Good

Humber NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Humber NHS Foundtion Trust
Trust Headquarters
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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	Willerby Hill	Childrens Community Team for Learning Disability	HU2 8TD
RV936	Willerby Hill	Hull Community Team for Learning Disability	HU6 8QG
RV936	Willerby Hill	Four Winds Community Team for Learning Disability	YO25 9LH

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.

Summary of findings

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

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 mental health service for people with learning disabilities as good because:

- Staff regularly risk assessed patients whilst on the waiting list across all services. Staff weighted caseloads to ensure caseloads were not excessive. Incidents were discussed during team meetings and appropriate debriefs took place with both staff and people who used the service. Facilities at Townend Court and Four Winds were safe and suitable to use for their intended purpose.
- Staff took the Mental Capacity Act into account at all services. The speech and language therapy team had devised a script to aid communication and ensure that staff gave people every opportunity to participate in capacity assessments. Patient assessments took place within 6 weeks of initial referral and prior to patients being added to the waiting list. Staff across all the services followed the National Institute of Health and Care Excellence guidance, which included recent transitions guidance. Staff had regular supervisions and appraisals were up to date. Specialist training was available and staff were keen to continue their development. Multi-disciplinary team meetings were effective across all services and decisions made were evident in people's care files.
- Patients and their family members reported they received an excellent service. Staff treated patients with dignity, respect and were supported by staff who understood their needs. Patients were involved with their care and staff used innovative methods to enable people to engage with their care.
- Staff made contact with patients whilst on the waiting list and staff managed the list well. Staff prioritised urgent referrals. Information was available in various formats, interpreters were used and some staff were trained in British sign language. Team meeting minutes had a British sign language 'sign of the week. Staff helped patients to complete patient passports and health check documents, which assisted patients when visiting or being admitted to hospital. There was a policy in place to manage complaints. Patients and their families knew how to complain.
- Staff spoke highly of the local management including the care group director. Managers investigated incidents and where appropriate they made to procedures. Staff understood the trust visions and values and these were integral to the way they worked. The service had introduced iPads to assist patients to be involved in their care and care planning.

However:

- Waiting lists were unacceptable with the longest wait being 94 weeks
- The environment at the children's community team for learning disabilities Victoria House was not appropriate. The building was in need of redecoration and repair. Interview rooms contained out of use equipment. Not all areas were clean. There were no fixed or portable alarms available for staff. Staff had not made a safeguarding referral for an incident witnessed at Hull community team for learning disability.
- There were staff vacancies at Hull and Four Winds community team for learning disability which impacted on the length of time patients had to wait for an allocated worker.
- Staff said the use of both System One and Lorenzo was difficult to manage, information on Lorenzo was not always updated. Staff working at Four Winds reported difficulties in ensuring records were updated on the day of the patient visit.
- Whilst generally managers had sufficient authority to carry out their roles, they reported delays of up to four months in recruiting staff to vacancies which was as a result of the recruitment process. Some staff members reported incidents of bullying, which they felt managers had not adequately dealt with until recently.

Summary of findings

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

Are services safe?

Good

We rated safe as Good because:

- People were regularly risk assessed whilst on the waiting list across all services. The trust weighted caseloads to ensure that staff did not have excessive caseloads. Despite extensive waiting lists, staff made contact with patients whilst on the list and they managed the list well. Staff prioritised urgent referrals.
- Incidents were discussed during team meetings and appropriate debriefs took place with both staff and people who used the service.
- Facilities at Townend Court and Four Winds were safe and suitable to use for their intended purpose.
- The trust shared best practice notes through a weekly global email to all staff.

However:

- The environment at the children's community team for learning disability at Victoria House was not appropriate. The building was in need of re decoration and repair. Out of use equipment was being stored in interview rooms. Not all areas were clean. There were no fixed or portable alarms available for staff.
- Staff had not made a safeguarding referral for an incident witnessed at Hull community team for learning disability.
- There were staff vacancies at across all the services. The trust had appointed some staff and recruitment was taking place for others. There were insufficient staff to significantly reduce patient waiting lists.

Are services effective?

Good

We rated effective as good because:

- Staff took the Mental Capacity Act into account at all services. The Hull community team for learning disability had devised a script to aid communication and ensure that patients were given every opportunity to participate in capacity assessments.
- Patient assessments took place within six weeks of initial referral and prior to being added to the waiting list.
- National Institute of Health and Care Excellence guidance was followed across all services, which including recent transitions guidance.
- Staff had regular supervisions and appraisals were up to date. Specialist training was available and staff were keen to continue their development.

Summary of findings

- Multi-disciplinary team meetings were effective across all services and decisions made were evident in people's care files.

