CQC report into Adult Learning Disabilities Inpatient Services across Durham Tees Valley and Plan for Improvement Work

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- Adult Learning Disabilities inpatient services are provided from two sites in Durham Tees Valley
  - Bankfields Court in Middlesbrough
  - Lanchester Road Hospital in Durham
- At the time of the inspection there were 14 patients across both sites – 4 at Lanchester Road and 10 at Bankfields Court
- There are now 2 patients at Lanchester Road and 9 at Bankfields Court
- The service is commissioned to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury
- These slides summarise the CQC report and the findings
- We also describe the improvement journey we have started since inspection and our next steps

NB- Decision had been taken in January 2022 to close to new admissions in light of emerging concerns

Quality Governance Team

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Wards for people with a learning disability or autism

Date of inspection visit: 29-30 May 2022 7-8 June 2022 22-23 June 2022
Date of publication: 05/10/2022

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

INS2-13240232681

Background

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- The inspection took place across both Lanchester Road and Bankfields Court ALD inpatient wards over three weeks between the evening of the **29 May to 24 June 2022**.

- The CQC carried out a responsive inspection in response to information of concern and extended this to a full comprehensive inspection because of the concerns the CQC identified.

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

What people who use the service reported during the inspection

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- The CQC spoke to 4 patients at Bankfields Court.
  - 3 said that they felt safe and that staff supported them to do activities.
  - 1 person said the staff played games and took them for ice cream.
  - 1 person showed the CQC 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.
  - 1 person showed the CQC around their flat and described the music they liked to listen to.
  - 1 person said that they would like more interaction with staff.
- The CQC were unable to speak to people at Lanchester Road due to 1 person being asleep, another person being involved in an incident and 2 people did not want to speak to them.
- The CQC spoke to 6 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. 1 family said that the person's quality of life had improved and that incidents had reduced. 1 family told the CQC that staff had managed to cut the person's hair and get them to shower.
- However, the families of people at Lanchester Road were unhappy with the care and treatment. 2 families told the CQC that 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.

Summary

- The rating for the service went down to **inadequate** due to:
  - 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. 2 people were cared for by a full core agency staff team due to absence of an appropriate alternative in-patient provision.
  - 3 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.

Summary

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- The rating for the service went down to **inadequate** due to:

  - For 6 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.
  - 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.

Summary

Areas of good practice included:

- 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.

Post-inspection

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On back of the CQC inspection and subsequent findings, the Trust commissioned an independent review by Mersey Care NHS Foundation Trust – a recognised expert in the field

This took place May and June and key findings were shared, which are summarised below:

Patient Care

- A number of individuals are admitted because there is no viable alternative, not because they met criteria for the service, therefore…….
- Clinical model not working effectively within context of wider system.
- Appropriate internal and external escalation
- Default to single occupancy which while helping maintain safety can restrict opportunities for growth and creates additional staffing pressures
- Care planning sophisticated but difficult to implement consistently
- Evidence of structured activity and community engagement but could do more

Culture

- The culture is positive and person centred
- Staff caring and treated service users with dignity and respect
- Some staff perceive a 'blame' culture
- Recognition of the plan including staff engagement, wellbeing support and support from FTSU
- More visible clinical leadership is required

Staffing

- Staffing pressures across the board
- Over reliance on agency
- Lack of dedicated MDT at LRH, sense of needing more hands on leadership
- Progress at that time around strengthened MDT and daily collective decision making. Guidance offered on how to take forward Least restrictive practice approach
- Immediate training plan implemented

Must do actions

1. 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)**
2. 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)**
3. 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)**
4. 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)**

Must do action - Workforce

- We are building on the strengths recognised in the report – where care was positive and person centred, delivered by staff who treated service users with dignity and respect.
- We have developed an improvement plan which includes staff engagement, wellbeing support and support from Freedom To Speak Up Guardian.
- At Lanchester Road, the staffing skill mix, MDT, and staffing gender ratios have been reviewed and developed for each ward.
- The Board have approved new rostered levels of staffing and new roles and this has informed the recruitment plan.
- SafeCare staffing module has been fully embedded and daily meetings take place to review staffing numbers and skill mix.
- Targeted work has been undertaken with agency staff to ensure robust induction and training in relation to the individual patient's care needs
- We are working with the Trust's Recruitment Team to develop and implement targeted recruitment campaigns for all professions
- Proactively working with colleagues in HR to develop retention schemes for staff in ALD services.
- A bespoke training plan for the service has been developed and is being implemented. This includes training in effective handovers; reducing restrictive practice; positive and safe workshops; practice leadership sessions; HOPE(s) awareness; Barrier to Change training

The above actions will ensure that people's care and treatment is designed and delivered in a way that meets their individual needs, resulting in a reduction of restrictive practices, including the routine use of intramuscular medication.

