Humber NHS Foundation Trust

Services for people with learning disabilities or autism

Quality Report

Willerby Hill,
Beverly Road,
Hull,
HU10 6ED,
Tel: 01482 301700
Website: www.humber.nhs.uk

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Townend Court	RV915	Willow	HU6 8QG
Townend Court	RV915	Lilac	HU6 8QG
Willerby Hill HQ	RV936	CTLD	HU10 6ED
Willerby Hill	RV936	Ullswater Humber Centre	HU10 6ED
Willerby Hill	RV936	CAMHS LD Teams	HU13 9NW

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.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Humber NHS Foundation Trust provides a range of inpatient and community services for people who have a learning disability (LD) or autism. These include community team learning disabilities (CTLD) services, Willow and Lilac inpatient assessment and treatment units, and Ullswater Ward, a forensic learning disabilities medium secure unit. The services are based at The Grange in Hull, Townend Court in Hull, Four Winds in the East Riding of Yorkshire and The Humber Centre for Forensic Psychiatry in East Yorkshire.

The trust had an effective system in place for reporting safety incidents. Staff knew about their responsibilities for reporting incidents and knew how to report them. There was also a system in place to make sure that incidents of potential or actual abuse were reported to the local authority safeguarding teams.

The service compiled and reviewed safety information from a range of sources including incident trends, safeguarding information and complaints.

Seclusion rooms at Willow assessment and treatment unit and Ullswater Ward were not fit for purpose and put people at increased risk. Staffing levels to maintain close observations were difficult at times on Ullswater ward. We found the noise levels of closing doors in corridors on Ullswater Ward could have a potential impact on people who required a low stimulus.

The service used evidence-based best practice and professional guidelines when people's needs, however assessment tools being used such as GRIST were not specific to learning disabilities.

There were issues with IT systems in place for example psychiatrists had not received training in the electronic SystmOne , which resulted in hard copies of information being made available , this had the potential risk of outdated information being in circulation.

Staff in the community and inpatient services worked well together to make sure that the service met people's needs. However Mental Health Act documentation was not always completed correctly. We identified common themes including staff not documenting people acting as statutory consultees in case records and outcome of capacity assessments not being recorded. People detained under the MHA also had access to an independent mental health advocate. We found that staff required further training in relation to the application of the Mental Capacity Act and DoLs.

People who used the service were positive about the staff and the care they received. Everyone we spoke with was happy with the way staff treated them, particularly in regards to kindness, dignity and respect.

The service had a safe and effective system in place to for managing referrals and there were some concerns about the management of waiting lists for CAHMS learning disability servcies. Access to some therapies was delayed, For example there was an eight month waiting list for psychology services.

Staff told us that they received information about the vision and strategy of the trust and were aware of the impact that had on their role. However staff did not have regular access to managerial and clinical supervision.

Staff also told us that there was a good working relationship within the team and with the management, including the chief executive and chairman.

Improvements had been made based on people's feedback about the service.

Summary of findings

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

Are services safe?
People who used the services told us that they felt safe. Staff understood how to escalate and report any concerns. They also assessed, monitored and managed risks to people. Risks within the CAMHs LD waiting list were not being effectively monitored.

Although there were systems in place to assess and monitor the safety of the environment, we found ligature risks in some of the seclusion rooms and on doors and the seclusion room in Ullswater ward did not comply with the Mental Health Act Code of practice.

Are services effective?
The service used evidence based practice and professional guidelines when assessing people's needs.

There were however, issues with the IT systems in place and we saw that Mental Health Act documentation was not always completed to demonstrate adherence to the Mental Health Act Code of Practice.

Are services caring?
People were positive about staff's attitude towards them and said that staff treated them with respect and dignity. The majority of people also told us that they were happy with their care, and that they felt supported and well-cared for by staff.

We saw good examples of staff engaging with people and including them in their care. We saw the use of interpreters during CHAMSLD home visits.

Are services responsive to people's needs?
The service had a safe and effective system in place for managing referrals and managed waiting lists well. With the exception of CAMHs services where there need to be improvement in managing the risk within waiting lists.

The autism assessment team reported waiting lists of a year. However, access to some therapies was delayed. For example there was an eight month waiting list for psychology services.

Are services well-led?
Staff told us that they received information about the vision and strategy of the trust and were aware of the impact this had on their role. They also said that there were good working relationships within the team and with the management team, including the chief executive and chairman. CHAMS LD staff reported they had accessed equality and diversity training.

Summary of findings

Background to the service

Humber NHS Foundation Trust provides a range of community and inpatient services for people who have a learning disability (LD) or autism.All services are provided to individuals with a primary diagnosis of learning disability some may have forensic profiles or contact with the criminal justice system. The enhanced service needed by individuals who become behaviourally distressed is provided by the continuum services that offer positive behavioural support in situ to the individual and their carers

Community Team Learning Disabilities (CTLD) services provide the same services:

- Hull (East) CTLD, based at The Grange in Hull, provides services for people aged 18 years and over and is currently supporting 300 people. It has staff co located from the local authority and the trust in the team.
- Hull (West) CTLD, based at Townend Court in Hull.
- East Riding CTLD, based at Four Winds in the East Riding of Yorkshire, supports people with mental health and forensic mental health problems (that is people who have a mental illness and have been involved with the police, court or prison).
- Child and adolescent mental health LD team based at Westend, consisting of learning disability nurses, clinical psychologist and arts therapists. The service provides assessment, intervention and advice on an individual basis. It does not have local authority staff co located within it

Inpatient services:

- Willow assessment and treatment unit, is a six bed male only unit based at Townend court. This was occupied by three people during our visit.
- Lilac assessment and treatment unit, and eight bed female only unit also based at Townend court. This was occupied by five people during our visit.
- Ullswater Ward an 11 bed forensic learning disabilities medium secure unit, based at the Humber Centre for Forensic Psychiatry in East Yorkshire.