However:

- Staff said the use of both System One and Lorenzo was difficult to manage, information on Lorenzo was not always updated.
- Staff working at Four winds reported difficulties in ensuring records were updated on the day of visits.

Are services caring?

Good

We rated caring as good because:

- Patients and their family members reported they received an excellent service.
- Staff treated patients with dignity, respect and patients were supported by staff who understood their needs.
- Patients were involved with their care and staff used innovative methods to enable patients to engage with their care.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Waiting lists were extensive and unacceptable with some patients waiting over 70 weeks to be allocated to a caseworker.

However:

- Information was available in various formats, interpreters were used and some staff were trained in British sign language. Team meeting minutes had a British sign language 'sign of the week'.
- Staff completed patient passports and health check documents to assist patients when visiting or being admitted to hospital.
- There was a policy in place to manage complaints. Patients and their families knew how to complain.

Are services well-led?

Good

We rated well-led as good because:

- Staff spoke highly of the local management including the care group director.
- The trust investigated incidents when they occurred, and where appropriate changes were made to procedures.
- Staff understood the trust visions and values and these were integral to the way they worked.
- iPads had been introduced to assist patients to be involved in their care and care planning.

However:

Summary of findings

- Whilst generally managers had sufficient authority to carry out their roles, they reported delays of up to four months in recruiting staff to vacancies which was as a result of the recruitment process.
- Some staff members reported incidents of bullying which they felt managers had not adequately dealt with until recently.

Summary of findings

Information about the service

The two adult community learning disability services at Townend Court and Four Winds are linked to geographical areas, local authority care management services, and GP practices. In Hull, the services are integrated with social services and have a single point of access to health and social care support.In the East Riding they work in partnership with social services. Each location has a Continuum support service, which provides behavioral interventions.

The children's community team is based at Victoria House and is a specialist child and adolescent mental health team, including learning disability nurses, clinical psychologist, and arts therapists.

Our inspection team

The team was led by:

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

Head of Inspection: Jenny Wilkes, Care Quality Commission.

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

The team that inspected the community mental health services for people with learning disabilities consisted of two inspectors, one specialist advisor who was a learning disability nurse and one specialist advisor who was a service commissioner.

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 a focus group.

During the inspection visit, the inspection team:

- visited all three community teams for learning disability locations and looked at the quality of the environment
- spoke with 21 carers of patients who used the service
- spoke with six patients who used the service
- spoke with the managers or acting managers for each of the teams
- spoke with 36 other staff members; including doctors, nurses and health care support workers
- attended and observed five multi-disciplinary meetings
- attended and observed 12 community visits
- reviewed 23 care records

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

We spoke with six patients and 21 family members who praised the service they received across all the community teams for learning disabilities.

Patients and their families spoke positively about staff. Staff were considered caring and supportive. Staff treated patients with respect and dignity.

Patients and their families told us they felt involved in decisions about their care.

Good practice

The speech and language therapy team had developed scripts to enable a consistent approach to carrying out capacity assessments. Staff had written these using language and pictures to ensure patients were given every opportunity to engage in the assessment.

Staff used innovative ways to encourage patients to engage in their care. Staff had worked with one patient in their garden to facilitate psychiatry involvement.

A family member told us the service had sought a palliative care psychiatrist to work with their family member.

The trust's introduction of iPads to encourage patient involvement with their care and care planning was seen to be very positive by staff, patients and their families.

The epilepsy nurses delivered training to care homes, which had resulted in a reduction of patient admissions to hospital.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure staffing numbers are sufficient to enable the reduction of patient waiting lists to within trust targets.

Action the provider SHOULD take to improve

- The trust should ensure the facilities at Victoria House are suitable for their intended purpose and maintained to a suitable standard. Out of use equipment should be removed and facilities should be more children friendly.
- The trust should ensure the recruitment process is streamlined to enable the prompt recruitment of staff to fill vacancies.

Humber NHS Foundation Trust

Community mental health 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
Childrens Community Team for Learning Disability	Willerby Hill
Hull Community Team for Learning Disability	Willerby Hill
Four Winds Community Team for Learning Disability	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.

At the time of our inspection, there were no patients subject to community treatment orders under the Mental Health Act 1983. Staff had a good understanding of the Mental Health Act and they told us they had completed some mental health act training although not all staff were up to date. Managers told us the trust had added further training dates and that staff had been booked on courses.

There was central trust team who were available to support staff with any Mental Health Act queries.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, there were no patients subject to Deprivation of liberty safeguards authorisations.

Community teams for learning disability staff training was slightly below that set by the trust. Figures provided by the trust showed that 70% staff had completed their training, which was below the 75% compliance figure.

