Tees, Esk and Wear Valleys NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires Improvement**
Are services responsive to people’s needs?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Wards for people with a learning disability or autism

Inadequate ● ↓↓

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support

Staff did not support some people to have the maximum possible choice, control, and independence over their own lives. Most people were being nursed in long term segregation and some people had very limited interaction with staff.

Staff were using high levels of restrictive practice including seclusion, restraint and rapid tranquilisation for some people. Restrictive practice was not always recorded, and staff did not learn from those incidents to reduce the levels or restrictions in place for some people.

Staff did not always support every person to make decisions following best practice in decision-making. Staff relied on some people asking to go on leave or take part in activities, with limited encouragement from staff.

Right care

The service did not always have enough appropriately skilled staff to meet people's needs and keep them safe. The wards at Lanchester Road regularly fell below the required number of staff. There were also two people who were cared for with an agreed agency staff team which had been contracted by the Clinical Commissioning Group. This arrangement was supported by core staff members from the trust.

People did not always receive kind and compassionate care and staff did not always understand and respond to their individual needs. Staff did not always understand how to protect people from poor care and abuse and three people at Lanchester Road had been injured during restraints.

People's care, treatment and support plans did not always reflect their range of needs and promote their wellbeing and enjoyment of life. Several support plans had not been updated and were not always readily available to staff. Staff did not always encourage and enable people to take positive risks.

Several people did not receive care that supported their needs and aspirations, that was focused on their quality of life, and followed best practice. Most people had stayed in hospital for too long as there was limited access to appropriate community provision.

Right culture

People did not always lead inclusive and empowered lives. Management had failed to effectively respond to significant concerns at Lanchester Road and there was a culture of fear among staff.

Our findings

People were not always supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities that people with a learning disability and/or autistic people may have. This meant that some people did not receive compassionate and empowering care that was tailored to their needs.

Staff sickness was high at 15% and some staff at Lanchester road told us they were leaving or considering leaving which meant that people did not always receive consistent care from staff who knew them well.

SUMMARY

Our rating of this service went down. We rated it as inadequate because:

- The service did not meet all the principles of 'Right support, right care and right culture'.
- People were not always protected from abuse and poor care. The service at Lanchester Road did not have sufficient, appropriately skilled staff to meet people's needs and keep them safe. There were high levels of vacancies and sickness with managers and members of multi-disciplinary team often falling into numbers for each shift. Two people were cared for by a full core agency staff team due to absence of an appropriate alternative in-patient provision.
- Three people had been injured during restraints at Lanchester Road Hospital and 32 incidents of injury were reported for health care assistants with some requiring treatment.
- Staff did not receive the right training to ensure that they had the skills and knowledge to meet people's needs. Training in learning disabilities, autism and alternative communication methods was not mandatory for non registered staff and a low proportion of staff had completed training in these areas. Several mandatory training courses and overall rates of supervision and appraisals fell below the trust target.
- People were not always supported to be independent and have control over their own lives. For some people their human rights were not upheld, and they were being secluded without the appropriate safeguards in place.
- Some people did not always receive kind and compassionate care from staff. Some staff did not always protect and respect people's privacy and dignity and did not always understand each person's individual needs.
- Some people's risks were not always assessed regularly and managed safely. Some people were not always supported and involved in managing their own risks.
- For six people, staff applied restrictions which were not proportionate to the level of risk. There was no clear rationale or plans to end these restrictions. In some instances, managers had failed to recognise the restrictions and reviews were not in place to try and reduce the use of these practices.
- The use of restrictive practice including restraint, and seclusion was high for some people. There was limited evidence of learning from incidents and multi-disciplinary team discussions about how to reduce people's restrictions. One person was given regular intra-muscular injections with no clear plan to reduce this.
- Several people were staying in hospital for too long with no clear plans in place to support them to return home or move to a community setting. Staff attempted to work with services to ensure people received the right care and support, but the lack of community provision delayed this.
- Some people did not always receive care, support and treatment that met their needs and aspirations. Peoples care and treatment did not always focus on good quality of life and did not always follow best practice. Staff did not routinely use clinical and quality audits to evaluate the quality of care.
- Staff did not always understand their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

Our findings

- Leaders were not always visible and approachable. Staff at Lanchester Road did not feel respected, supported and valued by managers. Staff had raised concerns about the safety across the wards to senior managers who had failed to appropriately respond to the serious concerns. Governance processes had failed to keep people safe, protect their human rights and provide good care, support and treatment.

However,

- Some people made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- Some people's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.
- Most people and those important to them, including advocates, were actively involved in planning their care. At Bankfields court a full multidisciplinary team worked together to provide the planned care.
- People's care and support was provided in a clean, well equipped, well-furnished and well-maintained environment which mostly met people's sensory and physical needs.

Background to the inspection

Tees, Esk and Wear Valleys NHS Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 TEWV achieved foundation trust status under the NHS Act 2006.

The trust provides a range of mental health, learning disability and eating disorder services for the people living in County Durham and Darlington, the Tees Valley and most of North Yorkshire and York.