The trust's LD service does not provide any day care. This is provided by the local authority and centres are shared between LD, physical disabilities and older people.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell CEO Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur and Cathy Winn, Care Quality Commission (CQC) inspection managers

The team included: CQC inspectors, Mental Health Act commissioners, a consultant psychiatrist specialist advisor, clinical psychologist specialist advisor, an occupational therapist specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use 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?

Summary of findings

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

We visited the learning disability services at Humber NHS Foundation Trust on 22 and 23 May 2014. During the visit, we spoke s with a range of staff individually and in groups who worked within the service, including nurses, doctors, and therapists. We talked with people who use services, their carers and/or family members. We also observed how people were being cared for and reviewed their care or treatment records. We used the information we hold about the service, as well as the information we gathered, to inform our inspection of the service and the questions we asked.

What people who use the provider's services say

We spoke with people who used the service at focus groups. Overall, they were positive about staff's attitude towards them, said that staff treated them with respect and dignity, and told us they felt safe. Every ward held service user meeting forums, and people who attended these meetings said they felt listened to.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider Must take to improve:

- The trust should ensure ligature risk reduction in the seclusion rooms at Ullswater and Willows wards occurs and the environment adheres to the Mental Health Code of Practice.

Summary of findings

Action the provider SHOULD take to improve:

- The trust should make sure that IT systems in place are suitable so that information can be recorded and communicated quickly and effectively. All staff in learning disability services, including psychiatrists, should receive adequate training on SystmOne until they are competent.
- 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 make sure that there are sufficient staff available to meet people's needs, in particular when increased observations are required on Ullswater Ward.
- 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 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.
- The trust should review noise levels of closing doors in corridors on Ullswater Ward and the impact this has on people.

Humber NHS Foundation Trust

Services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Willow	Townend Court
Lilac	Townend Court
CTLD	Willerby Hill Trust HQ
Ullswater	Willerby Hill Humber Centre
CAMHS Learning Disabilities team	Willerby Hill

Mental Health Act responsibilities

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

We found a lack of adherence to the MHA Code of Practice which provides guidance for good practice in the documentation reviewed on both Willow and Lilac Wards of three people using the service.

We observed conditions were not written to specify the number of staff escorts and the grade of staff required on section 17 leave forms. Some old section 17 leave forms had not been crossed out to show they were cancelled to ensure staff were aware of the most up to date leave conditions.

We found that people were given information about their rights in relation to section 132 of the MHA to their section, access to the Independent Mental Health Review Tribunals, hospital managers hearings so that they could appeal against their detention. Section 132 rights were recorded on paper forms and sometimes on SystmOne. The section 132 form used did not carry a section132 heading at top of page for ease of reference.

All people using the service had MHA care plans in place. We found one MHA care plan that was not specific to the

individual's detention under section 2 of the Act. We found one detained person using the service had been seen by a second opinion appointment doctor (SOAD). SOADs are responsible for undertaking a review of people's treatment plans. However we found no entries by staff acting as statutory consulted in notes or SystmOne records. There was nothing to demonstrate that the responsible clinician (RC) had informed the person of the outcome of SOAD visit and no clear recording of outcome of assessment of mental capacity by the RC.

Mental Capacity Act and Deprivation of Liberty Safeguards

In all the wards we visited staff had received training in and updates in relation to the MCA and Dols. In the light of the Cheshire judgement staff reassessed people to ensure they were adhering to the requirements of the Mental Capacity Act and Deprivation of Liberty legislation.

We found that medical staff who also confirmed they were not applying the MCA for the delivery of physical treatment not covered by the Mental Health Act (MHA) 1983. More importantly this extended to outpatient prescribing (where the majority of people are not detained under the Act).

We were concerned 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: MCA 2005) and mainly completed by the trust clinical appeared to only have tick boxes 'Yes' or 'No' for whether a person understands, retain, uses/weighs or communicates, but it does not provide any space beside these to explain what a person could not do if the 'No' box is ticked. 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 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

People who used the services told us that they felt safe. Staff understood how to escalate and report any concerns. They also assessed, monitored and managed risks to people. Risk within CAHMS LD services waiting lists was not being effectively monitored.

Although there were systems in place to assess and monitor the safety of the environment, we found ligature risks in some of the seclusion rooms and on doors, the seclusion room in Ullswater ward did not adhere to the Mental Health Act Code of Practice guidelines.

