CareQuality Commission

Good

Northamptonshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Kent Close	RP1X7	LD Assessment and Treatment Unit	NN5 4XB
1 Willow Close	RP1Q9	LD Inpatient Short Breaks	NN5 6UH
The Squirrels	RP1D7	Short breaks service for children	NN10 9JT
John Greenwood Shipman Centre	RP1JG	Short breaks service for children	NN3 8UW

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

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

Summary of findings

Where applicable, we have reported on each core service provided by Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare 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 Wards for people with learning disabilities or autism	Good
Are Wards for people with learning disabilities or autism safe?	Requires Improvement
Are Wards for people with learning disabilities or autism effective?	Good
Are Wards for people with learning disabilities or autism caring?	Good
Are Wards for people with learning disabilities or autism responsive?	Good
Are Wards for people with learning disabilities or autism 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 gave an overall rating for wards for people with learning disabilities as good because:

- There were robust risk assessments and plans in place to keep patients safe.
- Staffing levels were appropriate to need.
- There was good multi-disciplinary working within the teams and between other services.
- Staff showed a good understanding of the Mental Health Act and Mental Capacity Act.
- There were effective methods for obtaining feedback from service users and carers and feedback was acted upon.
- Staff were caring and committed to providing high quality care and showed a person-centred approach.
- Staff received regular supervision and all had received an appraisal in the last 12 months.
- The local managers monitored the environment, carried out local audits and checked the performance of staff on a regular basis.

However: -

- One of the four wards visited, the learning disability assessment and treatment unit, was not fit for purpose. It was recognised there was a plan to move to an alternative site in July 2015.The trust recognised the importance of ensuring that safety was maintained at this location. This included taking measures to ensure the physical safety of patients and staff, providing sufficient training for all staff, including bank or agency staff, and ensuring on-going leadership support to the recently appointed manager.
- There was sometimes a delay when the personal alarm system was activated.
- The same medicine cards were used for each stay at the short breaks wards. This resulted in gaps in the signature section which could cause confusion.

Summary of findings

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

Are services safe?

Requires Improvement

We rated wards for people with learning disabilities as requires improvement for safe because:

- One of the four wards visited, the learning disability assessment and treatment unit, was not fit for purpose. It was recognised there was a plan to move to an alternative site in July 2015.The trust recognised the importance of ensuring that safety was maintained at this location. This included taking measures to ensure the physical safety of patients and staff, providing sufficient training for all staff, including bank or agency staff, and ensuring on-going leadership support to the recently appointed manager.
- There was sometimes a delay when the personal alarm system was activated.
- The same medicine cards were used for each stay at the short breaks wards. This resulted in gaps in the signature section which could cause confusion.

However

• Individual risk assessments and plans were in place and updated regularly.

• Staffing levels met patients' assessed needs.

• Staff were aware of the safeguarding process and used it when necessary; a review of safeguarding issues was covered as part of supervision.

• Local managers monitored the environment and reported any repairs needed, minor repairs were addressed and managers had longer term plans for major work required.

• All staff were aware of the incident reporting process and learning was shared within the teams.

• Medicines were managed well.

Are services effective?

Good

We rated wards for people with learning disabilities as good for effective because:

- There was good multi-disciplinary working within the team and with other services.
- Full assessments were carried out involving all relevant staff.
- Care plans were updated according to changing needs.

Summary of findings

- Outcome measures were used to assess effectiveness of interventions.
- Staff accessed specific training when required to meet patient need.
- Staff had a good knowledge of and application of the Mental Health Act and Mental Capacity Act.
- Patients had access to advocacy when needed.

However:

- Information about the Independent Mental Health Act (IMHA) advocacy service was not available on all the wards.

Are services caring?

Good

We rated wards for people with learning disabilities as good for caring because:

- Staff were kind and respectful to patients and recognised their individual needs.
- Staff actively involved patients in developing and reviewing their care plan and made sure that patients had access to an advocate if they needed one.
- Staff also made sure families and carers were involved when this was appropriate.

However:

- Not all wards had easy read leaflets on display for patients to access.

Are services responsive to people's needs?

Good

We rated wards for people with learning disabilities as good for responsive because:

- There was a clear pathway for admission and good liaison with community teams.
- Care plans were updated according to changing needs.
- There was responsive working with families around admission.
- Diverse needs were considered, for example special diets or cultural need.
- Staffing levels were adjusted to meet patient need.
- Feedback from patients and relatives was acted upon quickly.

Are services well-led?

Good

We rated wards for people with learning disabilities as good for well-led because:

Summary of findings

- Staff felt supported by local and senior managers. Staff felt they could raise any issues with the local manager and they would be addressed.
- There were effective human resources (HR) policies and local managers felt supported by the trust's HR department.
- Wards had been visited by members of the executive team.
- Staff told us they received regular supervision and appraisal.
- Local managers monitored the standard of care, environment and staff performance.

Summary of findings

Background to the service

- The inpatient wards for adults with a learning disability were based on two sites at Kent Close and Willow Close.
- Kent Close was an assessment and treatment ward with four beds and Willow Close provided six beds for short breaks.
- The short breaks services for children with learning disability are provided on three sites, we visited two of these sites at the Squirrels and John Greenwood Shipman Centre.
- The John Greenwood Shipman Centre for children with learning disabilities was last inspected by the CQC in October 2013. It was found to be non-compliant relating to record keeping. We found them to be compliant during this inspection.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett - Consultant Psychiatrist, Oxleas NHS Foundation Trust

Team Leader: James Mullins - - Head of Hospital Inspection (mental health) CQC

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialists and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this core service consisted of a CQC inspector, a Mental Health Act reviewer and four specialist professional advisors; a specialist nurse, psychologist, social worker, occupational therapist, and an expert by experience a person who had experience of using services like these.

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 get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

- 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 we held about these services and asked a range of other organisations for information.

We carried out an announced visit between 03 and 05 February 2015.

During the inspection visit, the inspection team:

- Visited four wards at four sites and looked at the quality of the ward environment.
- Observed how staff were caring for patients.
- Spoke with two patients who were using the service.
- We spoke with three carers.
- Spoke with the managers or acting managers for each of the wards.

Summary of findings

- Spoke with 12 other staff members; including nurses, care workers, occupational therapist and a speech therapist.
- Interviewed the service manager with responsibility for these services.
- Attended and observed one hand-over meeting.

We also:

• Looked at 13 care records of patients.

• Carried out a specific check of the medicine management on all four wards.

• Looked at a range of policies, procedures and other documents relating to the running of

the service.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

What people who use the provider's services say

- Patients said they felt safe and staff helped them when needed. They said staff were nice.
- We spoke with three relatives who told us they were very happy with the care their relative received.
- They told us staff were caring and they felt their relative was safe during their stay and felt staff responded to any changes in circumstances or condition and worked with them to address any needs.
- Family carers would recommend the service to others.

Good practice

Not applicable

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that standards of relational safety are maintained at the learning disability and assessment unit (Kent Close) until the planned move and ensure support for the new manager is ongoing during the transition to the new ward.

Action the trust SHOULD take to improve

- The trust should ensure the personal alarm system is checked for effectiveness and repaired as required to meet the safety needs of staff using them.
- The trust should ensure that new medicine cards are produced prior to each short stay admission.
- The trust should ensure that information about the Independent Mental Health Act (IMHA) advocacy service is available on all the wards.

Care Quality Commission

Northamptonshire Healthcare NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The learning disability assessment and treatment unit	The Warren, 2 Kent Close
1 Willow Close	1 Willow Close
The Squirrels	The Squirrels
John Greenwood Shipman Centre	John Greenwood Shipman Centre

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 Trust.

- The documentation in respect of the act was mostly good. Paperwork about people's detentions was up to date and stored correctly. On one ward information about the independent mental health act advocacy service was not on display on the notice board. Staff showed us two different leaflets in an easy read format. The leaflet did not contain information about the IMHA service. It also contained out of date information about the CQC. Staff did not know which information was in current use and were uncertain about the type of support the IMHA service could provide. Staff told patients about their rights and repeated this every week. The trust's systems supported the appropriate implementation of the act and its code of practice. Administrative support was available from a team within the trust. The staff carried out regular audits to ensure the act was being implemented correctly. Staff had received training and had a good understanding of the Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff knew who to contact in the trust for advice on the act and the Deprivation of Liberty Safeguards. Assessment and treatment records showed appropriate use of mental capacity assessments and best interest assessments. The MHA Act (1983) Manager provides the Governance Committee with the Mental Health Act Scrutiny Report on a periodic basis.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

The learning disability assessment and treatment unit (Kent Close), Willow Close, The Squirrels, John Greenwood Shipman Centre

Safe and clean ward environment

- The ward environments were safe and clean. There were some repairs needed on some wards and these had been reported by the manager.
- All wards had individual bedrooms with access to designated bathrooms nearby. There were easy read signs on the doors to show when in use. Staff ensured privacy and dignity when bathing patients and accompanied patients to use the toilet. No breach of single sex accommodation guidance was noted.
- Two of the four wards had designated cleaning staff; the other two wards were cleaned by nursing staff.
- The wards were well-maintained and the corridors were clear and clutter free. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. These bins were not over-filled.
- At the Squirrels the manager showed us plans for replacement flooring in the bathrooms and a member of the estates staff visited whilst we were on site.
- There were a number of repairs and/or changes to the environment planned for the Squirrels on a phased basis. This showed the trust was monitoring the environment and taking action to address any issues to keep the building safe.
- Emergency equipment, including automated external defibrillators and oxygen, was in place. It was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medicine were also checked regularly. Most staff had had training in life support techniques.
- Personal alarms were carried by staff. Some staff said there could be a delay in alarm being activated and it registering, all staff said they generally knew where everyone was and there were wall alarms available which could be pressed. There had been no serious incidents reported.
- On the learning disability assessment and treatment unit; the seclusion room did not meet the guidance in the Mental Health Act Code of Practice. This had been pointed out in a previous MHA Review report. Staff were not managing risk to one patient safely. Patients could not always go to the toilet when they wanted to. Parts of the room could not be seen from the door. The ceiling was low which meant there was only a thin mattress on the floor. The room was cold and the intercom system was not working.
- The trust has provided information about the planned move of the learning disability assessment and treatment unit to alternative premises in July 2015 that met the needs of patients more appropriately.
- The sensory equipment for the de-escalation room at the learning disability assessment and treatment unit was in storage and the room had only a sofa frame with no seat cushions and a small TV in a large box for safety.
- The trust was reviewing an incident where damage to the seclusion room meant the staff had moved a patient to another hospital with a seclusion room in a potentially unsafe manner.
- Care plans included a description of methods used to manage disturbed behaviour by de-escalation. They also indicated that seclusion was to be used as a last resort.
- The trust was reviewing an incident when a support team from another location responded to an alarm at the assessment and treatment unit and were wrongly told there was no incident and left. The incident was taking place in the de-escalation room.

Safe staffing

- We reviewed the staff rotas for the weeks prior to our inspection and saw staffing levels were in line with expected levels and skill mix. The only exception occurred in response to late notice sickness absence where replacement staff could not be found in time. The John Greenwood Shipman Centre was split into a four bedded area and a six bedded area to meet the needs of

the different patient group. Staffing was adjusted accordingly. High levels of staff vacancies on the learning disability assessment and treatment unit resulted in a significant use of temporary staff to ensure there were enough staff on each shift to maintain standards of quality and safety. At the time of the inspection a plan was in place for one ward to move to another location. Some staff had left because of the new travel requirements and recruitment to vacancies was in progress.

- The manager at Willow Close was working towards raising staffing levels and showed us the plan for this. Staffing at the time of our visit was safe and we saw the rotas for previous weeks which showed sufficient staff for the needs of the patients, including bank staff where necessary. Managers told us that they were able to obtain additional staff when the needs of patients changed and more staff were required to ensure their safety. They completed a safer staffing tool daily which was centrally monitored. We observed the wards ensured at least one qualified member of staff was on duty per shift.
- Some staff reported working long shifts lasting 13.5 hours, with the small number of patients admitted to the ward this could reduce the effectiveness of staff interventions.
- Temporary staff, who had not worked on a ward before were given a brief induction to the ward. This included orientation to the layout of the ward. There were 1.5 wte staff nurse vacancies and 3 wte healthcare assistant vacancies at the assessment and treatment unit. Recruitment to these vacancies was underway but it meant a high use of bank and agency staff. The vacancy rate for the two adult wards was 14%. Separate data for the children's wards were not available; they had been included in an overall rate for all children's services.

Assessing and managing risks to patients and staff

- Individual risk assessments had been completed for patients on the wards and had been regularly updated. Staff told us where particular risks were identified; measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients' previous history, as well as their current situation.
- The last CQC inspection of the John Greenwood Shipman Centre in October 2013, found record keeping was below the standard expected. We found the trust had taken action to address this and records were maintained to a good standard on this inspection.
- Staff had been trained in the use of physical interventions but bank staff had not always received the same level of training in the trust's "Team Work" training. This could put staff and patients at higher risk of injury.
- Staff had received training in safeguarding vulnerable adults and children and most staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. Staff provided examples of safeguarding referrals that had been made. An 'easy' guide to managing safeguarding concerns was on display and available for staff on wards as a reminder of the action to take when concerns arose. Safeguarding was discussed at ward team meetings and it was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision, to ensure staff had sufficient awareness and understanding of safeguarding procedures.
- We received information from the trust on how they will work towards reducing the use of restraint as recommended in the guidelines "Positive and Proactive Care" produced by the Department of Health in 2014. The use of restraint is monitored by the prevention and management of violence and aggression group with oversight by the quality review group.
- Appropriate arrangements were in place for the management of medicines. We reviewed the medicine administration records of several patients on each ward we visited. Wards regularly audited medicine records to ensure recording of administration was complete. When we reviewed the medicine cards at the short breaks wards some gaps were found. Staff told us the same card is used between stays hence the gaps, a recorded explanation would clarify this for staff unfamiliar with the patient and for auditing purposes. At the Warren we reviewed two medicine cards. There were gaps in signatures, dates and one card had no front sheet for identification. There were no plans in place for medicine meaning new staff would not be aware of the arrangements for giving medicine to these patients.

Requires improvement

Are services safe?

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

- Patients had individual personal evacuation plans; these explain how to move the patient in the event of a fire, some had their plan displayed on their bedroom door.
- We looked at the recording of seclusion and this was to a good standard.
- The assessment and treatment unit was a ward on its own and isolated from the nearest hospital Berrywood, when staff needed help immediately they had to ring Berrywood for a response, this could take between 5 and 15 minutes according to staff.

Track record on safety

- In the last year there had been no serious untoward incidents within this core service.

Reporting incidents and learning from when things go wrong

- The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these. Staff told us, after a serious incident, they were given the opportunity to have a formal de-brief and they could access additional counselling support if needed.
- Staff knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team, who maintained oversight.
- Ward managers told us how they maintained an overview of all incidents reported on their wards. Incidents were investigated and some managers told us they were made aware of incidents that had occurred in other areas through governance meetings. One manager gave us an example of learning from drug errors and the actions taken to address the issue.

Are services effective?

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

Summary of findings

Our findings

The learning disability assessment and treatment unit (Kent Close), Willow Close, The Squirrels, John Greenwood Shipman Centre

Assessment of needs and planning of care

• Patients' needs were assessed and care was delivered in line with their individual care plans. Records showed risks to physical health were identified and managed effectively. Where physical health concerns were identified, care plans were put in place to ensure the person's needs were met and clinical observations were made more frequently.

• Care plans were in place that addressed patients' needs. We saw these were reviewed on a regular basis and updated or discontinued as appropriate. Involvement from patients and family was included wherever possible.

- Full assessments were carried out prior to admission wherever possible with the involvement of the family and other professionals.

Best practice in treatment and care

• Patients could access psychological and occupational therapies as part of their treatment. Psychologists and occupational therapists were part of the ward team.

• The ward staff assessed patients using the Health of the Nation Outcome Scales for learning disabilities. These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. Other outcomes measures were also used to assess effectiveness of interventions.

• Some managers carried out regular audits of care records and results were fed back to the team during team meetings.

- The service took part in the learning disabilities benchmarking project in 2014.

Skilled staff to deliver care

• The staff working on the wards came from a range of professional backgrounds including nursing, medical, occupational therapy and psychology.

• Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed most staff were up-to-date with statutory and mandatory training. Bank and agency staff reported that they did not receive training to the same level as permanent staff and this could lead to inconsistency in effectiveness of care.

- New staff had a period of induction before being included in the staff numbers.
- Staff received specific training to meet patient need. For example care of someone with a tracheostomy, how to use a suction machine and caring for someone with gastrostomy. The training was competency based and helped to ensure that staff were able to deliver care to people safely and to an appropriate standard.

• All staff told us that they received clinical and managerial supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. They all had received an appraisal within the last 12 months which identified training needs and set objectives. This was supported by those records seen.

• There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about their ward.

• Ward managers were provided with support through the human resources team. We were given examples of how poor performance had been dealt with.

Multi-disciplinary and inter-agency team work

• Assessments on wards were multidisciplinary in approach. People's records showed there was effective multidisciplinary team (MDT) working taking place. Care plans included advice and input from different professionals involved in people's care. There were weekly multi-disciplinary review meetings where care was discussed and reviewed and changes made to the plan if required. We observed inter-agency work taking place, with staff attending strategy meetings, school reviews or child in need meetings when required. There was close working with the care manager in children's services for LD.

Are services effective?

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

• In the short breaks wards there were good links with community teams and access to the local doctor when needed. There was a transition process for children moving into adult services, staff worked with community teams and the care manager to ensure a smooth transition.

- The transition policy for children moving into adult services required updating following the changes to the configuration of the services.

Adherence to the MHA and MHA Code of Practice

• Staff had received training on the Mental Health Act or were booked in to attend.

• The documentation we reviewed in detained patients' files was generally compliant with the act and the code of practice. One medicine card had consent from 2005 with no record to show this had been reviewed.

• Staff were aware of the need to explain people's rights to them. Easy read format was available; however there were two versions on the Warren and staff did not know which the correct one was.

• Staff knew how to contact the MHA office for advice when needed and regular audits were carried out throughout the year to check the MHA was being applied correctly.

Good practice in applying the MCA

• Staff told had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

• Records showed consideration of mental capacity and appropriate assessment when required.

Good

Are services caring?

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

Summary of findings

Our findings

The learning disability assessment and treatment unit (Kent Close), Willow Close, The Squirrels, John Greenwood Shipman Centre

Kindness, dignity, respect and support

• We observed staff interacting with patients in a caring and compassionate way.

- Staff responded to people in distress in a calm and respectful manner. Staff appeared interested and engaged in providing good quality care to patients.

• When staff spoke with us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

The involvement of people in the care they receive

• Two patients said they were involved in their care and their relatives were given a copy of their care plan to comment on and agree or disagree. Three relatives we spoke with said they were involved in care planning.

- On some wards there was a leaflet for patients giving them information about the service in easy read format.

• Details of local advocacy services were displayed on some of the wards.

• Three of the four wards held patient meetings on a monthly basis.

• The views of patients and family using the service were gathered through the use of a survey called "I want great care". Responses to surveys were fed back to ward staff, to enable them to make changes where needed.

- Patients were asked what questions they wanted asking of candidates at recruitment interviews.
- Some of the activities and materials used were not always age appropriate for use with adults. Not all wards used alternative communication methods for people with communication difficulties.

Are services responsive to people's needs?

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

Summary of findings

Our findings

The learning disability assessment and treatment unit (Kent Close), Willow Close, The Squirrels, John Greenwood Shipman Centre

Access, discharge and bed management

• Staff in the short breaks ward worked with other professionals and family to agree the best dates for admission, taking into consideration the mix of patients at the time.

- An emergency bed was available in one of the children's ward, in the event that a child needed urgent admission. One of the relatives we spoke with said it would be helpful to have an emergency bed for adults.
- Records showed good discharge planning with involvement from family and community staff and/or the care manager.

The ward optimises recovery, comfort and dignity

- All wards offered access to a secure outside space.
- Managers told us there was a quick response when repairs were required and there was a record of requests made with date of request and date of completion.

Meeting the needs of all people who use the service

- All patient areas were on the ground floor in all wards.
- The records seen showed us that patients' individual needs were met, including cultural, language and religious needs. This was supported by those carers spoken with.
- Some staff were trained in the use of communication methods such as Makaton, there were posters displayed with a symbol of the week for staff to learn. Other staff were booked on to do the training.
- A choice of meals was available. Pictures were used to help people choose their meals.

Listening to and learning from concerns and complaints

• Staff were able to describe the complaints process and how they would handle any complaints.

- The number of formal complaints received by the service was low and ward managers could describe how they responded to feedback both positive and negative. There were no current formal complaints.

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.

Summary of findings

Our findings

The learning disability assessment and treatment unit (Kent Close), Willow Close, The Squirrels, John Greenwood Shipman Centre

Vision and values

• The trust's vision and strategies for the service were evident and on display in some wards. Staff on all wards considered they understood the vision and direction of the trust and were able to explain them.

• Ward managers said they received good support from senior managers. Members of the executive team had visited three of the four wards recently.

Good governance

• The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust. One example of this was the electronic staff record that monitored the training staff had received and informed staff and their managers when training needed to take place. The records seen showed us that most staff were up to date with their training. Additional training opportunities were booked for staff to attend.

• The ward managers told us where they had concerns, they could raise them. Where appropriate concerns were placed on the trust's risk register.

Leadership, morale and staff engagement

• We found three the wards to be well-led, with the exception of the learning disability assessment and treatment unit at Kent Close. There was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care.

• Ward staff were enthusiastic and engaged with developments on the ward. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager.

• Sickness and absence rates were 6.8% across the wards and included long term sickness. Managers explained the policy for managing attendance and gave examples of when this had been followed

• At the time of our inspection there were no grievance procedures being pursued within the wards, and there were no allegations of bullying or harassment.

• Staff were aware of the whistleblowing process and said they would if they needed to use it.

• Most ward managers told us they had access to leadership training and development. This covered the theory of management as well as scenarios and techniques that could be used in practice. Most felt supported by their immediate line manager

- The new manager had been in post for two weeks at the learning disability assessment and treatment unit and their focus had been on recruiting staff ready for the move to the new ward. There was support from the senior manager during this time. The trust should ensure this support is ongoing during the transition to the new ward.

Commitment to quality improvement and innovation

- Staff demonstrated a commitment to providing high quality care.
- Local risk registers were in place.
- Local managers monitored the quality of care provision in order to improve services for patients.
- Trust wide and local audits took place with the findings used to improve practice.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The trust must ensure that standards of relational safety are maintained at the learning disability assessment and treatment unit (Kent Close) until the planned move and ensure support for the manager is ongoing during the transition to the new ward.** The trust must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of suitable design and layout; adequate maintenance and, where applicable, the proper operation of the premises which are owned or occupied by the service provider in connection with the carrying on of the regulated activity. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation (15) (1) (a) (c) (i).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The trust must ensure that standards of relational safety are maintained at the learning disability assessment and treatment unit (Kent Close) until the planned move and ensure support for the manager is ongoing during the transition to the new ward.** Care and treatment must be provided in a safe way for service users. The service must: • assess the risks to the health and safety of service users of receiving the care or treatment.

Compliance actions

- do all that is reasonably practicable to mitigate any such risks.
- ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (a) (b) (d).