The trust provides care to adults with learning disabilities and/or autistic people at Lanchester Road Hospital and Bankfields Court in Middlesbrough.

These locations are registered to provide the following regulated activities:

- Assessment or medical treatment of persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Diagnostic and screening.

The service comprised of;

Lanchester Road

- Bek, Ramsey and Talbot wards in Durham provide 11 acute assessment and treatment inpatient beds for adults with a learning disability and/or autistic spectrum disorder. At the time of the inspection there were three people being nursed in long term segregation on the wards.
- Harland ward - was a bespoke environment which had been adapted for one person who was nursed in long term segregation.

Bankfields Court in Middlesbrough provides assessment and treatment for adults with learning disabilities who also have associated mental health problems, challenging behaviour or severe epilepsy. It contains five smaller units:

Our findings

- Unit One Bankfields Court is an assessment and treatment unit for adults with a learning disability. There was one person in long term segregation on this unit during the inspection.
- Units Three and Four Bankfields Court are assessment and treatment units for adults with learning disabilities. Unit four has five beds and unit three has three beds.

Each unit had two people on the ward at the time of the inspection with two of these people in long term segregation.

- The Flats at Bankfields Court is a six-bed inpatient assessment and treatment unit for adults with learning disabilities. There were four people on the flats during the inspection with two being cared for in long term segregation within their own flats.
- The Lodge at Bankfields Court is a single occupancy inpatient assessment and treatment unit for adults with learning disabilities. There was one person in long term segregation on this unit.
- Unit Two Bankfields is a respite/short term care learning disability service
- We did not inspect the respite at Baysdale and the Holly Unit.

The wards were last inspected in September 2019 as part of the core service inspection. The core service was rated good overall with requires improvement in safe and good in the other four domains.

CQC carried out a responsive inspection in response to information of concern and extended this to a full comprehensive inspection because of the concerns we identified. The inspection took place across both Lanchester Road and Bankfields Court over three weeks between the evening of the 29 May to 24 June 2022.

What people who use the service say

We spoke to four people while we were at Bankfields Court. Three said that they felt safe and that staff supported them to do activities. One person said the staff played games and took them for ice cream. One person showed us a roller-coaster game that they had made with a staff member and described how they used this to help express how they were feeling. One person showed us around their flat and described the music they liked to listen to. One person said that they would like more interaction with staff. We were unable to speak to people at Lanchester Road due to one person being asleep, another person being involved in an incident and two people did not want to speak to us.

We spoke to six family members. The families of people at Bankfields Court were happy with the service. Families felt supported and involved in the care and treatment and said that staff understood how to care for their loved ones. One family said that the persons quality of life had improved and that incidents had reduced. One family told us that staff had managed to cut the persons hair and get them to shower.

However, the families of people at Lanchester Road were unhappy with the care and treatment. Two families told us their loved ones had been hurt during restraints and that they were worried about the safety on the wards. They did not feel listened to or reassured by managers especially after restraints and injures. They felt that people had stayed in hospital for too long.

How we carried out this inspection

Our inspection team comprised of one head of inspection, one inspection manager, three team inspectors, and one specialist advisor. An expert by experience supported our inspection remotely.

Our findings

This inspection followed our methodology for inspecting services for people with learning disabilities and autistic people and the quality of life tool.

During our inspection, we:

- toured the care environments and observed how staff were caring for people
- received feedback from four people in the service and six carers
- interviewed 22 staff including: pharmacists, ward manager, modern matron, nurse consultant, registered nurses, clinical leads, occupational therapist, speech and language therapists, occupational therapists, psychologists, behavioural support practitioner, a specialty doctor, consultant psychiatrists and nursing assistants
- reviewed seven people's care and treatment records
- reviewed four incidents including a review of CCTV footage
- observed four meetings including handovers and a daily report out meeting
- reviewed a range of policies and procedures and documents relating to the running of the service.
- we also received feedback from three commissioners and three advocates.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Inadequate ↓

Our rating of this service went down. We rated it as inadequate.

Safe and Clean Environments

- At the time of the inspection one person had damaged the floor in his environment and was living on a concrete floor. Staff had plans to relocate the person while new flooring was fitted. Most other people were cared for on wards that were clean, well equipped, well furnished, well maintained and fit for purpose. Most people were cared for in long-term segregation and wards had been adapted for this purpose.
- Staffing pressures at Lanchester Road meant that risks could not always be mitigated.
- Staff at Bankfields Court observed ward areas to check people were safe. Most people had staff with them all the time in order to keep them safe and meet their needs.
- People were cared for in wards where staff had completed risk assessments of the environment. Suicide prevention environmental surveys and risk assessments were in place and up to date on each ward. The trust had a reducing ligatures programme in place.
- People were being cared for on wards that complied with eliminating mixed-sex accommodation guidance. Many people were nursed independently to others in long term segregation.
- People had easy access to nurse call systems and staff had easy access to alarms.

Our findings

Maintenance, cleanliness and infection control

- People were being cared for in wards that were clean and well maintained. Cleaning staff were on site during the inspection and cleaning records were comprehensive.
- Staff used personal protective equipment effectively and safely. Masks and hand gel were situated at the entrance to all wards.