Our findings

Community Team- Learning Disability Teams (CTLD)

Track record on safety

There was an effective system in place for reporting safety incidents. All staff spoken with knew about the systems that were in place for reporting incidents and their responsibilities around reporting. Staff were also given updates about clinical incidents through team meetings and 'blue light' bulletins. These contained information about recent incidents and risks and the measures that they should take to help prevent reoccurrence. Serious untoward incidents (SUIs) were discussed by service managers at a weekly organisational risk management group (ORMG). We saw evidence that action resulting from SUIs were monitored and changes in practice were cascaded to staff.

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

There was a system in place to ensure that incidents of potential or actual abuse were reported to the local authority safeguarding teams. The service managers told us that the number of safeguarding alerts submitted was monitored as well as the progress. Staff told us that they had received mandatory training around reporting abuse and were able to inform us about the system that they used to do this. Staff were given updates on the progress of safeguarding cases through a dedicated safeguarding liaison group meeting and safety bulletins including the 'blue light' bulletin.

The CTLD compiled and reviewed safety information from a range of sources including incident trends, safeguarding information and complaints. We saw evidence that these were discussed at the weekly organisational risk management group (ORMG) and service managers meetings with appropriate action taken to learn from this information.

Assessing and monitoring safety and risk

We were shown examples about how risk was assessed by the service. There was a risk register in place that encompassed the risks for the trust's learning disability services. Service managers told us that they were able to submit additions to the risk register through and risk additions form when any new risks had emerged. Risk registers were discussed at the clinical governance meeting and were discussed up to board level.

There was a system in place in the CTLD that minimised risks to staff and people using the service when they were visiting them in the community. There was a safety board displayed in each office to inform staff about keeping safe on visits, checking in and out and what do in an emergency. This was outlined in the lone working policy which was available to all staff.

Understanding and management of foreseeable risks.

There was a 24 hour on- call system for the learning disability service across the trust. Community nurses who were on-call out of hours were co-ordinated via Townend Court. Staff talked to people by telephone and carried out urgent visits at home, some people were directed to the accident and emergency department.

People using the service were risk assessed using an assessment tool called GRIST (Electronic Galateon Risk and Safety Tool). The assessment tool captured risks associated with people using the service and identified any safeguards that may need to be put in place to ensure they were protected from potential abuse. The trust informed us that they were working with the authors of the GRIST tool to

Are services safe?

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

adapt it for learning disability services.We saw that people had risk management plans where required and these were kept up to date. The CAMHs LD were in the early stages of using Health of the nation outcome scores learning disabilities (HONOS –LD) that showed through repeated use show whether a person's health and social status has changed.

In the CAMHS LD team, there was a system for monitoring risks within waiting lists. People were informed they could contact their GP or the team if they needed help. A letter was also sent out to people to check if they still needed to remain on the waiting list. We were informed that a week prior to our visit that letters had not gone out and the trust acted responsively in contacting people to monitor the situation and found two people who needed immediate help. This meant the system of monitoring risk within waiting lists was not effective.

CAMHS LD team reported that records were lost in the floods at the Hull central office this year..The trust confirmed that no patient records were lost in the flood, Some staff PADR records and some resources that were used with families were water damaged,These items were signed off as destroyed

Lilac and Willow assessment and treatment units (Townend Court)

Track record on safety

There was an effective system in place for reporting patient safety incidents. Staff knew about the Datix electronic systems that were in place for reporting incidents and knew about their responsibilities around reporting. Staff were also given updates about clinical incidents through team meetings and 'blue light' bulletins which contained information about recent incidents and risks and the measures to be taken to help prevent reoccurrence. Serious untoward incidents (SUIs) were also discussed by service managers at a weekly organisational risk management group (ORMG). We saw evidence that actions resulting from SUIs, were monitored and any required changes in practice were cascaded to staff.

All incidents recorded on Datix by staff were reviewed by the modern matron, the ward managers and discussed at ward meetings. Episodes of the use of restraint, seclusion, absence without leave or deaths were recorded on Datix as an incident. There was a system in place to discuss safeguarding issues related to all incidents.

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

There was a system in place to ensure that incidents of potential or actual abuse were reported to the local authority safeguarding teams. The service managers told us that the service monitored the number of safeguarding alerts submitted and the progress. Staff told us that they had received mandatory training around reporting abuse and understood the system that they used to do this. Staff were given updates on the progress of safeguarding cases through a dedicated safeguarding liaison group meeting and safety bulletins including the 'blue light' bulletin.

The wards compiled and reviewed safety information from a range of sources including incident trends, safeguarding information and complaints. We saw evidence that these were discussed at the ORMG and service managers meetings and appropriate action were taken to learn from this information.

Assessing and monitoring safety and risk

We were shown examples of how risk was assessed by the service. There was a risk register in place that encompassed the risks for the trust's learning disability services. Service managers told us that they were able to submit additions to the risk register using a risk additions form when new risks emerged. Risk registers were discussed at the clinical governance meeting and at board level.

Looking at the seclusion room on Willow, we found areas where people could harm themselves including exposed 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. The trust confirmed after our inspection that seclusion rooms would be given priority capital funding to ensure they complied with the Mental Health Act Code of Practice, and have set standards for seclusion rooms.

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.

Understanding and management of foreseeable risks.

People using the service were risk assessed using an assessment tool called GRiST the trust reported they are working with the authours to make it specific to learning

disability services.. The assessment tool captured risks associated with people using the service and identified any safeguards that might have to be put in place to ensure that people using the service were protected from potential abuse. Some staff were not able to state what other assessment tools would be suitable to use for people with learning disabilities. We saw that people had risk management plans in place where required and these were kept up to date.