Detailed findings

Staff had a good understanding of the Mental Capacity Act and told us the principles of the act underpinned their work. We saw good recordings of patient's ability to consent to their care and where appropriate staff had carried out decision specific capacity assessments. Care records we reviewed contained details of best interest decision meetings.

Good

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

Staff at the adult learning disability services had access to portable alarms. This was not the case at the children's centre at Victoria House, which meant staff were at risk of harm should they need to summon help.

Hull community team for learning disability and Four Winds community teams for learning disabilities had good facilities, were suitable and appropriate for patients who used the service, were clean, and followed good infection control principles.

The children's community team for learning disability at Victoria House was in a poor decorative state, there were large areas of peeling paint. The trust had carried out a health and safety inspection in August 2015, which identified that the walls and ceilings were not in a state of good repair. This was still the case at the time of our inspection, although the trust had completed other actions.

Cleaning staff had not adequately cleaned some areas of Victoria House. We found dust and debris in the corner of one of the rooms and due to the poor state of decoration; it was difficult to ascertain if other areas were clean due to the poor state of decoration. One of the rooms used for patient sessions and psychiatry clinics contained discarded equipment, which included a large television and a large coffee machine. Both had portable appliance testing stickers on them from 2013. Staff told us this equipment had not been used for years.

In addition, there was a large boardroom style table, which was used to conduct patient sessions, which had a moveable glass top. This was not suitable for the purpose it was intended. There was a risk that this could cause serious injury should a child or adult fall onto it. As the glass top was moveable, there was also a risk that a child may trap their fingers under it. Another room used had an ornate open fireplace, staff told us that recently a child had tried to climb up the chimney; there was nothing in place to prevent this from happening again. We found in another room that there was a telephone cable box, which was broken with exposed wires. The majority of the windows in the building were old sash windows, and very few could be opened.

All locations, including Victoria House had access to hand sanitising gel.

Safe staffing

Each of the locations visited reported issues with recruiting staff and carried some vacancies. However, managers said told this was an improving situation. The manager at the children's community team for learning disability said they had one band 5 nurse vacancy. The manager at Hull community team for learning disability said they had vacancies for 1.6 band 5 nurses and one band 7 nurse and one nursing assistant. The manager said there was no use of agency staff. There was one vacancy for a band 7 nurse at Four Winds. There was one band 3 and one band 5 vacancy in the speech and language therapy team. There was one band 6 and one band 5 vacancy in the physiotherapy team. There had been several attempts via recruitment drives to recruit staff but this had been unsuccessful. This had impacted on the length of the patient waiting lists.

Staff at Hull community team for learning disability told us they were concerned that when staff members left the trust were not replacing them. We spoke with managers about this who said this was not the case. Each manager had looked at their staffing structure and in some cases where they believed the staffing structure was 'top heavy' and they had converted a band 7 post into a band 6 post.

Caseloads varied across each of the services, staff told us caseloads were manageable and said they never felt pressurised to take on more.

Staff at each location used a caseload measuring tool which weighted various factors. These factors included the individual's motivation, level of risk, communication needs, environmental factors and indirect activity factors. This tool ensured that each member of staff's caseload was manageable.

The psychiatrist at the children's community team for learning disability told us they conducted clinics at the service and were always available for telephone

Good

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conversations staff we spoke with confirmed this. They said they carried a caseload of approximately 30 patients. Hull community team for learning disability and Four Winds had access to the following doctors:

One WTE Learning Disability Consultant and 0.4 WTE Medical Director who worked in Learning Disability Services. All the doctors support the in-patient and Community Learning Disability Services

One specialist registrar

One specialist doctor

One Core trainee

One locum psychiatrist who had worked consistently for the trust

Staff said the medical director also worked at the service three days a week. Staff said doctors were available during the week and also on an out of hour's rota.

The trust provided us with details of the community teams for learning disability mandatory training compliance, which was 74%.

Assessing and managing risk to patients and staff

Patients referred to the service received a full risk assessment within two weeks. The results of the risk assessment fed into the overall assessment to ensure staff prioritised patients at the greatest risk.

We reviewed how services monitored patients on waiting lists. Staff attended meetings which were held on either a weekly or monthly basis during which information from various health professionals was used to determine if patients on the waiting list risks had changed.

With the assistance of staff at each location, we reviewed 23 patient records and found staff had carried out comprehensive risk assessments in most cases. However, we and the staff assisting us were not able to locate the risk assessments in four patient records. During our inspection, the trust advised us that there had been concerns raised with regard to the data quality of the trusts risk assessment system E-Grist. Therefore, the trust had suspended use of the E-Grist system.