Clinic rooms and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff maintained equipment and ensured that this was maintained in line with the manufacturers instructed and regularly cleaned.

Seclusion

- People were being secluded within their own ward environments and this was not recognised and recorded in line with the Mental Health Act Code of Practice. Staff told us that they locked doors during incidents. In some cases, this was in response to perceived risks rather than an actual assessed risk.
- Staff were not always recognising and recording seclusion, and so did not keep clear records when a person was secluded.
- One person was being locked in their flat area for short periods of time and staff were not recording this as seclusion. Staff described using this as an alternative to restraining the person, as they were removing themselves from the area and locking the door between themselves and the patient. Staff would stand at the locked door and encourage the person to utilise coping strategies. In response to the concerns we raised staff had started to record this seclusion in the person's care record.
- The Trust seclusion policy was under review at the time of our inspection and following our concerns being escalated about this, the trust took action to ensure this was being appropriately recorded by the time the inspection ended.

Safe staffing

Nursing Staff

- The wards at Lanchester Road hospital did not have enough nursing staff who knew the people and received basic training to keep people safe from avoidable harm. The wards were falling below safe staffing levels on a regular basis which was impacting on both staff and patient safety. Staffing data for the period of 18 April – 15 May 2022 showed that across the three wards there were 10 days out of 28 where safe staffing levels were not met across the wards. Minimum staffing levels were in place for all wards/people with senior managers and members of the multi-disciplinary team frequently made up the numbers on the wards.
- There was high use of agency staff with two people who were cared for with an agreed full agency staff team which had been contracted by the clinical commissioning group. This arrangement was supported by core staff members from the Trust.

Our findings

- Staff vacancies at Lanchester Road were high with vacancies for 30 health care assistants and 10 registered nurses. Staff sickness at Lanchester Road was higher at 15% compared to 5.8% at Bankfields Court. Services had been impacted by both short-term sickness and long-term sickness. Staff at Lanchester Road had sustained work related injuries which had impacted upon staff sickness rates.
- Some staff at Lanchester road told us they were leaving or considering leaving and the average turnover rate for both services for the last 12 months was 12% which was comparable to the overall trust rate of 13%. Staff did not want to cover bank shifts on the wards, and sometimes did not come back after working on the wards.
- On one day, three members of staff had left to attend the emergency department for five hours due to being injured whilst on shift at Lanchester Road. During this period of time members of the leadership team had supported the wards to maintain safe staffing levels.
- Managers had identified the need to have male staff on duty due to the level of risk. This was due to the number of restraints and staff injuries that had taken place. Due to staffing pressures this could not always be maintained. A large proportion of staff at Lanchester Road were female.

Medical Staff

- The service at Bankfields Court had enough daytime and night-time medical cover. A full-time psychiatrist worked at the unit as well as a full-time speciality doctor.
- The wards at Lanchester road were being covered by psychiatrists from other trust services after the permanent psychiatrist had left. Staff told us this did not provide consistency and we found that a part-time psychiatrist had been transferred to cover the wards by the time the inspection had finished.

Mandatory Training

- The mandatory training programme was not comprehensive because it did not meet the needs of people and staff in this service. Training on learning disabilities and autism was not mandatory for non-registered staff and was inconsistent across the service. We raised this with managers during the inspection and a training development programme was put in place to be completed by September 2022.
- None of the mandatory training courses were meeting the trust's 90% completion rate. It was not mandatory for all staff to attend moving and handling training.

Bankfields Court

- Positive and safe care level 2 57%
- Prevent training 70%
- Resuscitation basic life support 68%
- Incident reporting level 2 50% but equates to 1 person

Lanchester Road (Bek)

- Fire Safety - 1 Year 62%
- Fire Safety - 2 Years 62%
- Harm Minimisation 69%

Our findings

- Infection Prevention and Control - Level 2 - 1 Year 69%
- Information Governance and Data Security - 1 Year 62%
- Resuscitation - Level 2 - Adult Basic Life Support - 1 Year 54%
- Incident reporting 69%
- Positive and safe care level 2 update 63%
- Resuscitation - Level 1 - 1 Year – 0% (2people)
- Observation and engagement - 67%

Lanchester Road (Ramsey Talbot) Moving and handling 33%

- Prevent - 72%
- Rapid tranquilisation – 62%
- Basic Life Support - 67%
- Safeguarding level 3 - 64%
- Positive and safe care level 2 - 68%
- Incident reporting 33%

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff did a risk assessment of every person on admission, however we found that one person's risk assessment and safety summary was out of date. It stated the person was at risk of harm by staff due to sustaining injuries and bruising due to high levels of restraint. We were unable to see any evidence of interventions to support this within the persons care plans.
- Staff used a recognised risk assessment tool.