Staff on both wards told us that staffing levels were low due to some maternity leave and vacant Band 5 posts. We saw that this had been included on the risk register for the service and this was being managed through the regular use of bank staff as a temporary measure. This made sure that there was a full complement of staff on duty.

Staff had completed management of actual or potential aggression (MAPA) training course for management of violence and / or aggression. Qualified staff had received annual intensive life support (ILS) training. All support staff had received basic life support (BLS) training.

People using the service told us that they felt safe and that they would know how to report abuse. However they had not seen any abuse taking place at Townend Court. We saw that there were systems in place to maintain the safety of people who used the service and staff.

Ullswater Ward Humber centre

Track record on safety

There was an effective system in place for reporting patient safety incidents. Staff knew about the systems in place for reporting incidents and knew their responsibilities around reporting. Staff were also given updates about clinical incidents through team meetings and 'blue light' bulletins which contained information about recent incidents and risks and the measures to be taken to help prevent reoccurrence. Serious untoward incidents (SUIs) were also discussed by service managers at a weekly organisational risk management group (ORMG). We saw evidence that actions resulting from SUIs were monitored and any changes in practice were cascaded to staff.

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

There was a system in place to ensure that incidents of potential or actual abuse were reported to the local authority safeguarding teams. Managers told us that the service monitored the number of safeguarding alerts submitted and progress. Staff told us that they had received mandatory training around reporting abuse and were able to inform us about the system that they used to do this. Staff were given updates on the progress of safeguarding cases through a dedicated safeguarding liaison group meeting and safety bulletins including the 'blue light' bulletin.

During our visit we spoke with one person who said that they had experienced a safeguarding issue the night before. We spoke with staff about this and we were shown evidence that this had been appropriately escalated through the safeguarding procedure. People told us that they felt safe talking to staff about abuse.

Assessing and monitoring safety and risk

We looked at the seclusion suite on Ullswater Ward which had two separate seclusion rooms, each with an ante-room and a de-escalation room. We noted the following: the flooring of rooms (including ward bedrooms) did not have 'wet room' style flooring. The toilets were located off the de-escalation room so each person has to be calm before being allowed to exit seclusion and enter the toilet. Otherwise containers were passed through the hatch in door for people to use, which could poses infection control issues as food and drink passed would be passed via the same hatch. There was limited ventilation which could make the room uncomfortable for people. No intercom was installed to assist communication. Door frame of seclusion room one required repair

We discussed our findings with the trust at the inspection. We were told that an upgrade of the seclusion facilities had been identified as a high priority in the capital investment programme. They told us that risk to individuals was mitigated by the fact that as per their seclusion policy, people using the rooms were under constant supervision and observation.

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 service used evidence based practice and professional guidelines when assessing people's needs.

There were however, issues with the IT systems in place for example psychiatrists could not use SystmOne resulting potential risk of outdated printed notes being in circulation. We saw that Mental Health Act documentation was not always completed with the Mental Health Code of Practice.

Our findings

Community team- learning Disabilities (CTLD)

Assessment and delivery of care and treatment

There was a system in place for assessing the needs of the people using the service, which was based on evidence, based best practice. An initial contact assessment was used to identify the needs of the person accessing the service. We were told that a range of tools were used such as health of the nation outcome scores learning disabilities (HONOS –LD) that showed through repeated use show whether a person's health and social status has changed. Psychiatric Assessment Schedules for Adults with Developmental Disabilities (PASSAD) was used to assist clinicians in collecting standardised information to elicit and share knowledge about a person.

Electronic GRiST was used for every person using the service during assessment. GRiST an assessment tool was used across the trust and is mental health based. Community nurses told us that they used a version for older people which did not cover all aspects of learning disability and so was not fit for purpose. These tools enabled a comprehensive case formulation that informed care plans for each person. Each person using the service had a care plan in place. The trust told us they were working with the authors of GRIST to adapt the tool to learning disability services.

The service used the green light tool kit to auditing and improve mental health services so that it is effective in supporting people with autism or learning disabilities.

Outcomes for people using services

We saw that people's needs were assessed in line with guidance published by professional and expert bodies. This meant that people's needs were fully assessed so that they could be met in the most appropriate way by the relevant professionals in the community team.

Staff, equipment and facilities

The CTLD service worked out of an environment which was clean, with facilities to carry out group and individual therapeutic activities.

Staff told us about various issues relating to the trust's IT systems in the learning disability service. An electronic notes system called 'SystmOne' was in use however staff told us that it was often difficult to find the information they were looking for. Paper documents such as accessible care plans had to be scanned and stored as 'attachments' making them difficult to update and find again. This meant there was a potential risk that staff may not be able to find and access information to make clinical decisions in a timely manner.

We were told that psychiatrists kept paper notes and did not make entries in SystmOne. Staff therefore had to make paper copies of HoNOS, GRiST and PASSAD and post them to the psychiatrists even though all the information was already on SystmOne. This meant there were delays in the timeliness of clinical information. There were different computer systems for staff working in the team who were managed by the local authority (social care staff) and mental health services staff, which meant they could not access the same information about the people using the service when required and relied on paper copies being available.