Staff spoke confidently about their safeguarding responsibilities. Staff gave us examples of when they had made safeguarding alerts to the local authority. However, a member of staff at Hull community team for learning disability told us about an incident, which should have been referred to the local safeguarding authority that was not done. We advised the manager of this who agreed to look into the circumstances. We reviewed incidents recorded on the trusts Datix system and found other referrals had been made appropriately.

The trust had a comprehensive lone working policy and staff adhered to the policy. Staff logged their appointments in a central diary. When staff were heading home after their last appointment they rang the team to confirm their safety.

Track record on safety

Managers of two of the services told us about untoward incidents that had led to changes. At the children's community team for learning disability pathways were introduced by the team because of long waiting lists and to improve patient journey. At Hull community team for learning disability, the trust had carried out a serious event analysis as a result of a potential breach of data security. The manager told us that in line with the duty of candour, they had met with the patient and apologised and staff had documented this.

Staff at Four Winds told us there had been no serious incidents recorded within the East Riding locality but information from across the trust was shared. They said and we saw that 'blue light alerters' came through after a serious untoward incident took place and where appropriate details of changes made to practice. Managers discussed these within clinical governance meetings and then filtered back through multi-disciplinary team meetings or staff team meetings.

Reporting incidents and learning from when things go wrong

When incidents occurred, within community teams for learning disability services these were discussed within clinical governance meetings and also where appropriate fed back through multi-disciplinary team meetings or general team meetings. The trust shared best practice notes through a weekly global email to all staff.

Staff were clear about what needed to be reported on the trusts Datix system. Staff told us about safeguarding incidents they had added and incidents where the trusts computer system was running slow and had crashed.

We saw recent incidents recorded on Datix, one incident related to a medication error, the incident was fully

Good

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investigated and in line with the duty of candour, this was immediately discussed with the patient and their family and the trust made an initial apology. Once the investigation was completed this was fed back and the trust again apologised to the patient and their family.

Managers of the community team for learning disability's reviewed all incidents and where necessary made changes to how care was delivered. We saw a medication error had occurred. As a result of the error a new competence record had been set up for when qualified staff delegated the responsibility of administering medication to a non-qualified member of staff. A medication standing operational procedure was issued to ensure band 3 healthcare assistants competency and patient safety when they administer medication.

Managers conducted debrief sessions with staff when incidents occurred. Staff supported each other when incidents occurred and felt able to discuss concerns within clinical supervisions.

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

At the children's community team for learning disability, staff assessed the needs of children and young people to ascertain which was the most appropriate pathway. Staff at Hull community team for learning disability and Four Winds community team for learning disability carried out an assessment of patients whilst on the waiting list prior to them being allocated to a caseworker.

We reviewed 23 care records, which contained various assessments. Occupational therapy, health of the nation learning disability assessments, speech and language therapy and in some cases an assessment of motor and process skills.

Care plans focussed on specific needs and interventions. We saw one patient had a positioning and physiotherapy care plan; the plan had outcomes and specific interventions. One patients care record contained a speech and language therapy care plan, which stated the goals of the care plan. We reviewed five care records for patients on the waiting list. These documented the initial assessment and risk assessment.

Staff entries in patients' progress notes were detailed. There was information about each interaction with patients including how long the visit had lasted, what was discussed, what activity had taken place and what was achieved during the activity.

Most records were stored on System One, and some on Lorenzo. However, doctors still used paper records which were not scanned onto System One. Staff also had access to the paper records. Staff told us it was sometimes difficult to keep all the systems up to date and they concentrated on making sure records were up to date on System One. Staff told us they did not regularly update information on Lorenzo. Lorenzo captured logistical information, which included the number of visits and the number of hours of care each patient received. Staff working at Four Winds reported difficulties in ensuring records were updated on the day of their visits due to the distance they needed to travel between the office and patient's homes. This meant that on some occasions records were not updated until the following day.

Best practice in treatment and care

Staff recorded details of medication reviews in patient care records. Staff carried out the monitoring of anti-psychotic medication. Patients prescribed lithium had three monthly checks of their liver, kidney and thyroid function. Physical health checks were generally carried out by patients GP's. Staff told us if they had any concerns about a patients declining health they would take action and they ensured GPs were made aware.

Psychological therapies were available across all services. However, the waiting list for psychology was very long with some people waiting 100 weeks to access therapy. Staff told us they were able to refer patients to the autism diagnosis service at Townend Court although there was also a long waiting list for the service.

Staff were very clear that National Institute of Health and Care Excellence guidance was followed within the service. Consideration was given to the new 'transition from children's to adult's services' guidance, which was published in February 2016, and staff told us about the new guidelines for challenging behaviour.

The children's community team for learning disability had recently started using the therapy outcome measures tool. This is a tool, which measures the impact of therapies on an individuals' health. Staff reviewed the individuals' journey to evidence outcomes.

Patient records had evidence of staff assisting patients requiring help with claiming benefits and seeking housing. One patient record showed that the patient was in danger of losing their tenancy and staff had liaised with the housing provider to make sure this did not happen. We accompanied staff during visits to see patients and found staff offered advice and assistance to other health professionals supporting patients in either their own tenancies or within supported living. On one of the visits we were told that the speech and language therapist had delivered a training session to care home staff and had done some work with a supported living provider this had involved putting up a poster with the British sign language 'sign of the week'.

Staff carried out clinical audits, which specifically looked at the monitoring of antipsychotic prescribing in people with

Are services effective?

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learning disabilities. Where actions were required an action plan was instigated which had recommendations, actions required, an action by date, the person responsible and comments on the progress of the actions.

Skilled staff to deliver care

Each team we visited had access to a wide range of qualified professionals. These included occupational therapists, speech and language therapists, physiotherapists, psychologists and learning disability trained nurses. Where certain specialists were not directly employed by the learning disability teams they were sourced and referrals made. For example, one patient's family member told us their relative had been referred to a palliative care consultant which they described as excellent.

All of the nurses we spoke with were learning disability trained. Other qualified members of staff had not had specific learning disability training. For example a physiotherapist told us this had been covered during their initial training and before commencing a patient's treatment they would always seek advice from the patients nurse. A member of staff at the children's community team for learning disability told us they had attended the children and adolescent mental health service pathway training at York university and they had attained a master's degree in childhood and youth.

There were two specialist epilepsy nurses attached to the community learning disability teams. Patients diagnosed with epilepsy needed to be seen quickly to ensure their epilepsy was monitored and to ensure patients and their families understood their triggers. Staff said there was a massive need for the epilepsy training of staff where patients lived in care homes, and for family carers. They said that where care homes participated in their training they had seen a reduction in hospital admissions.

Staff had regular supervision. In some cases, this was done monthly and in others every six weeks. Staff said clinical and management supervision always took place and managers were always available in between times should they need any further support. All the staff we spoke with told us their appraisals were up to date. Managers provided us with some examples of staff appraisals, areas covered were, what didn't go well last year, work life balance, professional relationships, objectives, agreed milestones, mandatory training, development needs and an overall summary. Staff also completed an occupational health, health and safety and wellbeing at work form. This covered areas such as stress, violence, manual handling, night working, skin problems and other areas of concern.

Team meetings were held regularly and staff were able to submit items for the agenda. Staff reviewed minutes and actions at each meeting.

Multi-disciplinary and inter-agency team work

We observed five meetings, which included multi-disciplinary team meetings, clinics and a family therapy session. Each of the meetings were well structured and involved a range of professionals which included schools and school nurses at the children's community team for learning disability. Patients and their family members were involved with the whole process and their opinions and requests were taken into account when reaching decisions.

Staff across the community teams for learning disability told us there was good attendance at multi-disciplinary team meetings and decisions made fed into the patients care plan. One of the meetings we observed led to a discussion about the patient's involvement in activities and whether or not a respite placement would be suitable. Notes from the meeting were sent out to the patient's family to ensure they were in agreement with the outcome of the meeting.

We observed a family therapy session; the session had originally been set up to discuss a particular topic. However, there was a suggestion that the focus be changed to enable discussion and support for the family on another matter, which was causing the family distress. The session was patient and family led and the team worked collaboratively with everyone involved to ensure their concerns were addressed.

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

All the staff we spoke with told us they had received Mental Health Act and the Mental Health Act Code of Practice training. Managers of the community teams for learning disability services told us that staff had either attended Mental Health Act training or had been booked on a course. We were provided with evidence of this. However, prior to our inspection we received information from the trust showed that a very small percentage of community teams for learning disability staff had been trained in the mental health act and code of practice which was contradictory to

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.

the evidence we reviewed during our inspection. The trust training policy did not show Mental Health Act training as mandatory. Staff at the children's community team for learning disability said that the training appropriate for their work with children.

At the time of our inspection there were no patients subject to a community treatment order receiving a service within the learning disabilities services, we were therefore unable to check any documentation relating to the mental health act. There was a central Mental Health Act team, which staff could contact should they need any advice on the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff told us about the trusts Mental Capacity Act policy. Staff had a very good understanding of their responsibilities under the Mental Capacity Act and were able to give examples of when the principles of the act were applied.