Management of patient risk

- People had unwarranted restrictions placed on them because the service did not always assess, monitor and manage safety well. People were being restricted due to a perceived risk rather than actual incidents. Staff at Lanchester Road did not always use effective de-escalation techniques and people and staff were not always safe. There were 3 people injured during restraints and 32 incidents of injury were reported for health care assistants with some requiring treatment.
- Staff did not always follow the policy and procedure for observations. For one person we found that care rounds were signed in advance when the person had not been seen.
- Managers did not always recognise restrictive practice and staff made decisions for people without considering best interests.

Our findings

- Some people, including those unable to make decisions for themselves, did not always have as much freedom, choice and control over their lives as possible. People were not always encouraged to take positive risks and staff relied on people asking to go on leave or to take part in activities. Staff were not proactive in supporting people to take leave from the ward or engage in activities.
- People's care records were not always up to date, and staff did not always have access to high quality clinical and care records. Two peoples' one-page profiles were out of date at Lanchester Road.
- Staff did not always have the information to support them to recognise signs when people experienced emotional distress. Some staff did not have the skills and experience to support them to minimise the need to restrict their freedom to keep them safe.
- Staff adhered to best practice in implementing a smoke-free environment.

Restrictive Practice

- Staff restricted people's freedom without clear rationale within the persons support plan and did not always document and monitor and review restrictions. All four people at Lanchester Road were nursed in long term segregation and six people at Bankfields Court. There were no clear plans in place to identify how this level of restriction could be reduced.
- One person spent long periods of time alone while staff sat behind the locked door. Staff were not reviewing and considering what could be done to reduce this restriction. Staff had not explored other options such as internet shopping to help the person. We found that this was not being appropriately recorded at the beginning of the inspection, but the recording of seclusions was in place by the end of the inspection.
- The trust had reviewed its long-term segregation policy and referred to people as being in 'single occupancy care and support' for their own benefit. The policy meant that people did not always have the appropriate safeguards in place when they were secluded or segregated.
- Between March 2022 – May 2022 there had been 42 episodes of flexi segregation, (this was a term staff used to describe when someone was locked in the environment without staff for a short period of time), 40 episodes of seclusion and 130 long term segregation recorded.
- In the last 12 months there had been a total of 2201 restraints, 1634 at Bankfields Court and 567 at Lanchester Road. There had been 3 prone, 1609 supine, 185 standing, 3 kneeling, 209 seated 33 seated pat bag, 48 escorted and 241 were categorised as other.
- Staff had not recognised the use of mechanical restraint for two people where harnesses were used for transport. At the time of the inspection the Trust Policy for mechanical restraint was in final draft status and out for consultation.
- Two people had received 165 episodes of rapid tranquilisation over a 12-month period, with 198 in total for all people in the service.
- One person did not have access to the kitchen as staff felt they may flood the area. There had not been an incident of flooding which had led to this restriction.
- One person was having the ward door locked at night and staff had not recorded this as seclusion in the person's care record.

Safeguarding

Our findings

- The core service including the respite services had made 25 safeguarding referrals over the last 3 months. In total there had been 17 made from Bankfields court and Lanchester Road. Concerns had been raised by one commissioner that some safeguarding referrals had not been received in relation to a person's injuries.
- Staff had safeguarding training up to level three which included how to recognise, and report abuse and they knew how to apply it. Staff could give examples of when safeguarding referrals had been submitted.

Medicines management

- Staff completed medicines reconciliation for new admissions.
- Staff completed ward based daily audits and routine pharmacy audits including medicines optimisation and controlled drugs.
- The trust did not have a full pharmacy clinical service and the support to the teams was limited and they did not attend the multi-disciplinary meetings. Pharmacy technicians did visit the wards to look for new items or items that need issuing.
- Physical health monitoring was taking place in line with guidance from the National Institute of Health and Care Excellence. Bankfields Court employed a general practitioner who took the lead with this and ensured physical health monitoring took place and was recorded.
- The trust provided data which showed that one person received medication by intra-muscular injection 124 times between 7 November 2021 and 31 May 2022. Staff told us the person associated the use of intra-muscular medication with the end of an incident. There were no plans in place at the time of our inspection to review or reduce the reliance on the use of intra-muscular medication or consider less restrictive options. After we raised this issue with the trust, staff had started to review the use of intramuscular medication for this person. The trust was also seeking advice and support from another NHS trust to review and develop less restrictive interventions.

Track record on safety

- The service did not have a good track record for safety. There had been three serious incidents reported at Lanchester Road in May 2022. One person had sustained a broken arm and the second had facial injuries and damaged teeth resulting from a restraint. A further incident prior to the inspection resulted in another person sustaining an injury during a restraint.

Reporting incidents and learning from when things go wrong

- Three people and several staff had been injured during restraints at Lanchester Road. There was limited learning from these incidents.
- Restrictions at Bankfields Court were not always recognised, recorded and reviewed to reduce them.
- Staff told us that restraints were not always reviewed to support learning as part of the trust's restrictive intervention reduction programme. There was no evidence of learning from these incidents to prevent or reduce the number of injuries to staff.
- Learning from incidents was limited and failed to explore what could have been done differently. One person had absconded while out on leave with staff in October 2021. The person was refusing leave and staff were not looking at what could be done to support the person to start utilising leave again.