Staff in community services told us that they had regular training relevant to their role and helped them to develop their skills and knowledge. However, the uptake of training was not being effectively managed and service managers were not able to provide us with an accurate picture of which staff required updates on their training. This was attributed to the electronic system not being accurate for recording training uptake.

Staff told us that they only received one day training on SystmOne, but felt they could use it much better if they had more training.

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.

There was managerial and clinical supervision available for staff, but some members of staff did not know how to access this due to their integrated line management structures. An annual appraisal of all staff was being carried out.

Staff told us that they had difficulty managing notes and administrative work and often ended up working in their own time to upload their notes onto the system after visits. There was an ad-hoc system in place to ensure that new risks were entered onto the system at the office by phone with a a member of staff having to add a note into the case file as a temporary measure until the member of staff out on a visit was able to update the risk assessment at a later date. This was a potential risk in terms of timely accessibility of information to inform decisions.

Multi disciplinary team working

We saw that different professionals in the community and inpatient services worked together to ensure that each person who used the service had their needs met and that relevant information was shared between professionals. This meant that each professional knew how to support a person to meet their needs.

There were a range of specialist services and clinics available such as an epilepsy clinic, and Down's Syndrome dementia services. There was close working with the crisis team for emergency admissions and an integrated family therapy team. Staff reported that apart from family therapy there did not appear to be other forms of therapy that people with learning disabilities could access.The trust reported that the CTLD leaflet described interventions offered and the green light action plan was in place which promotes access to adult mental health services through mainstream access to a range of therapies.

Staff told us that they needed more support for young women with learning disabilities through pregnancy as there was no current provision for this service. The trust described this as a national deficit in learning disability services and that they respond to individual needs.

Day services were not provided by the CTLD, but there were close links with local organisations where day services could be accessed. These were outsourced from the local authority and local charities.

Lilac and Willow assessment and treatment units, Townend Court

Assessment and delivery of care and treatment

Case co-ordination was carried out through team and core meetings. People using the service were assessed using the GRiST assessment tool.

People's physical healthcare assessments were completed by the ward doctor. If needed appointments with people's own GP could be made.

Outcomes for people using services

We saw that people's needs were assessed in line with guidance published by professional and expert bodies. This meant that people's needs were fully assessed so that they could be met in the most appropriate way by the relevant professionals in the community team.

Staff, equipment and facilities

Staff told us, and we saw, that the environment was well maintained and any maintenance issues were resolved quickly.

Staff told us that they received the training they needed to meet people's specific needs and these could be discussed at staff supervision meetings and at appraisal.

Multi disciplinary team working

We were told that psychiatrists did not use the SystmOne electronic notes system that was used on the wards, but worked using a paper system. We saw instances where miscommunication had occurred and information had not been effectively passed on about people using the service due to two parallel systems being in place. Staff on the wards told us that this way of working was "not joined up" and "could lead to errors". Staff said they had raised these concerns with management.

The wards had daily contact then seven days follow up before handover to the CTLD. The wards had pre-discharge and as well as discharge meetings

Mental Health Act (MHA) 1983

We reviewed the MHA documentation of three people using the service on both Willow and Lilac Wards.

Conditions were not written to specify the number of staff escorts and the grade of staff required on section 17 leave forms. Some old section 17 leave forms were in place this posed a potential risk in that staff may not use the most up to date leave conditions.

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.

All people using the service had MHA care plans in place. We found that people were given information about their rights in relation to section 132 of the MHA, For example what their section meant and how to appeal against their detention. Section 132 rights were recorded on paper forms and sometimes on SystemOne. The section 132 form used did not carry a section 132 heading at the top of the page for ease of reference.

We found one MHA care plan that was not specific to the individual's detention under section 2 of the Act. We found one detained person using the service had been seen by a second opinion appointed doctor (SOAD) but we did not find any entries by staff acting as statutory consulted in notes or SystmOne records. There was no entry by responsible clinician (RC) recording that person was informed of the outcome of SOAD visit and no clear recording of outcome of assessment of capacity by the RC.

Mental Capacity Act and DoLs

We carried out an unannounced visit to monitor the Mental Capacity Act and Dols on the 29 May 2014. Whilst staff had received training, We saw that there were gaps in some staff's understanding about the use of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

We reviewed the case notes of four people using services. We found that medical staff were not applying the MCA for the delivery of physical treatment not covered by the Mental Health Act (MHA) 1983. More importantly this extended to outpatient prescribing (where the majority of people are not detained under the Act) the clinicians we spoke to confirmed this.

We were concerned the standard assessment of capacity and best interests form used by the trust andand social care agencies in Hull and the East Riding of Yorkshire: MCA 2005) and mainly completed by trust staff, appeared to only have tick boxes 'Yes' or 'No' for whether a person understands, retain, uses/weighs or communicates, but it does not provide any space beside these to explain what a person could not do if the 'No' box is ticked. Under the Act, the burden of proof fails on the assessor to prove that a person lacks capacity and simply ticking a box does not provide that level of evidence.