Must do action – Care and Treatment

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- An independent review has been undertaken by Mersey Care NHS Foundation Trust and their recommendations are included in the overarching service improvement plan.
- All patients in long term segregation have a 'barriers to change' checklist in place to address the range of and opportunity for meaningful activities and intervention targets are monitored weekly and monthly.
- NHSE, Local Authorities and Commissioners participate in a weekly focus group to expedite delayed discharges.
- Full review of the existing and proposed clinical model which includes learning and best practice from other secondary learning disability inpatient providers across England.
- Specialist clinical lead practitioners from Mersey Care are working with the inpatient teams to support complex individuals and develop the culture and clinical model
- Engaging with the Challenging Behaviour Foundation to explore learning opportunities
- Additional Positive Behavioural Support resource is now allocated, and a full team will be recruited to support ALD inpatients.

The above actions will ensure that people's care and treatment is designed and delivered in a way that meets their individual needs, resulting in a reduction of restrictive practices, including the routine use of intramuscular medication to control people's behaviour.

Must do action - Governance

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- ALD inpatient services provide monthly reports through the new governance processes that closely scrutinise and monitors patient safety and clinical quality across the service.
- ALD-specific post incident rapid review guidance has been developed and implemented to support rapid reflection and learning.
- An enhanced Quality Assurance framework has been implemented which includes proactive review of CCTV footage, pharmacy/clinical review, and peer reviews incorporating review of restrictive practice logs and restrictions. This is to provide immediate oversight and assurance.
- The MDT are integrating the and Safe Dashboard to review and inform individualised care and treatment plans and ensure we minimise the use of restrictive interventions. There are monthly and/or weekly checks by the MDT and/or the Positive and Safe Nurse, depending on the individual patient.

The above actions will ensure that effective governance systems and processes are in place to keep people safe and meet their individual needs. Managers will ensure that there is learning from incidents. This will support improved outcomes for patients and staff.

Must do action – Restrictive Practice and Safeguarding

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- Senior clinicians have reviewed care plans to ensure that, where restrictions are in place for individual patients, that they are necessary, proportionate, appropriately documented, endorsed by patients' families/carers or an IMHA and regularly reviewed.
- The MDT has undertaken a Barriers to Change checklist (HOPEs) with each patient which has informed an individualised care plan describing any individual restrictions in place and aims to reduce restrictive practice.
- All patients have an individualised PBS plan with a monthly review by a PBS Practitioner.
- A Briefing Sheet and video; 'What is a Restriction?' has been developed and shared with all staff, including new starters.
- The format of daily 'report out' sessions has been reviewed with a focus on supporting least restrictive practice.
- Implemented an ALD Reducing Restrictive Practice Local Group and a Reducing Restrictive Practice Care Group which meet monthly. This allows for appropriate challenge from both internal to the service and from across other specialties.

The above actions will ensure that restrictions imposed on people's freedoms are only in place when they are necessary and proportionate with regular planned reviews, in line with HOPE(s) model. Recording of restrictions will be timely and accurate and safeguards are in place for all episodes of seclusion and segregation. This will support improved patient experience.

Key Progress

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- Strengthened voice of and engagement with staff and service users (priority for Care Group Board Lived Experience Director)
- Strengthened MDT working
- Successful discharge of one highly complex individual
- Significant progress made with a number of other individuals
- Improving staffing position……but still a challenge
- Reduced the use of restrictive practice
- Strengthened Governance
- Better oversight of standards and care delivery
- Weekly ICB level meetings to review progress
- Reviewing all community care packages
- Continuing relationship with Mersey Care, including training for front line staff and leaders – including Board members

Next Steps….

- **Continued work to strengthen workforce**
- **Strengthened efforts with wider system colleagues in finding sustainable solutions to delivering high quality care within our wider communities**