Our findings

Is the service effective?

Inadequate ⬇⬇

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

- Most people had a comprehensive assessment of their physical and mental health either on admission or soon after.
- One person did not have a health action plan and hospital passports completed on admission. These were completed four months after admission.
- People did not always have current positive behavioural support plans in place. Members of the multi-disciplinary team at Lanchester Road reported that due to staffing they had been unable to implement plans.
- People had a range of support plans in place and it was difficult to establish which was the current up to date plan. People had delays in the completion care plans with one person waiting 16 months after admission and another person waiting four months after admission. One person had an interim plan in place.
- Care plans did not always evidence the specific treatment and interventions being provided to reduce the level of restriction and increase the skills or independence of people using the service. For some people the active support and interaction between staff and people in the service was limited due to the use of segregation and seclusion.
- During the inspection we wrote to the trust with immediate concerns and found that plans had been updated by the end of the inspection.
- People had food and fluid charts in place due to physical health issues. Assessments had identified issues relating to weight, allergies, medication and bowel problems. However, none of the staff could explain what the expectations were for the people around their food and fluid intake. One person was taking lithium and the nurse said that could be why the fluid chart was in place but there were no care plans around how much water they should drink.
- We reviewed seven care plans and found that these had all been updated during the inspection in line with good practice.

Best Practice in treatment and care

- People did not always have access to a range of suitable care and treatment interventions to meet their needs. People at Lanchester Road did not always have access to occupational therapy, and one person had waited several months for a sensory assessment.
- Members of the multi-disciplinary team at Lanchester Road often dropped into the ward numbers which limited the specific interventions that they could deliver.
- Staff did not always understand people’s needs for food and drink and for specialist nutrition and hydration.

During observations on the inspection, we found staff were overly restrictive with some people at Bankfields Court.

Our findings

- One person had an incentive plan in place whereby, they could access more of their own money over the month and have access to the kitchen area for 'good behaviour, not assaulting staff and being compliant with medication'. We saw evidence of the incident which had led to the kitchen being closed and there was evidence of a multi-disciplinary discussion taking place around removing this restriction.
- For one person staff had recorded care rounds in advance and the person had not been physically seen during the night. In response to the issues we raised the trust issued a safety alert to staff about the importance of completing care rounds in line with trust policy. The person's door was locked at night at their request and could be opened from the inside at all times. However, this was not recorded within the persons care plans. Staff had started to review the person's care plan by the end of the inspection.
- Some people were supported with their physical health and encouraged to live healthier lives. All patients had access to a mini-bus and most went out in the community daily.
- Some patients found it difficult to leave the hospital and staff had developed social stories to support people to feel more confident in going into the community. One person had a gazebo in the garden area where they sat for drinks and fresh air.
- There was some evidence of patients having hobbies such as artwork cooking and gardening.

Skilled staff to deliver care

- Staff had not received relevant and good quality training in evidence-based practice.
- Staff supervision rates were low at 13% at Lanchester Road and 39% at Bankfields Court. At Lanchester Road the Ward Manager had been off work for several months prior to our inspection. However, during the inspection an interim ward manager started working on the ward. Two nurses said that they had received an initial supervision by the end of the inspection.
- The percentage of staff that had had an appraisal in the last 12 months was 60% at Lanchester Road and 84% at Bankfields Court.
- Mangers had introduced a development programme at Lanchester Road in response to the concerns we raised. The programme had three stages and stage three of the development plan was to run a number of two-hour workshops with staff around incident management, behaviours that challenge, physical restraint and post incident. The plan was ambitious and staffing pressures would restrict staff being able to attend this training.
- New staff at Lanchester Road reported that they were not always prepared for working on the wards in terms of understanding the needs of people and the level of incidents. Staff did not always have a comprehensive induction.

Multi-disciplinary and interagency teamwork

- Staff at Lanchester Road did not have access to a full multi-disciplinary team. The consultant psychiatrist had left, and people were supported by psychiatrists from others teams within the trust. There was one part time psychologists and no occupational therapist. We observed nurses asking for assistance from the multi-disciplinary team during the morning meeting we attended and observed frustration with the lack of support. By the end of the inspection period, members of the multi-disciplinary team were helping staff to devise a plan around a person’s head banging and other harmful behaviours.
- Positive behavioural practitioners had been employed by the trust. Their role was to develop positive behavioural support plans for people, but nursing staff said that they were not involved in these developments which were written in isolation. Staff felt that there was a disconnect between the staff responsible for developing plans and the staff that supported people on the wards daily.