Ullswater Ward, Humber Centre

Assessment and delivery of care and treatment

We reviewed three sets of case notes and all clinical notes were paper-based. We saw GRiST risk assessments were in place and people's needs were assessed. We saw that a medical review and a physical examination, bloods, weight, ECG, and blood pressure had been carried out on admission. Each person had a folder which they owned and contained all relevant care plans in a person centered format. All relevant care plans were included to guide staff how to care for someone safely. These included, where applicable, the use of restraint and the management of specific conditions such as epilepsy. We found that people had a health action plan which contained details about people's physical health needs. People also had a communication passport. This was a special way of providing key information useful on a daily basis to guide people in communicating and supporting people using services effectively.

We did not find evidence of the responsible clinician's assessment of a person's mental capacity to consent to medication. We asked a member of staff to see if they could locate where it had been recorded but this was not available. A certificate for detained people who are able to consent (T2) was located in the drug charts. This showed staff under what legal authority they were administrating medication.

Outcomes for people using services

The unit provided therapies for example; anger management, social skills training, occupational therapy, psychology, sex offender treatment and art therapy. We were told that the main intervention used was called 'social story'. People using the service told us that there were activities to keep them occupied. One person told us "I like the woodwork. I like to be busy and I get support to be busy, like going to the gym, I go once or twice a week."

Some staff told us that there had been a reduction in activities for people using the service with occupational therapists only coming in two or three times a week. Access to the allotment off site had been reduced due to low staffing levels. Staff felt that this had reduced people's motivation to engage.

Staff, equipment and facilities

Some staff told us that they found it difficult working on Ullswater ward due to increased levels of observation of one person using the service. They said that they did not

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.

have sufficient staffing levels to carry out the observations. Staff told us that they sometimes they worked up to nine hours observations on a shift without a break due to observations. The managers on the unit were aware but staffing levels were not always adequate to cover increased observations and there was not always sufficient bank staff to provide cover. The trust observation policy stated limits in how long staff should undertake observation, which were not followed at the time of our inspection. Staff told us as a result that they had low morale and were tired.

There was training, managerial and clinical supervision and appraisal available for staff which was monitored effectively.

Multi disciplinary team working

We saw that different professionals in the inpatient services worked together to ensure that each person who used the service had their needs met. We saw that relevant information was shared between professionals ensuring they each knew how to support a person to meet their needs.

Multi disciplinary team (MDT) meetings took place on a regular basis and people could choose to be involved. We were told that a MDT team day took place around every six weeks where clinical issues could be discussed.

Mental Health Act (MHA) 1983

We undertook an audit of two sets of case records and found the MHA Code of Practice guidance was not being followed For example following a second opinion advisory doctors (SOAD) visit the people acting as statutory consultees did not record their outcome of the discussion with the SOAD. We did not find entries regarding the outcome of capacity assessments in case records from the time of original detention or at the three month point of detention in relation to medication.

We reviewed a record made in regard to the use of seclusion and found that there was adherence to the MHA Code of Practice and that the person was being appropriately managed in the circumstances.

Are services caring?

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

Summary of findings

All of the people that we spoke with were happy with way they were treated by the team in regards to kindness, dignity and respect.

People using the service were positive about the staff and the care they received. We saw interpreters being used by the CAMHS LD team within home visits.

All detained people using the service had access to an independent mental health advocate

Our findings

Community team- learning disabilities (CTLD)

Kindness, dignity and respect

We visited a number of people using the services at home and attended therapies being offered at the CTLD offices. All of the people we spoke with were happy with way they were treated by the team in regards to kindness, dignity and respect. All staff we spoke with, were passionate about the job they did and were motivated to ensure that people who used services were well cared for.

Involvement of People who use services

We saw that staff used appropriate communication, and made adjustments where necessary, to help people to express themselves and their views about the service provided. Staff spent time with people who used the service to explain their care plan and ensured that they agreed with it. We saw that people's relatives, where appropriate, were involved in their care.

Emotional support for care and treatment

We observed visits to people using the service to arrange activities and carry out physical health screening. People's emotional needs were taken into account with sensitivity when discussing their physical and sexual health. People's social needs in regards to carrying out activities in the local community were met for example attending local support groups.

Lilac and Willow assessment and treatment units (Townend Court)

Kindness, dignity and respect

Staff were able to explain people's backgrounds and history and how this information was important to their daily routine to enable them to communicate and care for them. Staff treated people kindly and in a caring and respectful manner during our visit. We observed staff responded appropriately and with care to people using the service who were distressed.

We saw evidence where one person had been allocated their own space on Lilac Ward when distressed and windows and doors had privacy film installed to protect the person's privacy and dignity.

People's involvement in using services

The trust was engaging in people's involvement in trust activities, for example people using the service told us that they had been involved in staff interviews, which meant they had a say in who would deliver services to them.

All detained people using the service had access to an Independent Mental Health Advocate (IMHA) through the 'Voicability' service and had been informed about this.

Emotional support for care and treatment

One person told us "The service is pretty good. You can ring up if you've got problems. My CN goes to my hospital appointments with me. The team here are all nice. They will sort you out. They won't turn you away."

Ullswater Ward Humber Centre

Kindness, dignity and respect

People using the service were positive about the staff and the care they received. We were told that the unit was a "nice place" and "staff are kind".

People's involvement in using services

People using the service told us that they were involved in planning therapies, and in the multi disciplinary team evaluation (evaluation of therapies and activities). The unit used the recovery star, specifically two of the stars that were more applicable to learning disability.

