in the community mental health teams were below this target. Staff spoke of difficulties in

accessing training. Training courses that they were booked on were often full with future dates far in the future or no further dates to book on to. The team managers were aware of their compliance rates and told us that they were trying to get training delivered within their teams.

Assessing and managing risk to patients and staff

Care-coordinators completed risk assessments and risk management plans at the first appointment with the patient. We reviewed 17 risk assessments and found that all the patients had a detailed risk assessment and management plan that reflected the patients' needs. However, three risk assessments were found to be out of date.

In all 17 risk assessments we reviewed, patients had clear risk and relapse plans in place that showed what should happen should their mental health deteriorate.

All services with the exception of Pocklington Health Centre had waiting lists. Standard operating procedures were in place for all the services that agreed the procedure for monitoring the waiting list.

With the exception of Rosedale Community Unit, all community teams contacted the patients on their waiting lists monthly. In some of the services, this was the responsibility of the duty worker. In other services, the patients were divided between the staff and it was the staff's responsibility to contact their allocated patients monthly. Staff discussed any concerns in their morning meetings, multi-disciplinary team meetings and referral meetings.

Rosedale Community Unit operated a priority waiting list that consisted of those patients who had been referred from out of area, were discharged from the inpatient service or crisis team, or posed an immediate risk to themselves or others. At the time of inspection there were seven patients currently deemed as a priority. The duty worker contacted these patients weekly. For those patients who were not seen as a priority staff wrote to them to ask them to contact the service should their presentation or needs change. Those patients were not contacted monthly. This meant that 44 of 51 patients on the waiting list were not contacted or monitored routinely; therefore, there was no oversight of their on-going risks or needs.

Staff were trained in safeguarding adults and children. The trust overall target for both adults and children was 80%. Compliance figures as of February 2016 for each service were:

- Pocklington – adult 60% and children 80 %
- Rosedale Community Unit – adult 83% and children 92%
- John Symons House – adults 43% and children 52 %
- Waterloo Centre – adults 82% and children 89 %
- Alanby Clinic – adults 37% and children 62%
- The Grange – adults 39% and children 48%

With the exception of Rosedale Community Unit and Waterloo Centre, the community services were not meeting the trust target.

Staff were able to describe types of abuse and the procedure for reporting safeguarding alerts. There were notices displayed in office areas with the contact numbers for the different local authorities to contact. Links for safeguarding had been identified within the team. Safeguarding concerns were discussed within the morning and multidisciplinary team meetings. In one care record we reviewed, there was evidence that safeguarding concerns had been raised, discussed and actioned.

Lone working procedures were in place across all community mental health teams that we visited. All staff we spoke to said that they knew the lone working procedures and that these worked effectively. The duty worker and the administration team monitored staff's time for returning to the service. They were able to describe what they would do should there be any concerns about staff's personal safety.

With the exception of Pocklington Health Centre, all other community mental health teams held medication on site although this was minimal in most areas. This was mainly depot intramuscular medication. However, the teams advocated that where possible patients take the responsibility for holding their own medications as part of their recovery journey. Medication with the exception of clozapine was ordered through the patient's own pharmacy. The responsible psychiatrist prescribed clozapine and it as dispensed from the trust's pharmacy.

GPs were responsible for prescribing all medication with the exception of clozapine. Where the community teams

Requires improvement

Are services safe?

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

held medication, this was for those patients where there was a risk of non-compliance or there was a risk that the patients would not take their medications as prescribed. Written agreements were in place between the patient and community team staff to pick up their medication from the agreed pharmacy, to store this on site or to take straight to the patient's home to administer.

Medication was stored in lockable medication cabinets in designated clinical rooms. Medication charts were in use to record and manage dispensing.

Track record on safety

There were six serious incidents that occurred from April 2015 and March 2016:

- Four deaths of a patient.
- One attempted suicide.
- One short-term moderate harm to a patient.

All these incidents were investigated by the trust as per their own policy. The Care Quality Commission and the safeguarding teams were contacted following these incidents where this was seen to be appropriate.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system 'DATIX' to report all incidents. Staff were aware of types of incidents that should be reported and that this should be done using the DATIX system. Staff were aware of duty of candour and two staff gave examples of where duty of candour was used positively.

Staff gave mixed feedback in relation to whether they had received feedback on incidents and investigations that had been undertaken. All staff were aware of the 'blue light' alerts that came out from the trust that gave feedback from trust wide incidents. Feedback from serious incidents was discussed at staff business meetings. However, staff at Alanby Clinic spoke of a serious incident that they had been involved in and that feedback had been poor. Staff at The Grange felt that they had not had much feedback on incidents as they had not had a team manager in post until four weeks prior to the inspection.

Staff told us that they received debriefs and support following serious incidents. However, at Alanby Clinic some staff did not feel that they had adequate support following a serious incident and staff sought support within the trust outside of what had been put in place locally.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

The single point of access team completed initial assessments for all referrals to the community mental health teams. Further assessments were completed by the community mental health teams when patients were allocated a care co-ordinator. We observed one visit that a carer's assessment took place; this was also evidenced within the care records.

We reviewed 17 care plans and found all patients had a care plan in place, that was up to date, personalised, holistic and recovery orientated. Care plans also included management of risk and relapse plans.

Records were a mixture of paper-based records and electronic records. All health care staff used the paper-based system and social care staff used an electronic recording system to write their notes. Social care staff printed their documentation and put it into the paper records to ensure they were accurate and reflected the patient's current care plan and needs. Another electronic recording system 'Lorenzo' was used to capture data to inform their key performance indicators.

Paper based records were kept in lockable cabinets that were locked at night when the building was closed. Keys for the record cabinets were then placed into a key cupboard, which was locked, and then the key for this was placed in a lockable drawer or other agreed place for security. This meant that paper records were stored in a secure way that would protect the information and data that was held in them.

The paper-based records moved between the services such as inpatient ward and crisis services. Staff raised concerns during the inspection that particularly following a patient's discharge from inpatient services that records could take a while to be returned. This was due to discharge letters being written and the requirement for an ICD-10 code, which is a diagnosis code, to be populated following discharge. The records were sent to the trust headquarters for ICD-10 coding then on to the community service. However, this process could take time and meant that the historical information about patients was always not available at the point of care and treatment being delivered.

Best practice in treatment and care

Medical staff followed National Institute for Health and Care Excellence guidance when prescribing medication. Staff told us of practice notes that were sent out via the intranet, this came up immediately at the point of logging on to the computer. The practice notes contained information about National Institute for Health and Care Excellence guidance and best practice. Staff would have to click on the link and read the information and tick to say that they had read this before they could move on from this screen. These were also discussed during multi-disciplinary team meeting and business meetings.

The community mental health teams ran a number of psychological intervention groups and offered one to one psychology for patients. These included family therapy, dialectical behavioural therapy, cognitive behavioural therapy, and a psychotherapy service where once a month staff could refer complex cases for discussion and formulation.

Care officers and care workers were employed within the teams to look specifically at supporting patients with housing and employment.

Physical health care checks were completed by the GP. Care co-ordinators supported patients to attend GPs, opticians and dentists to help regularly monitor their physical health care. Physical health care was observed to routinely be part of care co-ordinators' holistic assessments during each visit. This was reflected in the 17 care records and care plans that we reviewed.

The community mental health teams used a number of outcome measures such as Recovery Star, Health of the Nation Rating Scale (HoNOS), Krawiecka, Goldberg and Vaughan rating scale (KGV), Hamilton Rating Scale for anxiety and depression and Beck's inventories.

Staff were unable to tell us of any current clinical audits that were taking place in their teams. Two team leaders we spoke to explained that all the clinical audits that were being completed were reviewed last year and that these had not been completed since. At this time, there had been no feedback as to what the outcome of this review had been.

Staff did explain that they received feedback through the friends and family test and the performance report. The performance reports had been clearly displayed in each area and were discussed through their business meetings.

Are services effective?

Good

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

Skilled staff to deliver care

There was a full range of professionals across the community mental health teams including occupational therapists, social workers, care workers, nurses, doctors, psychologists and support time recovery workers. The services also had access to a family therapist and a psychotherapy service.

Some of the services held vacancies for some of the professional groups and therefore did not have as much in put into their teams as others; the team leaders told us that there was ongoing recruitment in to these posts.

Staff were skilled, experienced and qualified to complete their roles. All staff completed a trust induction on starting with the trust. Staff also received continuing professional development in courses such at cognitive behavioural therapy, dialectical behavioural therapy and psychosocial interventions.

Staff received supervision and appraisals. From the information received from the trust for clinical supervision from June 2015 to December 2015 Pocklington, The Grange, and Waterloo Centre were all achieving 100% compliance. John Symons House was 90% and Alanby Clinic 50%. Staff during inspection all told us that they received monthly supervision and yearly appraisals. The appraisal figures for the same period ranged from 100% at Pocklington to 30% at The Grange.

Multi-disciplinary and inter-agency team work

Multidisciplinary team meetings occurred weekly in all community mental health teams. Waterloo Centre had just restarted theirs. Staff told us that they had not happened, as the previous service manager did not feel that they were beneficial. During inspection, we were unable to see any multidisciplinary team meetings. However, we did review the minutes of the last 3 months' multidisciplinary team meetings. They covered a range of subjects including complex cases, safeguarding, the waiting lists, carers' assessments and seven-day follow up. Staff told us that they found these beneficial and effective.

There were morning meetings in all services with the exception of Rosedale. These meetings were used to hand over any duty issues from the previous day and to discuss any issues for the day ahead.

Staff described good links with the improving access to psychological therapies service, psychotherapy service, safeguarding teams within the local authority, and GPs.

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

Training in the Mental Health Act was not mandatory. From the figures provided by the trust, 13 staff had received training in Mental Health Act. These were staff from the Waterloo Centre.

Staff who held patients on their caseloads who were subject a community treatment order had a good working knowledge of the Mental Health Act. They told us that patients had their rights read monthly, and that the patients' capacity to continue to consent to their treatment was also reviewed at this point. We reviewed the care records of six patients subject to a community treatment order and found that they adhered to the Mental Health Act code of practice.

Staff received support from the legislation department, for advice and guidance around the Mental Health Act.

Community treatment order paper work was stored within the paper-based clinical records. In the records that we reviewed, we found the paper work to be completed correctly.

Independent mental health advocacy services were available for patients, and staff we spoke to were able to tell us how they accessed this service.

Good practice in applying the Mental Capacity Act

The figures provided by the trust for compliance with the Mental Capacity Act training were variable across the services. Rosedale was the only service to meet the compliance target of 75%. All other community services ranged from The Grange with 4% compliance to Pocklington with 40% compliance. This did not meet the trust target.

There was a clear policy in place on the Mental Capacity Act, and staff were aware of the policy. Staff also told us as they had social service staff integrated into their team. They had a number of staff who were best interest assessors and they often used this experience from within their teams should they need help and guidance on the Mental Capacity Act.

In the care records we reviewed, we found that people were supported to make decisions regarding their care and treatment, whether they were felt to lack capacity or not.

Are services effective?

Good

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

Capacity assessments took place on an individual needs basis and staff understood that patients should be presumed to have capacity to make their own decisions unless this had been agreed otherwise through formal processes.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed seven visits or meetings with patients and carers. We saw that staff were caring, professional, polite and respectful during the visits or meetings. The staff were knowledgeable and understanding of the patients' and carers' needs. We observed staff being compassionate and offering support and reassurance. In one visit, we observed a patient was visibly distressed; the staff member provided emotional support and comfort.

We spoke with 11 patients and seven carers. All 11 patients we spoke with praised the staff within the community mental health teams. They said 'they listen to me, help me do things', 'all staff are polite and they treat me like a person', and 'secondary mental health have been so supportive, and acknowledge that my feelings are real'.

The carers we spoke with were all positive about the care and treatment they and the person they were caring for received. They said 'they ask how I'm coping too', 'they treat me with kindness caring and respect', 'very good and understanding', and 'staff are kind and responsive'.

The involvement of people in the care that they receive

Patients and carers told us that copies of care plans were given to them if they wanted a copy. The majority of the patients we spoke with told us that they were involved with their care plan, and were offered alternative treatments and therapies. They told us their care plan was written by their care co-ordinator and they could add things or change things within this if they wanted to. During the visits and meetings with patients and carers clear discussion took place about the patients care plan. Staff clarified whether patients understood and agreed with their care plan.

Of the 17 care records we reviewed, there was evidence that seven patients had been given a copy of their care plan. We found no evidence in the other records to say whether these had been offered or refused.

The carers we spoke with all said that they felt involved and three of the carers told us that they had been involved in care planning and had received a copy of a care plan. We observed a carer's assessment taking place, which covered their physical and mental health. The staff member carrying out the assessment offered practical help and support as well as emotional support during the visit.

Advocacy services were available for patients to access, for both patients detained under the Mental Health Act and those who were not. Patients told us that they were given information on advocacy.

The community mental health services conducted monthly patient surveys. For February 2016 the services received:-

- Pocklington Health Centre – 100% positive feedback for all areas
- Rosedale Community Unit – 100% positive feedback for all areas
- John Symons House – Did not receive any feedback for February, for January they received 100% positive feedback
- Waterloo Centre – 100 % positive feedback in all areas, with the exception of one patient who was unsure if they would recommend the service.
- Alanby Clinic – Did not receive any feedback in the months of January or February.

Information from the survey was fed back to the services through their key performance indicators. Action plans were in place to address any concerns raised within the responses, also to address the uptake of patients completing this survey. Overall responses from the patient survey were good, which reflected the information we were given from families, patients and carers.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

The single point of access completed all initial assessments for the community mental health teams. Staff discussed patients who were referred at multi-disciplinary team meetings or morning meetings. The data that the trust provided showed that there were no specific targets for assessment to treatment and the mean number of days for patients to receive treatment from assessment was five days. However, the key performance indicators received from the trust for each service this showed for February 2016, the target for this was 14 days. The average waiting time for each service was:-

- Pocklington – 127 days
- Rosedale – 75 days
- John Symons – 204 days
- Waterloo Centre – 55 days
- Alanby Clinic – 89 days
- The Grange – 21 days

This meant that the average waiting time from assessment to treatment was significantly above the target time of 14 days in five of the six community teams.

All referrals to the community mental health teams were placed on a waiting list. Referrals that were received from the inpatient wards that were due to be discharged on intramuscular depot medication or on a community treatment order were allocated straight away as there would be a need for ongoing monitoring and treatment following discharge. Urgent referrals were reviewed at each team meeting and the patients' needs considered for allocation. Non-urgent referrals would remain on the waiting list and were allocated based on where their place was on that waiting list.

Each community mental health team allocated a duty worker on a daily basis. Patients that were allocated care co-ordinators and those who were on the waiting list were able to contact the duty worker for support, advice and when in a crisis. That meant that the duty worker could respond quickly to patients especially when they were in crisis.

The community mental health teams all had operational procedures in place that set clear admission criteria. For those teams based in the East Riding area they accepted all patients over the age of 18 years of age and were in cluster four to 17 according to the mental health clustering tool. The services based in the Hull area were divided into recovery support services for patients with psychosis clusters 11-17 and those with non-psychotic illnesses clusters four to eight.

Active steps were taken to engage patients who found it difficult to engage or did not attend appointments with the community mental health teams. Staff told us that they would take a more practical approach looking at what the patient would find useful or helpful as a starting point. Staff said this often led to patients being more willing to engage in other interventions such as groups.

Staff told us that they were flexible with their appointments and offered patients a choice of times suitable for them. Very rarely, appointments were cancelled or moved and this only happened in an emergency.

The facilities promote recovery, comfort, dignity and confidentiality

Each team had adequate interview rooms, group rooms and clinical areas. The interview rooms provided a private area for discussions with patients, and maintained confidentiality.

There were a number of offices available for staff to have access to a workspace and computer.

There was a wide range of information leaflets available that ranged from duty of candour, complaints and compliments, advocacy, and other support services that could be referred to.

Meeting the needs of all people who use the service

All the community mental health teams had disabled access into the buildings for wheelchairs or for those patients who had difficulties in walking. All interview rooms were on the ground floor with disabled toilets available for use.

Information leaflets were not available in different languages in the teams, but these could be accessed for individuals if required. Interpreters were available on request.

Are services responsive to people's needs?

Requires improvement

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

Listening to and learning from concerns and complaints

The trust provided information on complaints received from March 2015 to February 2016.

- Pocklington –two complaints – one upheld
- The Grange – three complaints – one partially upheld
- John Symons – two complaints – none upheld
- Alanby Clinic – onecomplaint – none upheld
- Waterloo Centre – one complaint – one partially upheld.

The team leaders confirmed the low level of complaints. They told us that when a complaint was received it would be allocated to them for investigation by the complaints team. There were no evident themes from a review of the complaints received by the teams.

Staff told us they knew how to handle complaints and that these would be given directly to the team leader who would escalate these to the complaints department if necessary. The care co-ordinator or the team leader would deal with informal complaints. There was no clear record of how informal complaints were recorded.

Patients told us that they were able to approach their care co-ordinator or the team leader should they have any complaints. The patients and carers we spoke with all told us that they had not had any complaints about the community mental health teams.

Staff received feedback from complaints through supervision and their staff business meetings where lessons learned would be shared.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

Staff were aware of the vision and vales of the trust. Staff received annual work performance appraisals; these for the year 2015-2016 had been based on the knowledge and skills framework. There was a newly developed work performance appraisal that was now closely linked with the trust values.

The teams across East Riding had clear team plans and objectives in place. The team plans closely linked into the organisational business strategy and the business continuity plan.

Staff were aware of their immediate managers and service managers, both operational and clinical. However, they were not aware of who the care directors were and told us that they were not visible in their areas.

Good governance

At a service level, team leaders had clear structures in place to monitor governance, for mandatory training, supervision, safeguarding, waiting list and waiting times. However, the key performance indicator report that was received by the team leaders was felt not to be responsive to their needs and often not reflective of their current position. This information often did not include figures and data from the social care staff therefore giving a poorer picture in the key performance indicators such as mandatory training.

The team managers all felt that they had sufficient authority to manage and lead their teams with sufficient administration support. However, the teams based in the Hull area, although they felt their immediate managers listened to them, felt there was very little understanding from those above service manager level. The team leaders told us that they raised concerns through their business meetings about staffing and waiting lists but that they had received very little feedback.

All the risks identified by the team managers during inspection, such as waiting times, mandatory training, increased work load for the local authority staff, and the transformation process for Hull community services, had been placed on the adult mental health care group risk register. Team managers were aware of the risk register and that it held these risks.

Leadership, morale and staff engagement

The trust implemented the Health and Safety Executive Management Standards for work-related stress. From August 2011 to August 2015 the trust surveyed staff about their work-related stresses. In August 2015 two of the community mental health teams undertook this survey which outlined a number of similar areas that staff said contributed to work stressors. These were:-

- Different groups at work demand things from me that are hard to combine.
- I have unachievable deadlines.
- I have to work very intensively.
- I have to neglect some tasks because I have too much to do.
- I have unrealistic time pressures.

One of the services that participated in this survey scored in the lowest 20th percentile of the national data in 27 out of the 32 areas assessed. This service had an action plan put in place to address these issues and was reassessed in February 2016. The service continued be in the lowest 20th percentile in 26 of the areas assessed.

Team managers we spoke with all told us of the concerns around sickness and absence and that this was mainly due to long-term physical health illnesses and stress-related illnesses. They told us that they believe the work-related stress was attributable to the increase in workloads and caseloads.

The recovery teams based in the Hull area were at the time of inspection going through organisational change. Staff spoke of a level of uncertainty around their role and jobs. The staff were welcoming of the new change to the structure of the services they were providing, however, they felt that they had not been engaged with by the trust regarding the process.

The team managers we spoke with told us that there had been no bullying or harassment cases within their services over the last 12 months and there had been no whistleblowing concerns raised. Staff told us they were aware of the whistleblowing policy.

Staff all felt that they were able to raise concerns with their immediate line managers without fear of this affecting their

Are services well-led?

Requires improvement

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.

role. Despite staff raising concerns staff all told us that they felt well-supported by their immediate line managers, and that teams worked well together and were supportive of each other.

There was a strong sense that staff worked hard and were proud of their role and the work they did. Patients and carers we spoke to all praised the work that the staff within the community mental health teams did for them. It was clear that despite the challenges faced by staff and the teams that patient care did not suffer. There had not been any reported adverse incidents or complaints that were linked to being short staffed or having high workloads. The impact of this was seen mainly within the staffing teams.

Although staff told us that there were a number of opportunities for continuing professional development, it was felt that there were little opportunities for progressing in their career. The posts within the community mental health teams particularly for the qualified nursing staff were mainly band five. Very few posts were band six or above, which meant that promotions were sought outside of the organisation.

Staff had regular team business meetings in which they were able to give feedback on their services.

Commitment to quality improvement and innovation

There were no quality improvements or innovations seen during this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must meet their needs. Waiting times between assessment and treatment for all six teams were above the 14 day target. This was a breach of regulation 9(1)b

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that the persons employed by the services receive such support training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform. Staff were below the trust target of 75-80% in their mandatory training in most areas. The staff work related stress figures were below the 20th percentile of the national data. This was a breach of regulation 18(2)a

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. Caseload weighting tools were not used to assess the weight of individual caseloads.

This section is primarily information for the provider

Requirement notices

Waiting lists were not managed and monitored constantly. Therefore this was not responsive to the needs of the patients

This was a breach of regulation 17(2)b