Our findings

- Staff at Bankfields Court had access to a full multi-disciplinary team and staff said they felt supported. During the inspection a half-day session had taken place to strengthen and continue development into a more holistic team rather than medical focused. During the inspection members of the team had started spending more time on the floor to encourage staff to get more involved.
- One person at Lanchester Road had waited several months for a sensory assessment. Staff told us that this was provided by the local authority as the trust did not have a dedicated person within the service to offer this assessment. The Trust had arranged for a sensory assessment to be completed as a matter of priority.
- Staff shared information through handover meetings and daily report out meetings took place. Weekly staff support session took place at Bankfields Court and staff said that these were helpful. In response to the concerns we raised a staff support session had taken place at Lanchester Road.
- **Adherence to the Mental Health Act and the Mental Health Act Code of Practice.**
- Staff did not always have a good understanding of the Mental Health Act, its code of practice and the guiding principles. Staff were not recognising restrictive practice and people did not always have the relevant safeguards in place. Staff had received level one and level two Mental Health Act training.
- Staff had access to administrative support and legal advice on implementation of the Mental Health Act through a central Mental Health Act office and administrators. The trust had relevant policies and procedures that reflected the most recent guidance and staff could access these easily.
- People had their rights under the Mental Health Act explained regularly in a way they could understand and had easy access to independent mental health advocates.
- People's records contained copies of detention papers, consent to treatment documentation and Section 17 leave forms (permission to leave hospital) which were up to date and reflected their care and treatment.
- Staff did not always take effective measures to support people to take Section 17 leave when this had been granted.

Good practice in applying the Mental Capacity Act

- Staff had received training on the Mental Capacity Act but did not always apply this to their work. Staff understanding varied of the Mental Capacity Act and its five statutory principles.
- Staff did not always support people to make decisions on their care for themselves. Staff were making decisions for people and not always recording that they had assessed and recorded capacity.
- People had access to Independent Mental Capacity Advocates to help them if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.
- People's freedom was overly restricted as most people were being nursed in long term segregation.

Is the service caring?

Requires Improvement ↓

Our rating of caring went down. We rated it as requires improvement.

Involvement in Care

Our findings

- Some staff did not always treat people with compassion and kindness. One person at Lanchester road had an independent review of their care that identified that staff did not always act well towards the person. Some staff had not been considerate to a family after the person had sustained an injury.
- Staff did not always understand people's individual needs and did not always support them to understand and manage their care, treatment or condition**.** The staff at Lanchester Road were struggling to meet people's needs due to staffing pressures and a lack of support from the multi-disciplinary team and senior managers.
- Most people at Bankfields Court were supported positively and warmly by staff that knew them and their individual needs well. Staff were kind and compassionate and they were committed and enthusiastic about their work with people.
- One person had been supported to create a visual roller-coaster to help them communicate daily emotions with staff and express how they were feeling.
- Most people at Bankfields Court were supported to go on leave and we saw examples of people going for walks, bike rides, visits to the seaside, and for ice creams.
- Some people and their families told us that staff supported them to understand and manage their care and treatment, do things that they enjoyed and to plan for their future.
- People preferred to be supported by regular staff that knew them and their needs well rather than bank or agency staff that they were not as familiar with.
- Staff did not always involve people in care planning and risk assessment. Staff at Lanchester Road did not always have the time to understand and develop a rapport with people.
- People and families were supported to provide feedback and in the last 12 months the service had received a total of 62 surveys, 39 from patients 23 from carers. During the reporting period there were 72 comments received from patients and carers, of these 34 were positive and 26 were negative, of the negative comments received eight were categorised as "care and treatment", 10 as "environment" and five as "feeling safe".
- Some people were enabled to make choices for themselves. One person had an app on their phone to monitor food intake and staff supported people to communicate in a way that they preferred.
- People were supported to access independent, good quality advocacy.

Involvement of carers

- Four carers from Bankfields Court told us that they felt fully involved in the person's care. One carer said that they had worked with staff to reduce the number of incidents that took place and they felt that staff had listened to the family's views.
- Families at Lanchester Road did not always feel listened to and fully involved.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

Access and Discharge

Our findings

Bed Management

- The service was closed to new admissions at the time of the inspection and there had been no recent admissions. Two people had bespoke packages of care with staff teams provided by an agency outside of the trust who were supported by core members of trust staff.
- Most wards had been reconfigured to provide single occupancy units and most people were in long term segregation.
- Two people at Lanchester Road were staying in the service from outside the area. This meant that it was more difficult for them to maintain their connections to their local communities and made it more difficult when preparing for leaving hospital. There were examples where it was more difficult for hospital and community staff to work during transition and less opportunity for people to visit and spend time in the places they were moving to after their discharge.

Discharge and transfers of care

- Most people had stayed in the hospital for longer than they needed. Staff had been unable to discharge people due to a lack of suitable community placements. The service recognised that some people were experiencing delayed transfers of care and system partners were taking actions to address this.
- One person had been in hospital for four years at Lanchester Road and a person at Bankfields Court had been in the service for ten years.
- Most people were staying in long-term segregation because staff had assessed this as being the most suitable option to meet their needs. While these people were waiting for the right care and support to be built in the community, they were staying in hospital for longer than needed and they were being segregated from other people. This was not in line with the principles of Right Care, Right Support and Right Culture, and for some it was having a negative effect on their quality of life.