There was a monthly regional service user meeting in place that people could attend. There was a monthly patient committee in place and a weekly patient meeting held at the weekend. People

who used services told us that the patient meetings were held at a time convenient to them and were effective in addressing their needs.

All detained people using the service had access to an independent mental health advocate (IMHA) through the 'Voicability' service and had been informed about this.

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

The service had a safe and effective system in place for managing referrals and managed waiting lists well. However access to some therapies was delayed, for example there was an eight month waiting list for psychology services.

Our findings

Community team learning disabilities (CTLD)

Planning and delivering services

There was a system in place to safely and effectively manage referrals to the service. The open referral system allowed all referrals to be considered. Staff attended a weekly referral assessment meeting. Referrals were accepted if a person had a learning disability according to ICD-10 and health care needs. The team provided assessment and signposting to non-learning disability vulnerable referrals. Six weeks were allowed for screening which included 'first contact' assessment. Then they were referred to the specific clinician at a weekly multi disciplinary meeting.

The CTLD were flexible in taking referrals for young people wanting to access or being more appropriately place in the adult service. There was also geographical flexibility at the convenience of the person using the service who may have been in the catchment area of a different part of CTLD and if people moved during their treatment. This was dictated by the needs of the person using the service.

CAMHS LD held transition meetings for people who were reaching adulthood to plan their care into adult services.

Managers reported that there were approximately 30 people placed out of the area for Hull and East Riding and include individuals in low secure, independent hospital, specialist autism placements, specialist treatment services and some social care and educational placements, including young adults.The trust reported it aims to always to have a bed available for people in a crisis to reduce the risk of out of area placements.. The only patients transferred have been individuals assessed as needing low secure environments. The work supports the Winterbourne concordat actions.

Right care at the right time

The CTLD effectively managed waiting lists for referrals to the service using a case load management tool (Hertfordshire model) integrating a priority triage system for people at higher risk. There was no waiting list in place for people requiring urgent treatment. Community nurses reviewed their waiting lists every six weeks. Waiting lists existed for access to therapies such as psychology, occupational therapy (OT), speech and language therapy (SALT), physiotherapy, which was attributed to staff vacancies across the community teams. There were plans in place to reduce waiting lists in these areas through recruitment and flexibility across the community teams to share our workload. There was an unassigned list of 60 for OT across Hull and 36 across East Riding with a maximum 11 month waiting list, although a locum OT had been recruited in Hull (west) and a band 5 has been recruited in the east team.

The autism assessment team reported that waiting lists were now starting to be electronic. All referrals were acknowledge within 24 hours. Child Protection referrals were seen within four weeks of referral. The team reported that the assessment took a minimum of 6 hours per child to complete and based on these figures only ten children a month could be seen, however there were approximately 30 referrals per month being made. Therefore there were complaints about waiting times.

In the CAMHS LD team the waiting list for nursing support was one year, the waits for art therapy were shorter, and currently there was no access to psychologists. The team were hoping to set up clinics to shorten waiting lists.

Staff told us that care co-ordination was done on an ad-hoc basis by trusting that staff would look at each other's entries on SystmOne (apart from the CAMHSLD team who are not on Systemone). Staff told us that communication was good amongst team members working with same person using the service. Multi-disciplinary reviews of people using the service were carried out where care co-ordination was carried out. There was however no formal system in place for care co-ordination. This meant that people using the service did not have an assigned care coordinator or key worker to ensure that care was consistent and risks would be coordinated by a single responsible staff member.

We observed that there was consideration given to least restrictive practice. For example following a risk

Are services responsive to people's needs?

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

assessment some people using the service were given the door code so they could enter and exit the wards. There were designated gender specific areas in order to maintain people's privacy and dignity in accordance with the MHA Code of Practice.

Staff we spoke with were aware of how to meet people's religious and cultural needs. Staff showed that they were sensitive to the person's needs and that of their family, when visiting them in the community. We were able to observe this during home visits.

Learning from concerns and complaints

We saw that information about how to make a complaint was displayed and available to people who used the service in a format that was easy to understand. People we spoke with told us that they knew how to make a complaint. People said that these would be listened to and action taken to make improvements.

Lilac and Willow assessment and treatment units (Townend Court)

Planning and delivering services

There was a screening system for referrals to the community teams which was developed by the psychologists. If there was doubt about whether person had a learning disability, psychologists undertook appropriate mental health assessments.

The wards used the green light tool kit for people who needed access to mental health services. This is a tool to ensure that mental health problems were picked up as part of initial screening.

We were told that there was no funding for occupational therapy on the in-patient wards. There was an activity coordinator in place for three days per week who provided activities for people using the service. On the day of our visit there were activities available for those that wanted to undertake them, such as cooking in the OT kitchen.

Right care at the right time

The waiting list was around eight months for psychology, which staff told us was a concern for them as it meant that people did not receive the psychological input to support their mental health treatment plan. Speech and language therapists (SALT) held a waiting list for people with dysphagia and they told us that they saw people within two weeks although the trust policy was that people were to be seen within 48 hours. This meant that there was not always access to therapies in a timely manner to provide the right care at the right time for people using the service.

Learning from concerns and complaints

We saw that information about how to make a complaint was displayed and available to people who used the service in a format that was easy to understand. People we spoke with told us that they knew how to make a complaint. People said that these would be listened to and action taken to make improvements.

Ullswater Ward, Humber Centre

Planning and delivering services

The unit had a colour- coded activity board which was wall mounted in the lounge. This helped people who could not read, to identify their individual daily activities.

We noted that closure devices on ward corridor doors caused the doors to constantly bang shut. People told us that they had informed staff about the noise but this had not yet been rectified.

Learning from concerns and complaints

We saw that information about how to make a complaint was displayed, and available to people who used the service, in a format that was easy to understand. People we spoke with told us that they knew how to make a complaint. People said that these would be listened to and action taken to make improvements.

Are services well-led?

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

Summary of findings

Staff told us that they received information about the vision and strategy of the trust and were aware of the impact this had on their role. They also said that there were good working relationships within the team and with the management team, including the chief executive and chairman. Staff did not have access to regular formal managerial and clinical supervision.

Our findings

Community team- learning Disabilities (CTLD)

Vision and Strategy

Staff told us that they received information about the vision and strategy of the trust and were involved in this and how it impacted on their role. Staff told us that they shared good practice

within the trust. Teams were integrated with health professionals and social workers all working together to benefit people who used services.

Responsible governance

We saw that audits were completed which provided the team with knowledge about how well the service was performing and what could be done to make improvements. We saw that improvements to services had been made as a result of these.

Leadership and culture

Staff told us that there was a good working relationship within the team and with the management team, chief executive and chairman. The chairman of the trust has been out on visits with team staff and the senior management including the chief executive had visited the CTLD. Staff told us that they could approach senior managers if they had any concerns.

Most staff told us that they received regular supervision and appraisals which were focussed and useful to the member of staff in improving their performance. Live supervision (LCAS) was available to all staff which could be requested.

Engagement

We saw that teams worked together and shared practice across each other and with external providers and networks. This meant that best practice was shared to benefit people who used the service.

There were multiple methods of collecting people's views, including a patient satisfaction survey in place which was in an appropriate format for the needs of the people using the service. We saw how improvements had been made based on people's feedback about the service.

Performance Improvement

There were systems in place to ensure that the team looked at performance and improvements made if needed.

The service reviewed itself against recommendations from the Winterbourne report, including having a nominated clinician responsible for reviewing people using the service who were placed out of area. Areas for improvement had also been identified looking at specialist autism services following the service review.

A 'Fit for Purpose' review arising from Mid Staffordshire recommendations had been adopted to ensure robust recruitment. This included a three day trust induction followed by a comprehensive local induction programme.

There was a learning disabilities clinical network in place, which met bi-monthly. Within the network was a senior clinician responsible for passing on updated NICE guidance.

There were opportunities for staff to develop management skills through a one week course for Band 6 nurses and above across all professions and some Band 5 nurses also had access to this training. This meant that staff were supported to improve their own performance which benefitted the trust as a whole.

Staff in the CAMHS LD services reported that they were unaware of the Health and Well Being Board and the support it offered to staff.

Lilac and Willow assessment and treatment units (Townend Court)

Vision and strategy

Staff told us that they received information about the vision and strategy of the trust and were aware of this and how it

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.

impacted on their role. Staff told us that they shared good practice within the trust. Teams were integrated with health professionals and social workers all working together to benefit people who used services.

Responsible governance

We saw that audits were completed which provided the team with knowledge about how well the service was performing and what could be done to make improvements. We saw that improvements to services had been made as a result of these.

Leadership and culture

Staff told us that there was a good sense of teamwork in the ward areas. The psychologists and speech and language therapists (SALT) told us that the service was well-led by the service manager and by the SALT and psychology leads.

Engagement

We saw that teams worked together and shared practice across each other and with external providers and networks. This meant that best practice was shared to benefit people who used the service.

There were multiple methods of collecting people's views including a patient satisfaction survey in place which was in an appropriate format for the needs of people using the service. We saw how improvements had been made based on people's feedback about the service.

We spoke with a service user representative who told us that user groups were actively engaged with at the trust. They had also participated in interviewing for the new CEO of the trust.

Performance Improvement

We were told that the local Clinical Commissioning Group (CCG) were reviewing the learning disabilities service, especially against Winterbourne in order to help improve the service.

SALT used the 'Five Good Communication Standards' produced by the Royal College of Psychiatrists in response to Winterbourne. The SALT team were looking at the implementation of these across the trust.

We saw that audits were being carried out such as an evaluation of the experience of clients and families of the family therapy input. SALT undertook case note audits annually with the SALT lead.

Ullswater

Vision and strategy

Staff told us that they received information about the vision and strategy of the trust and were aware of this and how it impacted on their role. Staff told us that they were involved in the strategy and vision and that good practice was shared within the trust. Teams were integrated with health professionals and social workers all worked together to benefit people who used services.

Responsible governance

We saw that audits were completed which provided the team with knowledge about how well the service was performing and what could be done to make improvements. For example there were audits in relation the MHA detention papers, section 17 leave, infection control and audits of the legal authorities to give medication to detained people under T2 (for consenting detained people) and T3 for non-consenting detainees. We saw that improvements to services had been made as a result of these.

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
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:** • Door frame of seclusion room one in Ullswater 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(1)) HSCA 2008 (Regulated Activities) Regulations 2010