We saw evidence in patient records detailing capacity assessments for specific decisions. Where the patient was able to consent to their treatment staff had documented this. Where staff had assessed that the patient lacked the capacity to consent to their treatment a best interest decision meeting had taken place. These meetings were made up of professionals involved in the patients care and treatment and in some cases the patients family members or their independent advocate.

The speech and language therapy team for adults had devised a script to be used across their team to ensure continuity of the way capacity was assessed. These scripts were written in an easy read format and staff used communication methods to meet the needs of the patient to enable them to engage effectively in the process.

Staff told us they were up to date with their Mental Capacity Act training. Records we saw confirmed that the majority of staff had completed Mental Capacity Act training. The trust policy stated that Mental Capacity Act training only had to be completed once. The percentage of staff trained was approximately 70% which was slightly below the trust requirement of 75%.

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 accompanied staff on 12 visits to meet with patients and their families. Staff were kind, respectful, supportive and maintained patients dignity. During one visit the patient who was living in a care home was able to indicate to us that their community nurse was very kind and helpful. Another patient's family member said their nurse was brilliant and was very effective at communicating and supporting their relative.

It was clear from interactions we observed that staff knew patients well and were able to communicate effectively with patients. Patients responded well to staff and where they were able to, were engaging with staff.

Family members told us they could not manage without the support of staff across the community teams for learning disability, some said they were life savers.

The involvement of people in the care that they receive

We reviewed 23 care plans and it was clear from some of the records we saw that patients had been involved in the creation of their care plans. Although this was not the case in all of them. Staff reviewing records with us were not always able to determine whether patients had been involved. However, we spoke with patients, families and carers who all said they had been involved in the creation of care plans.

Family members told us they felt very well supported by staff across all the community teams for learning disability. One family member told us eight sessions had been booked for their relative with a mid-way review. They said the review had been very helpful. Staff had assisted the relative with arranging a medication review for their family member, which they had been struggling to organise.

During one visit to a care home with a member of community team for learning disability staff, the patient was having difficulty choosing food from the menu. The member of staff spoke with staff and the chef at the home and arranged for the patient to have alternative food choices printed on the menu.

During another visit to carry out an assessment, it was very clear the patient was at the forefront of the conversation. Staff explained everything in a way the patient could understand. The patient was given opportunity to explain their problems and symptoms and why they were feeling the way they were. As a result of the assessment the patient was referred to psychology and the speech and language therapy team. The member of staff explained to the patient they would refer them to their G.P for a physical health concern.

The development of the facilities in the reception area of Townend Court had been done in conjunction with patients. Patients had been able to give their opinions about what worked and what did not. This had been taken into account and changes made. Patients where possible were involved in the recruitment of staff. Patients were present for a small section of the interview, which ensured patients were able to give their opinion on candidates.

Despite the extensive waiting lists patients and family members did not report any concerns at the length of wait. All said they thought the care given was excellent.

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 trust had set a target of 18 weeks for patients to be allocated a caseworker from the time of referral. There were very few areas across all the community teams for learning disability that were meeting the target. In some cases there were waits of in excess of 90 weeks. Waiting lists provided by the trust at the time of our inspection were as follows:

Hull Nursing

- 48 patients on the waiting list
- Longest wait 61 weeks
- Average wait 36 weeks

East Riding Nursing

- 40 patients on the waiting list
- Longest wait 32 weeks
- Average wait 25 weeks

Physiotherapy Hull

- 46 patients on the waiting list
- Longest wait 75 weeks
- Average wait 45 weeks

Physiotherapy East Riding

- 45 patients on the waiting list
- Longest wait 58 weeks
- Average wait 29 weeks

Occupational Therapy Hull

- 123 patients on the waiting list
- Longest wait 77 weeks

Occupational Therapy East Riding

- 50 patients on the waiting list
- Longest wait 90 weeks

Speech and Language Therapy – Hull and East Riding - Dysphagia

- 11 patients on the waiting list
- Longest wait 6 weeks
- Average wait dysphagia 3 weeks

Speech and Language Therapy – Hull and East Riding - Communication

- 49 patients on the waiting list
- Longest wait 47 weeks
- Average wait 17 weeks

Speech and Language Therapy – Hull - Continuum

- 11 patients on the waiting list
- Longest wait 18 weeks
- Average wait 15 weeks

Psychology Hull

- 42 patients on the waiting list
- Longest wait 94 weeks (next longest case 71 weeks)

Psychology East Riding

- 44 patients on the waiting list
- Longest wait 100 weeks

Psychology Family Therapy

- 8 patients on the waiting list
- Longest wait 30 weeks

Children's Community Team for Learning Disability

- 49 patients on the waiting list
- Longest wait 22 weeks
- Average wait 11 weeks

There were weekly meetings in some areas of the Humber community teams for learning disability and monthly meetings in other areas to discuss patients on the list. During the meetings, they looked at how urgent the patients need was. Patients newly added to the list received an initial assessment within two weeks of being added to the list. Patient's priority could change throughout their wait and if there were changes to the patients' needs they would move up the list quicker. There was a system in place, which allowed patients to be seen by both risk and how long they had been on the list.

The trust provided us with some additional information about other issues that impacted on these waiting times, as well as their key actions to reduce the waiting lists and to manage the risks for patients who were waiting.

The trust were recruiting additional speech and language therapists, psychologists, occupational therapists and nursing staff. At the time of the inspection, the trust had only partially met their target for the number of staff they needed to recruit. In addition, the trust told us that maternity leave within the occupational therapy teams, psychology and physiotherapy department, was having a

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significant impact within these teams with regard to sufficient staffing. The trust in response to these vacancies had employed bank and agency staff to reducing the waiting list.

There were full and regular reviews of the waiting lists by teams in an attempt to manage the risks for those patients on the waiting list. The teams would attempt to refer to mainstream services if this was appropriate to provide the patient with support. There was also a priority system implemented for each team, which we identified in some of the learning disabilities teams we visited. However, the trust acknowledged that further work was required to ensure approaches were consistent across the service.

The trust informed us that there continued to be data quality issues, which they were trying to resolve. This included the correlation between System One, manual waiting lists and Lorenzo. Another issue highlighted by the trust was that due to data management issues, they were unable to differentiate between primary and secondary waiter. This meant they could not differentiate between those who had already been offered an appointment and were waiting (secondary waiter) compared to those who had not yet been offered an appointment.

The data we received was the must up to date and accurate as this was the data held by the professional lead for each service. The trust told us that most patients on the waiting list were 'secondary waiters' and that the professional leads for each service were aware of this and considered this when they were reviewing the waiting list and triaging patients.

Patients who required the most urgent care would be seen by either the Hull or East Riding Continuum teams. These teams were specifically for patients at the highest risk. Continuum support services provided behavioral interventions.

We reviewed the Continuum team meeting minutes where new patient referrals were discussed. We saw there was an assessment of need noted, any identified issues, and who was involved with the patients' care. In some cases they identified a plan of what would be required. Consideration was given to deprivation of liberty safeguards, capacity assessments, an assessment of sexual knowledge tool and a risk assessment was completed for all new patient referrals.

Patients and their families told us staff were responsive to their calls. They said there was always someone available to assist them. Staff and patients told us appointments were not cancelled and often took place in the patient's home. Appointments where possible were arranged at a time suitable to the patient.

We found all the teams worked closely with each of the disciplines to ensure patients were given every opportunity to engage with services. We accompanied one of the nurses to a patient who had been resistant to accepting services. The nurse had discovered the patient was interested in gardening and through gardening with the patient the patient had agreed to accept the support being offered.

The facilities promote recovery, comfort, dignity and confidentiality

We found the facilities at Victoria House where the children's community team for learning disability did not promote recovery. On arrival at Victoria House, the premises were not welcoming; there was no indication that it was a facility for children and young people. There was a clinic room at the health centre behind Victoria House, which was used by the children's community team for learning disability. This had a couch and screens which enabled patient examination

The facilities at the Hull community team for learning disability were very good. The waiting area was bright and airy, there were easy read signs and buttons patients could press should they need assistance. These could be used to ask where the toilet was or to ask for the sensory bag, which could be used if the patient was becoming distressed whilst they were awaiting their appointment. There was a button, which the patient would press to alert staff that they needed information about bus timetables and a button for if they required general assistance. There were notice boards with various easy read notices and a map of the area with pictures to show where local services were.

Four Winds community team for learning disability was based in a remote location, which meant there were few clinics or sessions held there. However, the environment was pleasant and fit for purpose. Most appointments were held in patient's homes or in some cases day centres.

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Requires improvement

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Clinic rooms and rooms used for therapy sessions were not soundproofed however; we did not have any concerns about patient confidentiality, as during our visits conversations held in these rooms could not be heard from the outside.

Meeting the needs of all people who use the service

All the services with the exception of Victoria House had good disabled access with wheelchair accessible toilet facilities. Not all the rooms at Victoria House had disabled access; however, staff took this into account when planning appointments.

Leaflets were available in easy read format and staff used various communication methods including Makaton. Some staff were trained in British sign language. We saw team meeting minutes always included the 'sign of the week'. There was good access to an interpreter service for patients whose first language was not English.

Patient passports were developed for each patient should they require a hospital visit. Staff developed passports with the patient and they were written in easy read format. We saw there were also 'health check' booklets which had been developed for patients to take with them to hospital. These covered patients' general health and included, hearing and feet, teeth and eyes and items specific to gender like prostate checks and cervical screening.

Listening to and learning from concerns and complaints

There were low level of complaints across all the community teams for learning disability We reviewed the complaints log for each location and found there had only been three complaints in the last 12 months. One complaint had been fully upheld and another partially upheld.

Staff were aware of the trusts complaints policy and told us they would always try and resolve complaints locally where possible, and would always report any complaints to their manager. Patients and their families told us they had not had any cause for complaint. All said they knew how to complain and said they thought their complaints would be taken seriously.

There had been three formal compliments; however, staff said they often received compliments that were not recorded.

Are services well-led?

Good

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

The trusts vision was to offer a caring, compassionate and committed service. The trust values were:

- Putting the needs of others first.
- Acting with compassion and care at all times.
- Continuously seeking improvement.
- Aspiring to excellence.
- Valuing each other and teamwork.

Staff understood the visions and values of the trust. It was evident from conversations that we had with staff, patients and their family members that the trust values were integrated into how care was delivered. One member of staff said, we believe in ensuring patients reach their potential. A manager said staff tended to go over and above what was expected and they were very passionate about the care they delivered.

Some senior managers had visited the service and each location reported that they had a good relationship with their care group director. Staff at Four Winds said they felt part of the trust in the sense that the trust communicated with them via emails. They said they worked closely with Townend Court. Staff at Four Winds said they felt a little isolated and they were not aware of any visits from board members.

Good governance

Staff we spoke with told us that whilst they had administration tasks to carry out the majority of their time was spent working with patients.

Staff received adequate training, appraisals and supervisions. We saw a clearly set out supervision structure, detailing each member of staffs direct report. There was a calendar showing staff appraisals and supervision dates.

We reviewed the risk register for each of the services and found concerns raised during the inspection were on the risk register. These included the premises at Victoria House, children's community team for learning disability and the waiting list across all of the services. The trust had originally rated the waiting lists as severe this had recently been downgraded to medium. One of the service managers said they did not necessarily agree with this and thought the trust had downgraded it due to the effective way each location was managing the waiting lists.

At the time of our inspection, there were no key performance measures in place across the community teams for learning disability.

Managers told us that generally they had sufficient authority to make decisions about the service they managed. However, whilst the manager of each service held their own recruitment budget a manager said that due to the recruitment authorisation procedure this could mean in some cases it could be up to four months before a member of staff was replaced. The procedure was that the manager of the service submitted a request to human resources, which was loaded onto the system. This then went to the finance department for approval, then to the care group director and then the director of operations. This process to approve could take on average three weeks then the vacancy would go out to advertisement.

Leadership, morale and staff engagement

Sickness rates were low across the community teams for learning disability. The biggest challenge was covering maternity leave and a high number of staff retiring with more due to retire. Managers told us that whilst the trust were actively trying to recruit staff this was proving difficult. An example we were given was an advertisement for a physiotherapist had been placed four times in the previous six months without success.

Most staff told us they had not been subject to or been aware of any bullying or harassment. However, some staff said there had been some instances of bullying, which they felt that until recently, managers had dealt with allegations adequately. Staff said they were happy managers were now following the correct processes. We were aware that the trust had investigated allegations of bullying and harassment, and that they took them seriously. We were told that staff would now be happy to follow the whistle-blowing procedure without any concerns they would be victimised.

Staff had mixed views on morale. Most staff said they thought there was excellent team working and felt supported by members of their team and local managers.

Are services well-led?

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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.

All the staff we spoke with said the waiting lists caused them concern although they never felt pressurised to take on a larger caseload All staff said they loved their job and felt a great deal of satisfaction.

Commitment to quality improvement and innovation

The trust had supplied iPads to patients to assist and enable communication. Patient's care plans were created on their iPads, which meant patients could be fully involved in the creation of their care plans. Software had been loaded onto each iPad in the most suitable format for the patient.

The community team for learning disability Speech and Language Therapy Team, jointly won The Care Team Award for their work as communication champions, promoting and developing communication with people with a severe and profound learning disability at the Great British Care Awards in November 2015.

The trust have a children and learning disability service transformation plan, the care groups transformation programme which will reflect;

- National policy direction
- Changing commissioning footprints and specifications
- The needs of those who access services
- Emerging best practice and innovation
- Pathways which seek to integrate health, social care, education and housing
- Better use of technology

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were insufficient staff to reduce the number of patients on the waiting lists across all the community teams for learning disability. 18 (1)