Facilities that promote comfort, dignity and privacy

- People had their own bedrooms and were not expected to sleep in bays or dormitories and had access to their own en-suites. There were quiet areas for privacy and most people were cared for in their own environments.
- People had single occupancy of either a full or half a ward each. Within this space they each had a bedroom with en-suite toilet and shower, one or more lounges/activity rooms, a dining area, an outdoor area and access to a kitchen. Rooms were customised to the needs of each individual patient in respect of furnishing and other contents, in line with the reasonable adjustments for people with learning disability or autism requirements of the Equality Act 2010.
- The food was of good quality and most people could make hot drinks and snacks at any time. However, two people had restricted access to their kitchens.
- The service had quiet areas and a room where people could meet visitors in private.
- Most people had access to their own mobile phones and could make phone calls in private.
- People had an outside space that they could access. For two people we found that this was locked, and they had to ask staff if they wanted access.

Patients' engagement with the wider community

Our findings

- Some people had access to activities of their choice and where possible people accessed community activities that were meaningful and recovery oriented. Staff supported people with family relationships and community activities outside the service, such as work, education and family relationships.
- Two people who were living away from their local area were able to stay in regular contact with family who visited regularly, and one person had been out on family holidays and day trips and was able to visit home.
- Some people from Bankfields took part in their chosen social and leisure activities on a regular basis. People went to the local leisure centre, gardening centre and beach.
- For one person staff had created an outside area with a gazebo to help encourage the person to go outside more often.
- All people had access to a mini-bus and most went out in the community daily.
- Some people received person-centred support with self-care and everyday living skills. We saw two people being supported to have their hair cut and washed during the inspection.

Meeting the needs of all people who use the service

- Wards were accessible for people with a disability and most people had information available in an accessible format.
- Some people were not being supported to reach their goals and aspirations and, in some instances, aspirations were not known. Staff were not always using person-centred tools and approaches to help people reach their goals and aspirations.
- Some people at Bankfields Court were being supported with learning everyday living skills, and staff had managed to get one person to shower and have their hair cut. The persons carer described this as significant progress since coming into the hospital.
- Staff had been creative with notice boards in one person's environment and had designed staff information boards which reflected the persons interests.
- Staff identified people's preferences and appropriate staff were available to support people. This was reflected in the variations across different people's environments. While some people's environments were personalised, others had minimal furniture and belongings to support the person's needs.
- Where assessed as needed weighted blankets and sensory chairs were used to meet people's sensory needs.

Listening to and learning from concerns and complaints

- People and those important to them could raise concerns and complaints easily, and staff supported them to do so. The service clearly displayed information about how to raise a concern in areas used by people.
- We spoke to six family members who all said they knew how to make a complaint. Two of the six said that they were still awaiting a response to the concerns they had raised.
- The trust had failed to treat concerns and complaints seriously at Lanchester Road and lessons had not been learnt from incidents. One family reported that they felt victimised for raising significant concerns with the trust and outside agencies. They felt that the relationship with staff had become fragmented since they had formally raised concerns.
- There had been no formal complaints at Bankfields Court in the previous 12 months. Managers were dealing with concerns at a local level.

Our findings

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

- Some leaders did not have the skills, knowledge and experience to perform their roles. There was a lack of leadership at Lanchester Road hospital and managers did not have a clear understanding of people's needs. There was limited oversight of the issues and concerns in relation to the people and staff on the wards.
- There was a blame culture at Lanchester Road with staff not feeling valued and listened to. Staff felt that managers had not acted upon the significant concerns they were raising.
- We received mixed feedback about the visibility and approach of managers. Staff at Bankfields Court felt supported by managers who visited often while staff at Lanchester Road described senior managers as punitive.
- Managers at Bankfields Court were unaware or did not recognise the restrictive practice being used with some people. There was a lack of oversight by management in relation to the updating of documentation and observations. The ward manager was unable to describe the risks within the service without referring to the risk register.
- Staff at Lanchester Road told us they didn't feel supported by senior managers and felt there was a blame culture by management within the service. They said that they were often put into unsafe situations due to staffing and not having a core team staff to support interventions. Staff had resulted in whistleblowing to CQC as they did not feel that senior managers were taking the concerns seriously.
- The process to escalate concerns about poor practice and abuse by agency staff were unclear. We did not see that appropriate steps had taken place to prevent the staff from working in other services.

Vision and Strategy

- Although the trust had a vision for the direction of the service this was not fully understood by all staff. Events had taken place in Autumn 2021 to develop a programme to look at the provision of inpatient learning disability services. There was limited evidence of the impact of this programme.
- There was a lack of ambition among staff and managers to support people to achieve the best outcomes possible.
- During the inspection, managers did accept the feedback in a constructive way. During the inspection the trust had accepted the offer from another trust to help them develop and challenge working practices on the wards.

Culture

- Staff at Lanchester Road did not feel respected, supported and valued. Staff had raised safety issues with managers and had not felt listened to. They felt that managers had failed to respond to the concerns around the safety of staff and the people they were caring for.
- Staff at Lanchester Road did not always feel respected, supported and valued by senior staff. There appeared to be a blame culture which had left some staff feeling fearful. The staff survey 2021 showed that 42% of staff at Lanchester Road felt unable to speak out and 83% were looking to leave the trust.

Our findings

- Managers did not always set a culture that valued reflection, learning and improvement. Managers at Lanchester Road had not responded effectively to the issues being raised by staff.
- Staff at Bankfields Court felt supported by managers. They reported that managers took staff wellbeing seriously and wellbeing champions worked at the service and wellbeing baskets were available to staff.

Governance

- Governance processes were not effective and to keep people safe, protect their rights and provide good quality care and support. Systems and processes had failed to address the significant staffing issues at Lanchester Road. Senior managers were not able to easily show how many shifts had fallen below staffing requirements and the rotas were difficult to read.
- There was a lack of positive risk taking to reduce restrictions and long-term segregation for several people and multidisciplinary team reviews did not challenge this.
- The systems had not ensured that restrictive interventions had been sufficiently reviewed and monitored. There were high levels of restrictive interventions across both sites. Managers at Bankfields Court had failed to recognise some restrictive practices.
- There were differences in the governance systems across the two sites who had only recently come together under the same senior leadership.
- Staff did not always use clinical audit, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care.
- The management of records and recordings of surveillance ensured they were protected and stored safely.

Management of risk, issues and performance

- The service had been closed to admissions since January 2022. Managers submitted daily staffing figures to show if the wards were safe and twice weekly meetings took place to review safety issues and staffing.
- The risk register was an overall register for the inpatient learning disability services with individual site risks specified. The manager from Bankfields Court was unable to describe what was on the unit risk register. Risk registers contained staffing, bed availability, staff safety and skill mix in terms of appropriately trained staff and male to female ratios. The risk register did not contain the issues we highlighted during inspection such as restrictive practice, and the lack of a multi-disciplinary team at Lanchester Road.
- Senior staff had failed to respond to the risk and issues identified at Lanchester Road and so appropriate safeguards and plans had not been put in place.

Information Management

- Systems used to collect data from wards were not always effective. Where data was collected this was sometimes difficult to interpret and could not be used to effectively make changes to improve the safety and quality of care.
- Staff had access to the equipment and information technology to do their work. Systems were accessible to staff. Information governance systems included confidentiality of patient records.
- Managers at Lanchester Road did not have access to good staffing data as there were different staff rotas for each ward with staff were often shared across the wards. Therefore, it was difficult to identify the actual staff shortages for management information.

Our findings

- Staff made notifications to external bodies when required.

Engagement

- Staff had not engaged well with families of people at Lanchester Road and relationships were fragmented after people had been injured.
- Some people and those important to them worked with managers from Bankfields Court to develop and improve the service.
- The service did not always work well with local commissioners to ensure the smooth transition of people back into the community. The transforming care agenda was limited in this area.
- The service worked in partnership with advocacy organisations and other health and social care organisations, which helped to give people using the service a voice to improve their health and life outcomes.

Learning, continuous improvement and innovation

- The provider did not keep up to date with national policy to inform improvements to the service. The provider had not implemented the principles of 'Right support, right care and right culture'.
- Rapid improvement workshops had taken place for the trust which had evolved into an inpatient design event to look at environments

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with four legal requirements. This action related to wards for people with a learning disability or autism services.

- The service must ensure that there are sufficient suitably qualified, competent, skilled and experienced staff deployed. Staff must have received appropriate training, supervision and support to enable them to have the skills and knowledge to meet the needs of people with learning disabilities and/or autistic people. (Regulation 18 (1) (2)(a) Staffing).
- The service must ensure that people's care and treatment is designed and delivered in a way that meets their individual needs. The trust must ensure that plans are in place to reduce the routine use of intramuscular medication to control people's behaviour. (Regulation 9 (2) (b) Person Centred Care).
- The trust must ensure that effective governance systems and processes are in place to keep people safe and meet their individual needs. Managers must ensure that there is learning from incidents. (Reg 17 (2) (b) Good Governance)
- The service must ensure that restrictions imposed on people's freedoms are only in place when these are necessary and proportionate. Staff must record and ensure safeguards are in place for all episodes of seclusion and segregation. (Reg 12 (2) (b) Safe Care and Treatment)

Our inspection team

Our inspection team comprised of one head of inspection, one inspection manager, three team inspectors, and one specialist advisor. An expert by experience supported our inspection remotely.

This inspection followed our methodology for inspecting services for people with learning disabilities and autistic people and the quality of life tool.

During our inspection, we:

- toured the care environments and observed how staff were caring for people
- received feedback from four people in the service and six carers
- interviewed 22 staff including: pharmacists, ward manager, modern matron, nurse consultant, registered nurses, clinical leads, occupational therapist, speech and language therapists, occupational therapists, psychologists, behavioural support practitioner, a specialty doctor, consultant psychiatrists and nursing assistants
- reviewed seven people's care and treatment records
- reviewed four incidents including a review of CCTV footage
- observed four meetings including handovers and a daily report out meeting
- reviewed a range of policies and procedures and documents relating to the running of the service.
- we also received feedback from three commissioners and three advocates.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment