

Coventry and Warwickshire Partnership NHS Trust

Community mental health services for people with a learning disability or autism

Inspection report

Trust Headquarters, Wayside House
Wilsons Lane
Coventry
CV6 6NY
Tel: 02476362100
www.covwarkpt.nhs.uk

Date of inspection visit: 25-27 July, 7-9 August and
17 August 2023
Date of publication: 29/02/2024

Ratings

Overall rating for this service

Requires Improvement 

Are services safe?

Requires Improvement 

Are services effective?

Requires Improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Requires Improvement 

Are services well-led?

Requires Improvement 

Our findings

Community mental health services for people with a learning disability or autism

Requires Improvement  

We carried out this announced focused inspection because this core service was last inspected in 2017 and rated requires improvement for the responsive key question. The inspection was announced to the trust the day before to ensure people using the service and staff were available to speak with us.

We visited all five locations of the community learning disability teams and both adult learning disability respite services.

The community team locations inspected were:

- The North Warwickshire team based at the Loft in Nuneaton.
- The Coventry and Rugby team based at Windmill Point in Coventry and the Railings in Rugby.
- The Solihull team based at Brooklands Hospital in Solihull.
- The South Warwickshire team based at Whitnash Lodge, Leamington.

The adult learning disability respite locations inspected were:

- Ashby House in Nuneaton.
- Shirley House in Solihull.

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: Model of Care and setting that maximises people's choice, control and independence.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

Our overall rating of this service went down. We rated them as requires improvement because:

- Governance processes did not always operate effectively, and performance and risk were not always managed well. Services were not always assessed, monitored and improved in relation to the quality of people's experience.
- Not all staff kept up to date and accurate care records for all people using the service.

Our findings

- People's privacy was at risk due to the lack of soundproofing in interview rooms.
- Managers did not ensure the community teams met their referral to assessment and treatment targets or have plans in place to address this.
- While managers had systems and processes in place to monitor and manage staff absences. It was not always possible for managers to make arrangements to cover staff sickness and absence. This impacted on staff workloads and people waiting to access the service.
- Managers did not ensure all staff were up to date with basic life support training and appraisals.

However:

- People's care and support was provided in safe, clean, well equipped, well-furnished and well-maintained environments which met people's sensory and physical needs.
- People were protected from abuse and poor care. The service had sufficient, appropriately skilled staff to meet people's needs and keep them safe.
- People were supported to be independent and had control over their own lives. Their human rights were upheld.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.
- The service provided care, support and treatment from trained staff and specialists able to meet people's needs.
- People and those important to them were actively involved in planning their care. Multidisciplinary teams worked well together to provide the planned care.
- **Since our inspection the trust have told us they have made a number of further improvements.**

How we carried out the inspection

We looked at all 5 key questions: safe, effective, caring, responsive and well-led.

The inspection team consisted of 2 CQC inspectors, 2 specialist advisors and 1 expert by experience.

During the inspection visit, the inspection team:

- visited 5 community team locations and 2 respite services.
- looked at the quality of the environments and observed how staff were caring for people.
- observed 5 clinical review meetings.
- observed 5 episodes of care.
- spoke with 6 people who were using the service.
- spoke with 10 carers of people who were using the service.
- interviewed 7 managers, including team managers and one senior manager.

Our findings

- spoke with 31 other staff members; including learning disability nurses, consultants, doctors, occupational therapists, psychologists, art therapists, speech and language therapists, physiotherapists and student nurses.
- looked at 22 care and treatment records of people using the service.
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further 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>.

What people who use the service say

We spoke with 6 people using the service and 10 carers of people who were using the service. Feedback was mostly positive with people and their carers telling us staff were compassionate, kind and helpful. Carers described staff as going the extra mile and providing a life changing service. People and their carers told us that staff involved them and fitted the service around them to meet their needs. People and their carers told us that staff communication was good, and teams would ensure they communicated using the persons preferred methods. A carer at the North Warwickshire team told us staff consider the family as a whole and “as a family I don’t feel we could have asked for more.” A carer at Ashby House told us, “Staff moved heaven and earth, our family member gets so much out of her time here. Staff are incredibly responsive.”

One person supported by the Rugby team provided written feedback stating “- x (nurse) is really nice and I can speak freely to her and everyone else. My confidence has grown. “TOP BANANA!!!.”

However, one carer of a person at the North Warwickshire team told us they were “left out of the loop” after the psychiatrist left. They reported communication was not as good after the psychiatrist left.

Is the service safe?

Requires Improvement ● ↓

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

Safe and clean environment

All clinical premises where people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced risks they identified. Managers completed annual ligature risk assessments for all locations that people accessed. Managers identified and mitigated all ligature risks. Managers at Shirley House respite service were in the process of adapting a bedroom to make it safe for a person who wished to access the service that was at risk of tying ligatures.

Staff were provided with personal alarms to use in interview rooms.

Our findings

All clinic rooms had the necessary equipment for people to have thorough physical examinations. Clinic rooms at Shirley House and Ashby House were clean and tidy.

All areas were clean, well maintained, well furnished and fit for purpose.

At Shirley House there were 3 kitchens; 2 for people and 1 main food preparation kitchen where all meals were cooked from fresh. Kitchens were clean and tidy. Staff followed a 'food safety management system' to complete safety and cleanliness processes. However, we identified 4 days in July 2023 when staff had not checked the fridge and freezer temperatures.

We saw evidence of maintenance tasks being raised and actioned in a timely manner.

Staff made sure cleaning records were up-to-date and the premises were clean. Premises for the community teams visited were clean and tidy. The trust completed monthly internal cleaning audits. Over the 6 months preceding the inspection all locations visited scored an average compliance rate of over 95%.

Staff followed infection control guidelines, including handwashing.

Staff made sure equipment was well maintained, clean and in working order. Staff at Shirley House completed daily checks of emergency equipment and other medical equipment.

Safe staffing

Most locations had enough staff, who knew the people and received basic training to keep them safe from avoidable harm. The number of people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each person the time they needed.

Nursing staff

The service had enough nursing and support staff to keep people safe.

The community teams had low vacancy rates. Across all roles in the community teams there was a vacancy rate of 1% at the time of inspection. The Rugby and Coventry team had no staff vacancies at the time of inspection. The South Warwickshire team reported a vacancy rate of 10% with vacancies for unqualified staff and 'other' staff. The North Warwickshire team reported a vacancy rate of 6% with vacancies for 'other' staff. The Solihull Team reported a vacancy rate of 0.6% with vacancies for 1.3 whole time equivalent nursing staff.

The respite services had high vacancy rates with vacancies for qualified, unqualified and 'other' staff. Ashby House reported a vacancy rate of 26% and Shirley House reported a vacancy rate of 18%. Managers told us permanent staff filled some of the hours left by vacant posts.

The trust told us they had a recruitment plan in place with new staff due to start.

The service had low rates of bank and agency nurses. The community teams reported no use of agency staff for the 12 months preceding the inspection and an average of 0.1 whole time equivalent shifts filled by bank nurses each month. The respite services reported no use of agency nurses and an average of 1.8 whole time equivalent shifts filled by bank nurses each month.

Our findings

The service had low rates of bank and agency nursing assistants. The community teams reported no use of agency nursing assistants and an average of 0.6 whole time equivalent shifts filled by bank nursing assistants each month for the 12 months preceding the inspection. The respite services reported an average of 0.05 whole time equivalent shifts filled by agency nursing assistants each month and an average of 0.9 whole time equivalent shifts filled by bank nursing assistants each month for the 12 months preceding the inspection.

Managers did not always make arrangements to cover staff sickness and absence. At the South Warwickshire Team there were 4 staff on long term absence (1 speech and language therapist, 2 nurses and 1 psychiatrist). One vacant nurse role and the speech and language therapist were fully absorbed by the team, the psychiatrist role was partially covered; and 1 nurse role was awaiting bank cover. A staff member at another team told us their long term absence was not covered and work was left for them to pick up when they returned. Other staff told us people on the waiting list would not be allocated until staff members returned from long term absence.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. The trust reported a staff turnover rate of 12% for the 12 months preceding the inspection for this core service. Ashby House had the highest staff turnover rate of 22% for the 12 months preceding the inspection. Shirley House had a staff turnover rate of 20% for the 12 months preceding the inspection. Coventry and Rugby team reported a turnover rate of 13%. North Warwickshire team reported a turnover rate of 12%. South Warwickshire team reported a turnover rate of 6%. Solihull team reported no staff leavers over the 12 months preceding the inspection.

Managers supported staff who needed time off for ill health.

Sickness levels were low. Across the community teams the trust reported sickness of 4.39% from 1 July 2022 to 30 June 2023.

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. Staff across teams told us the psychiatrists were very responsive. The service consultants provided out of hours support through an on call rota.

Mandatory training

Staff mostly completed and kept up to date with their mandatory training. The trust reported a mandatory training compliance rate of 91% across all locations from 1 June 2022 to 30 June 2023. The North Warwickshire Learning Disability team reported the highest rate at 96%. Ashby House respite service reported the lowest at 85%.

Our findings

However, the trust reported a compliance rate of 50% for basic life support training at Ashby House respite service and 56% at Shirley House.

The mandatory training programme was comprehensive and met the needs of people and staff. This included Oliver McGowan training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to people and staff

Staff assessed and managed risks to people and themselves well. They responded promptly to sudden deterioration in a person's health. When necessary, staff worked with people and their families and carers to develop crisis plans. Staff monitored people on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of peoples' risk

Staff completed risk assessments for each person on admission / arrival, using a recognised tool, and reviewed most of these regularly, including after any incident. We reviewed 22 care records. Staff completed and regularly updated risk assessments in 18 of these records. We found staff at the Rugby and Coventry team and South Warwickshire team had not updated 2 risk assessments each.

Staff used a recognised risk assessment tool. Staff used the Steve Morgan risk assessment tool and the trust's 'working with risk' tools. The Steve Morgan risk assessment tool is a recognised tool used in mental health settings.

Management of peoples' risk

Staff responded promptly to any sudden deterioration in a person's health. Teams arranged urgent virtual care and treatment reviews (CTRs) to put emergency support in place. There was an intensive support team and the option of an 'enhanced bed.' The enhanced bed was located in a separate unit at the respite service and provided additional support for a person experiencing a crisis. However, staff reported it was often better to keep the person in their home and wrap the support around them. In a recent example where a person was struggling, the South Warwickshire team contacted a local service that the person was familiar with and arranged a respite bed for them. This prevented a hospital admission. The Solihull team provided an enhanced support service and described recent examples of how this service prevented hospital admissions for 2 people.

Staff continually monitored people on waiting lists for changes in their level of risk and responded when risk increased. Teams met weekly to review people on waiting lists and prioritise anyone needing support urgently.

Staff followed clear personal safety protocols, including for lone working. Staff used a lone worker system to log in/out of visits. Staff kept their diaries up to date, so managers and colleagues were aware of their whereabouts.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role. Staff we spoke with were able to describe how they recognised and reported abuse.

Staff kept up to date with their safeguarding training. The trust reported an overall compliance rate of 91% for level 2 and level 3 safeguarding training across the service.

Staff could give examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff at the South Warwickshire team gave an example of a person who was being discriminated against by family and how they kept the case open with the local authority to ensure the person was protected. Staff at the Solihull team spoke about a person discharged from hospital with a do not attempt resuscitation order in place. The hospital had not consulted the person, their family, or any other agencies before putting this in place. Staff challenged this and it was removed.

Staff could identify when a person was subject to restrictive practices and worked with other agencies to reduce these. Staff at the Coventry and Rugby team discussed a person who attends a day centre. The day centre staff stopped taking the person on group outings due to inappropriate behaviour. The occupational therapist was exploring strategies to manage the behaviour rather than restrict the person's opportunities.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff at the Coventry and Rugby team described a safeguarding case where a person wanted a change in their living arrangements. Staff involved respite services, and the trust legal team to help safeguard the person.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw numerous examples where staff had made safeguarding referrals and raised concerns. Staff told us they had good relationships with the local authority. Staff were well supported by the trust's safeguarding leads and legal team to ensure people were protected from harm.

Staff access to essential information

Staff kept detailed records of people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

People's notes were comprehensive and all staff could access them easily. Staff in the community teams used electronic records. The trust was impacted by a national outage of the records system they use last year. Staff told us a back up system was quickly implemented to enable ongoing records to be made. The system was restored at the time of the inspection and staff reported most information was transferred back over.

When people transferred to a new team, there were no delays in staff accessing their records.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Shirley House used a mix of electronic and paper based systems. Staff reported that agency workers were unable to access the electronic records and permanent staff had to do this for them. There was no current evidence of this impacting on people using the service. However, we were not assured that agency workers would have timely access to people's records in order to provide individualised care.

Records were stored securely.

Our findings

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines, where these were needed. Staff regularly reviewed the effects of medications on each person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes to prescribe and administer medicines safely. Psychiatrists would only prescribe medication for mental health issues. Staff across the community teams did not administer medicines. Nurses at the respite services would support people to take any medicines they brought from home. The trust's medicines management team supported the respite services with regular audits.

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines. Psychiatrists supported people to understand any medicines they were taking.

Staff stored and managed all medicines and prescribing documents safely. Staff at Shirley House checked the clinic room and medication fridge temperatures daily and took action when the temperature was above or below acceptable parameters. We saw evidence that staff asked for advice when the clinic room went above the acceptable temperature on one occasion.

Staff followed national practice to check people had the correct medicines when they were admitted or they moved between services. Staff at the respite services checked people had the correct medicines during their stay.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Psychiatrists across the service did not prescribe any medicines to manage behaviours.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). We reviewed team meeting minutes for the Solihull team which evidenced STOMP being discussed.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed person safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff reported serious incidents clearly and in line with trust policy. There were no serious incidents reported in the 12 months preceding the inspection.

The service had no never events.

Our findings

Staff understood the duty of candour. They were open and transparent and gave people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff reported debriefs after incidents and learning from incidents through protected learning time and team meetings.

Managers investigated incidents thoroughly. People and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff reported that lessons learnt were communicated through emailed bulletins 2-3 times a week and fed back through multi-disciplinary team (MDT) meetings.

Staff met to discuss the feedback and look at improvements to person care. The manager of the South Warwickshire team discussed that nationally people with learning disabilities were still dying from preventable conditions, for example, constipation. The team were involved in work to improve understanding of bowel health.

There was evidence that changes had been made as a result of feedback. Staff at the Coventry and Rugby team shared learning from an incident and changes made as a result that included an alert put on the system for the person and staff to visit in pairs.

Managers shared learning with their staff about never events that happened elsewhere. The trust reported there had been no specific safety alerts for this core service, but service leads were copied into trust wide safety alerts.

Is the service effective?

Requires Improvement  

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

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff completed a comprehensive mental health assessment of each person. We saw these in the records reviewed.

Staff made sure that most people had a full physical health assessment and knew about any physical health problems. At the Coventry and Rugby and South Warwickshire teams, staff had not recorded allergy or medication information in the person's records we reviewed.

Staff developed a comprehensive care plan for most people that met their mental and physical health needs. We reviewed 22 care plans and found staff had not completed a care plan for 1 person at the South Warwickshire team.

Positive behaviour support plans were present and supported by a comprehensive assessment for most people.

Our findings

Staff regularly reviewed and updated most care plans and positive behaviour support plans when people's needs changed. However, we found staff had not regularly updated care plans for 6 people. In the Coventry and Rugby team, staff last updated 1 care plan in March 2021 and the other in September 2019. In the South Warwickshire team staff last updated 2 care plans in March 2022, one in May 2022 and one in June 2021. We reviewed records for 1 person with numerous physical health issues but staff at the South Warwickshire team had not recorded these in the physical health section of their notes. Although staff recorded physical health information in their visit records, we were concerned that this information was difficult to find.

Although the staff had not reviewed all the care plans, we looked at, they were personalised, holistic and strengths based.

All people had an up-to-date hospital passport. We saw these in records reviewed.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. They ensured that people had good access to physical healthcare and supported them to live healthier lives.

Staff understood and applied National Health and Care Excellence (NICE) guidelines in relation to behaviour that challenges. This included support for families, early identification and assessment, psychological and environmental interventions, medications and interventions for co-existing health and sleep problems.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the people in the service. Care and treatment offered was in line with 'Right support, Right care, Right culture' guidance.

The North Warwickshire team offered art therapy, music therapy, eye movement desensitisation and reprocessing (EMDR) as part of a pilot project, cognitive analytical therapy (CAT) and a dialectical behaviour therapy (DBT) group.

The Coventry and Rugby team provided learning disability friendly DBT cards, compassion focused therapy developed for people with a learning disability and relationship cards to help people identify where they are in relationships with significant others. We spoke with one person who advised the team helped him to work on relationships and he completed a relationship group. The psychologist offered EDMR as part of the trial for 'Trauma Aid' for people with a mild to moderate learning disability. The team used a trauma informed care approach and worked with providers supporting people, to help them develop this approach. Staff supported people to make decisions about engaging in sexual activity. Staff looked at environments, resources and trigger times to help keep environments calm and stress free. The psychologist was working on 'capable environments,' which was an approach to ensuring people were in capable environments that met their needs with a focus on quality of life.

The South Warwickshire team offered relationship work, choice boards, emotional regulation work, photo symbols, profiles, charts, meltdown management and prevention, assessment of process and motor skills and sensory strategies.

Our findings

The Solihull Team offered assessments for sensory needs, communication and occupation. The psychologist used the CONNECT tool to take a holistic approach, this was a visual document capturing outcomes and demonstrating progress. The team supported one person to purchase their own property. The team's enhanced support service provided multi-disciplinary input to people with complex needs to access appropriate ongoing support and accommodation. Staff told us they used a trauma informed approach.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. NICE). At the North Warwickshire team, we accompanied an occupational therapist (OT) visit to a person using the service. The OT completed a sensory assessment ahead of an Autistic Spectrum Disorder (ASD) assessment to ensure a full understanding of the person's needs along with how each condition interacted and impacted on their physical health.

At Ashby House respite service staff used the disability distress assessment tool and National Early Warning Signs (NEWS) charts.

Staff understood people's positive behavioural support plans and provided or supported others to provide the identified care and support. We spoke with a provider who supported a person on the South Warwickshire team's case load. They reported that the team checked with the service to see if suggested strategies have worked and follow up with further actions and recommendations, they felt the team ensured positive outcomes for the person.

Staff made sure people had support for their physical health needs, either from their GP or community services. At the Coventry and Rugby team we accompanied a nurse to a person's support session. The nurse discussed physical health with the person and went over their physical health annual check.

Teams completed desensitisation work with people who were afraid of having blood tests. A nurse at the South Warwickshire team shared an example of desensitisation work with a person who had not had a blood test for over 15 years. Nurses visited weekly and worked with the person until they felt able to have their blood taken.

Staff at the South Warwickshire team told us they would screen for any physical health issues if a person's behaviour changed. We also saw evidence in care records of sensory assessments and care plans from OT, psychiatry, psychology and speech and language therapists (SALT).

Staff at the Coventry team gave an example of working with family and other agencies to support a person with a recurring health condition by creating a new plan and hospital passport with clear directions for any treating staff to follow.

Staff supported people to live healthier lives by supporting them to take part in programmes or giving advice. We spoke with one person at Ashby House who told us staff supported them to eat healthier options to help with management of their body mass index (BMI).

Staff used recognised rating scales to assess and record the severity of people's conditions and care and treatment outcomes. We saw evidence of staff using outcome measures and evaluating interventions. Staff completed Health of the Nation Outcome Scales (HoNoS) and used the 'Model of Human Occupation' and 'Humanistic Occupational assessment' tool. Staff used evaluation measures including basic scoring from 0-10; adapted 'Clinical Outcomes in Routine Evaluation' (CORE); adapted 'Person Health Questionnaire 9' (PHQ9) and 'Generalised Anxiety Disorder Questionnaire' (GAD7) to screen and detect depression and anxiety symptoms; use of visual aids, for example, cups that are half full or half empty.

Our findings

Staff used technology to support people. The Speech and Language therapist in the South Warwickshire team gave an example of setting up an electronic tablet with communication aids for a person from the Asian community whose mum also found it difficult to communicate. The tablet really helped the person and their mum and supported the person to make choices.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The trust completed audits of LeDeR and NICE QS101 Learning Disability: Behaviour That Challenges between August 2022 and July 2023.

Managers used results from audits to make improvements. The North Warwickshire team completed a quality improvement initiative; QI1190 – Improving the Environment at The Loft for Clients with Sensory Sensitivity.

Skilled staff to deliver care

The teams included or had access to, the full range of specialists required to meet the needs of people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the people. Teams included learning disability nurses, psychiatrists, psychologists, physiotherapists, speech and language therapists, occupational therapists and art therapists. Social workers were accessed from the local authority.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training. We reviewed training records which evidenced staff completion of numerous learning disability and autism courses including mandatory Oliver McGowan training, social interaction and communication, environmental and sensory considerations, certainty and predictability and vulnerability to mental health issues.

Managers gave each new member of staff a full induction to the service before they started work. The trust reported 100% completion of induction for all new starters since April 2023.

Managers supported staff through regular, constructive appraisals of their work. For the appraisal window from April 2023 to July 2023 the trust reported an appraisal compliance rate of 64% overall. The trust reported 33% for Ashby House, 100% for Shirley House, 96% for Coventry and Rugby LD team, 56% for the North Warwickshire Team, 29% for the Solihull LD team and 67% for the South Warwickshire Team.

Managers supported staff through regular, constructive clinical supervision of their work. The trust reported an overall compliance of 82% for clinical supervision from January 2023- June 2023. The trust reported 56% for Ashby House, 80% for Shirley House, 84% for Coventry and Rugby LD team, 91% for the North Warwickshire Team, 92% for the Solihull LD team and 89% for the South Warwickshire Team. However, some non-nursing professionals told us it was difficult to access clinical supervision for their speciality and they relied on peer support. Managers advised this was being looked at.

Our findings

Managers did not ensure staff attended regular team meetings. Community teams met weekly to review referrals, waiting lists, cases for discussion and vulnerable people. However, there were no meetings to discuss other topics. For the respite services 1 team meeting took place in April 2023 at Shirley House for the 6 months preceding the inspection. This meeting covered a wider range of topics than the community teams. There was no evidence of team meetings taking place at Ashby House.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw evidence of this being discussed in supervisions.

Managers made sure staff received any specialist training for their role. Across all teams the trust reported the following specialist training had been completed; Bronze level epilepsy training, silver level epilepsy training, Health Assessment module, 3-day epilepsy course, Positive Behaviour Support training, Queens Nursing Institute aspiring leaders, DipHe in Positive Behaviour Support, trauma training, Self-neglect and Mental Capacity Act, Masterclass in Mental Capacity Act, Independent Mental Health Advocate training with an external advocacy service. One staff at the Coventry and Rugby team, completed Makaton training and was planning to share this learning with colleagues.

Managers recognised poor performance, could identify the reasons and dealt with these. There was a trust policy in place to support managers to deal with this.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss people and improve their care. Community MDTs met weekly to discuss current caseloads and identify actions to improve care. We sat in on 3 of these meetings, which evidenced this.

Staff made sure they shared clear information about people and any changes in their care, including during transfer of care. We sat in on an MDT meeting attended by the person, internal staff and external agencies. Staff shared clear information during this meeting.

Staff had effective working relationships with other teams in the organisation. We reviewed care records for a person at the North Warwickshire team which evidenced joint working with mental health and eating disorder teams to meet the person's multiple needs.

Staff had effective working relationships with external teams and organisations. We spoke with 3 external providers supporting people using the service. All were positive about how the teams worked with them to ensure the best outcomes for people. Teams provided external organisations with training and interventions to support people. The OT in the Solihull team was involved in joint work with NHSE, housing providers, a specialist company who provide mortgages, Solihull council and the housing team looking at home ownership for people with a learning disability. The aim of this project was to keep people out of secure hospitals. We reviewed care records for 1 person with complex needs at the Solihull team. Staff worked with multiple professionals and agencies to keep the family together, they challenged other services and secured a positive outcome for the person.

Staff supported and participated in care and treatment reviews. We saw evidence of this in people's records.

Our findings

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

It was not clear if staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Managers reported staff completed this training. However, the trust training data did not include Mental Health Act (MHA) training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us they could access support from the trust's MHA team.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had a clear policy for staff to follow.

People had easy access to information about independent mental health advocacy. Teams provided this information when required.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the person's notes each time.

For people subject to a Community Treatment Order, staff completed all statutory records correctly. There were no people subject to a Community Treatment Order at the time of the inspection.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity. Staff worked with the person's support network to ensure best interest decisions were made when relevant.

It was not clear if staff received and kept up to date with training on the Mental Capacity Act. Managers reported staff completed this training. However, the trust training data did not include Mental Capacity Act (MCA) training. However, staff spoken with were able to describe the principles of the act and how they applied in their work. Post inspection the provider submitted data showing that 100% of staff had completed training for both Mental Capacity Act and Deprivation of Liberty safeguarding levels 1 and 2.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. The trust had a clear policy for staff to follow and staff knew how to access this.

Staff knew where to get accurate advice on Mental Capacity Act. Staff told us the trust have a team to support and a legal panel where complex cases can be presented for guidance and support. The trust provided face to face MCA masterclasses for staff.

Our findings

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Capacity assessments, best interests meetings, use of Deprivation of Liberty safeguards (DoLs) and Court of Protection involvement, were in people's records reviewed. At Ashby House we saw staff used different communication methods, including use of pictures and toys, to gain consent.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. Staff gained consent from people during our inspection, using individual approaches for each person. The manager of another provider told us they saw staff gaining consent from people in their care. However, at the South Warwickshire team staff did not always clearly document decisions relating to capacity and consent. In 1 record, staff documented that the person lacked capacity and the best interest decision was to continue the assessment to establish the person's needs but had not documented the best interest decision process. In another record staff stated, "X (patient) has agreed to OT intervention although lacks capacity to give informed consent".

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, culture and history. This was evidenced in records reviewed where best interest decisions needed to be made. At the South Warwickshire team, we reviewed a case where staff held numerous best interest meetings with external agencies and the case has now progressed to the Court of Protection.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Managers reported the trust MCA team completed audits with the next one due in 2024.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They understood the individual needs of people and supported people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for people. We saw positive engagement and interactions between staff and people across all teams. Staff treated people with compassion during MDT meetings we sat in on.

Staff gave people help, emotional support and advice when they needed it. A person at the Coventry and Rugby team provided written feedback telling us the "team really helps and give a way forward."

Staff used appropriate communication methods to support people to understand and manage their own care treatment or condition. At the North Warwickshire team, SALT were involved in creating communication passports, Makaton and adaption to lights. At the Coventry and Rugby team staff used easy read information, visual aids and speech and language input to help adapt resources.

Our findings

Staff directed people to other services and supported them to access those services if they needed help. At the Coventry and Rugby team, staff encouraged people to use mainstream services where possible and helped to access community resources and schemes.

People said staff treated them well and behaved kindly. We spoke with 6 people across the teams. All were positive about the support they received and told us staff were helpful, kind and responsive. We spoke with 10 carers who were all positive about how staff treated their loved one. One carer of a person at the North Warwickshire team, described the staff as “brilliant and life-saving.”

Staff understood and respected the individual needs of each person. This was evident in care records reviewed and feedback from people, carers and other agencies. At Shirley House staff displayed a poster in the kitchen with people’s drink preferences, what drinks they liked and didn’t like and how they liked them, for example, sugar in tea. A person told us the service was flexible with respite dates to fit in around family activities.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people and staff.

Staff followed policy to keep person information confidential.

Involvement in care

Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Staff informed and involved families and carers appropriately.

Involvement of people

Staff involved people and gave them access to their care plans. Care records seen showed people were involved and offered a copy of their care plans.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication difficulties). We accompanied a nurse at the Coventry and Rugby team supporting a person. The nurse encouraged the person to lead and express themselves. The nurse listened, acknowledged, validated, and praised the person for their achievements. We accompanied a home visit at the South Warwickshire team, the nurse supported the person to understand how to use an asthma pump through demonstration and ensured they understood what to do in the event of an asthma attack.

Staff involved people in decisions about the service, when appropriate. Community teams involved people in the recruitment of staff.

People could give feedback on the service and their treatment and staff supported them to do this. Staff offered this informally during the inspection.

Staff tried to ensure people could access advocacy services. However, staff at the Solihull team reported they were not able to access advocacy support for a person, as the local authority had not yet allocated them a social worker.

Our findings

Involvement of families and carers

Staff supported, informed and involved families or carers. We spoke with 10 carers. Nine carers told us they were supported, informed and involved.

The Speech and Language therapist in the South Warwickshire team told us families were involved with the person's consent. The team gathered information from the people who knew the person well. They met family's needs as well, for example, a communication preference for one mum who preferred a text for a quick reminder and an email for full detail. The team ensured care plans were accessible for families as well as people.

At Shirley House we saw photo displays of people engaged in activities during their respite stay. When new photos were ready to be displayed, staff took the oldest photos down and gave them to people involved to take home to their families.

At the Solihull team, 3 carers told us how responsive the team were, they were involved in care planning and staff had accessed additional support when required for their loved ones.

Staff helped families to give feedback on the service. Carers told us they were able to do this informally. Staff and managers across the teams reported that the trust's virtual application to get feedback from people and carers was not suitable for their client group. The trust reported "Community LD teams at present do not have service user or carer forums. This has been identified previously by the teams and is on the Community LD Quality Improvement Plan." Ashby House used social media sites to engage with carers and people.

The service follows the principles of Ask, Listen, Do, in relation to feedback, concerns and complaints. Carers and people felt able to feedback and would raise concerns or complaints if needed.

Staff gave carers information on how to find the carer's assessment. We saw evidence in some care records of staff signposting carers for carer's assessments.

Is the service responsive?

Requires Improvement   

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

The service was easy to access for most people. Its referral criteria did not exclude people who would have benefitted from care. Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment. Staff followed up people who missed appointments.

The service had clear criteria to describe which people they would offer services to and offered people a place on waiting lists. Community team managers were able to describe the service criteria as for people over 18 with a learning

Our findings

disability and health needs that cannot be met by mainstream services. People meeting the criteria were placed on a waiting list and sent a letter explaining this and estimated length of time they would be waiting. The respite services aimed to “support Primary Care Services, families and carers, in enabling adults with a Learning Disability to achieve optimum health.”

The service did not always meet trust target times for seeing people from referral to treatment. This was an issue at the last inspection in 2017. The trust target time for referral to assessment was 28 days and for referral to treatment was 18 weeks. We reviewed ‘external’ waiting list data for the Coventry and Rugby teams which showed 8 people waiting over 18 weeks for treatment. The longest wait was 92 weeks. The trust standard operating procedure for Access and demand (Waiting Lists) in Community Learning Disability Services states “the external waiting list is defined as those who are waiting and have no input from any professional in the Community Learning Disability Team.” The discipline with the most waits was physiotherapy with 7 people waiting for over 18 weeks.

We reviewed ‘internal’ waiting list data for the Coventry and Rugby teams which showed 24 people waiting for over 18 weeks. The longest wait was 131 weeks. The trust policy describes internal waits as “those who are open to other community learning disability team professionals and are waiting for another specific intervention from another professional group within the CLDT.”

Staff at the Coventry and Rugby team raised concerns about the waiting times for people requiring physiotherapy and occupational therapy. Staff told us that long term staff absences that were not being covered were increasing people’s time on waiting lists.

The trust did not provide waiting list data for the other community teams.

Staff did not always see urgent referrals quickly and non-urgent referrals within the trust target time. Two people waiting for physiotherapy interventions were flagged as urgent priorities but were waiting for treatment since May 2023. However, staff used a prioritisation tool to help ensure urgent cases were usually seen quickly.

Physiotherapists met weekly across teams to discuss urgent and critical cases and find capacity to support. Managers were proactive in trying to address the physiotherapy demand and advised commissioners agreed to streamline the physiotherapy offering to people who are unable to access mainstream physiotherapy services, even with reasonable adjustments in place.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from learning disability services. Staff at the South Warwickshire team told us if a person refused to engage, they would find out areas of interest and use these to encourage engagement, staff would also find out where the person felt most comfortable and fit the service around them.

Staff tried to contact people who did not attend appointments and offer support.

People had some flexibility and choice in the appointment times available. People and carers told us they were offered flexibility and choice with appointment times. Carers of people at the North Warwickshire team told us that there were no issues with appointments. One reported their relative had the same slot every week and staff changed their relative’s appointment from face to face to virtual when they were unable to attend. The carer said this prevented distress to the person. Another carer told us appointments took place at home which was much better for them and the person.

Our findings

Staff worked hard to avoid cancelling appointments and when they had to, they gave people clear explanations and offered new appointments as soon as possible. People and carers we spoke with told us appointments were not cancelled. One person told us they sometimes had to wait for a meeting room to be available.

Appointments ran on time and staff informed people when they did not.

The service used systems to help them monitor waiting lists/support people. Staff proactively managed the waiting lists with weekly reviews and signposted people waiting to other services. People waiting were provided with contact details for the team and advised to call if their circumstances changed. Staff called people on the waiting list every 4- 6 weeks.

At the South Warwickshire team, we observed a nursing allocation meeting which reviewed and allocated referrals. These meetings took place weekly. Staff discussed urgent cases and agreed actions. Staff discussed people on waiting lists and made plans to address any urgent needs.

Staff supported people when they were referred, transferred between services, or needed physical health care. The service employed acute liaison nurses to support people requiring acute care in hospitals.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported people's treatment, but did not always support privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Community team locations where people were supported included rooms for individual and group sessions.

Both respite services were equipped with specialist furniture and equipment that met individuals' needs. There were well-equipped sensory rooms for people to access when they wanted with staff support.

Not all interview rooms in the service had sound proofing to protect privacy and confidentiality. We identified concerns with the soundproofing of interview rooms at 3 out of the 7 locations visited. Interview rooms were not soundproofed at the North Warwickshire team location, the Coventry team location and at Brunel House- used by people at the Rugby team. The inspection team that visited the Coventry team location reported conversations in therapy and group rooms could be clearly heard whilst they were in the corridor. This potentially impacted on people's privacy. The trust reported they would be seeking external advice on how to resolve this.

The service had considered and responded to the needs of people with autism in the environment. The Coventry team location had sensory objects and headphones available for people in the waiting area.

The North Warwickshire team recently refurbished their space with input from people and carers to make it autism friendly. This included muted colours and soft lighting.

Meeting the needs of all people who use the service

The service met the needs of most people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

Our findings

Staff had the skills, or access to people with the skills, to communicate in the way that suited the person.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. People across all teams had hospital passports and communication plans in place.

Most locations visited by people were accessible. However, we were concerned about the location of the Solihull team which was located on the trust's Brooklands site. This site is located within the Solihull community. The site accommodates forensic/secure services for people with a learning disability. Staff expressed concerns that the location is not community based, is hard to access and some people were previously patients on the forensic wards and found it distressing when passing the site to see the community team. One carer told us this was an issue for their relative, so the team arranged visits at other locations to prevent distress to their loved one.

Staff at the Coventry and Rugby team gave an example of using 1 person's love of hamsters to help them communicate how they were feeling, for example, happy hamster and sad hamster. Staff used social stories to help people's communication and understanding.

Kitchen staff at Shirley House created dietary requirement cards for all people and designed the menus to meet people's preferences and specific dietary needs.

A carer of a person at the North Warwickshire team told us that staff quickly managed to get support in place and actively chased up their relative's unmet needs. Another carer told us that staff made reasonable adjustments to suit the person and family relating to the location of appointments and communication needs of their loved one.

Staff made sure people could access information on treatment, local services, their rights and how to complain. The North Warwickshire team displayed easy read posters with person information including PALS/complaints, advocacy, local resources and CQC ratings.

The service provided information in a variety of accessible formats so the people could understand more easily. Teams provided easy read information and utilised different methods of communication, including use of pictorial aids, talking mats and toys.

The service had information leaflets available in languages spoken by the people and local community. Teams were able to access information in other languages when required.

Managers made sure staff and people could get hold of interpreters or signers when needed. All teams were able to access interpreters. The Solihull team used British Sign Language (BSL) interpreters, and Cantonese interpreters. The team employed an independent interpreter for a person with complex needs. The trust was flexible for the service to employ this interpreter. Staff at the Coventry and Rugby team accessed interpreter support to translate a report into Bosnian.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Our findings

People, relatives and carers knew how to complain or raise concerns. People and carers spoken with told us they knew how to complain but had not raised any complaints about the service. However, one person told us they do not always get a prompt response to concerns raised.

Staff understood the policy on complaints and knew how to handle them. Staff were able to describe how they would deal with any complaint. One carer of a person at the North Warwickshire team told us staff supported them to raise a complaint about another organisation which resulted in improved care for their relative.

At the South Warwickshire team, staff supported a carer with a complaint which resulted in their relative moving into better accommodation.

Managers investigated complaints and identified themes. In the 12 months preceding the inspection the trust reported receiving 1 formal complaint. Managers investigated the complaint; it was not upheld. At Shirley House, the manager told us that they resolved a concern raised by a relative by accessing more suitable furniture for their relative.

The service used compliments to learn, celebrate success and improve the quality of care. The trust reported receiving 55 compliments for the service in the 12 months preceding the inspection. We saw thank you cards displayed and shared with teams.

Is the service well-led?

Requires Improvement ● ↓

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for people and staff.

Most staff reported that managers were visible and approachable. Staff told us that board members had visited the service. One staff member told us there was no input from managers above the team managers.

The CEO hosts regular virtual 'chats' that staff can attend. A weekly trust brief is sent out to all staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

This was evidenced by talking to staff and observing their interactions with people. The trust vision and values were displayed throughout service locations.

Culture

Our findings

Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

We spoke with 31 staff across the service. Most told us they felt respected and valued and were able to raise concerns without fear. One staff member told us they did not feel valued as a learning disability nurse by the trust. Another staff member said they were not supported by their manager in relation to their wellbeing.

Managers told us that there were opportunities for career progression. Managers had created an additional role to support healthcare assistant (HCA) development, with HCAs at Ashby House trained to become nurses. Staff reported opportunities for additional training and the trust supports training requests if staff can provide a clear rationale of how it will enhance the person experience. However, some staff in the community teams felt there was limited career progression for their role.

The trust reported they recruited a clinical mentor to work with staff across all services to develop leadership skills. The trust reported they provided coaching and leadership apprenticeship opportunities.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Governance systems and processes had not identified gaps in care records, non-compliance with referral to assessment and treatment times, or the impact of staff long term absences. Due to the long term absences the team caseloads had increased and the waiting list had increased.

While the Trusts governance systems had identified the fact that some interview rooms were not soundproof. The processes put in place had not resolved the issue of soundproofing in all interview rooms at 3 out of the 7 locations we visited.

Managers had not addressed low compliance rates for basic life support training at the respite services and low appraisal rates for Ashby House, the North Warwickshire team, the Solihull team, and the South Warwickshire Team.

The impact of this was that peoples' records were not always accurate and complete. Services were not always assessed, monitored and improved in relation to the quality of the person experience.

However, managers completed peer reviews of each other's services and attended safety and quality meetings for the learning disability and autism directorate.

Management of risk, issues and performance

Whilst teams had access to the information they needed to provide safe and effective care they did not use this information to good effect.

Managers accessed dashboards for an overview of risks, issues and performance in their teams which highlighted low levels for supervision, appraisal and training compliance. Managers did not then have plans in place to increase the performance in these areas.

Our findings

Managers reported the trust response to the electronic records outage last year was prompt and effective. The IT team provided a core of record templates to use as a contingency and set up a full back up system within a few weeks.

Managers advised they were able to submit risk items to the trust risk register. The Solihull team manager told us physiotherapy waits were on risk register as they struggled to recruit physiotherapists with the right experience.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Teams evaluated and analysed outcomes for people using the service. Teams were engaged in local quality improvement initiatives including hosting a learning disability event attended by external providers and providing a sex and relationships group jointly with the local authority.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The trust sat on the 'Working in Partnership Learning Disability Board' which was chaired and attended by experts by experience. Other attendees included trust staff and staff from other statutory and third sector organisations. The board discussed different topics, for example, employment and relationships and what could be done to improve these areas for people with a learning disability.

The trust formed a 'Learning from lives and deaths of people with a learning disability and autistic people' (LeDeR) subgroup to look at preventative work, including bowel training for staff and providers and ensuring GPs ask people about bowel health in annual checks.

Managers reported positive relationships with local commissioners and integrated care boards which enabled creative responses to people with complex needs.

Learning, continuous improvement and innovation

The trust hosted annual award ceremonies for services. Ashby House team won the award in 2021 for 'seeking excellence'. The Coventry and Rugby team won the award for 'integrity' this year.

The manager of the Coventry and Rugby team advised a quality improvement plan was in place. This included working with the research department on a weighting tool for caseload management. This has been developed for and used in supervision to manage staff workload and help forward planning. This was identified in a peer review as good work and is being rolled out across all community teams within the trust.

The Coventry team accessed charitable funds to mount and frame people's artwork and set up an art gallery.

The North Warwickshire team set up a Makaton choir and won a community managers award.

Our findings

Shirley House was nominated for a national care award.

Our findings

Areas for improvement

Action the trust **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 trust MUST take to improve:

- The trust must ensure that governance systems operate effectively to identify and address quality, safety and performance issues. (Regulation 17)
- The trust must ensure the community teams have plans in place to increase their compliance their referral to assessment and treatment targets. (Regulation 17)
- The trust must ensure that staff are trained in basic life support training at the respite services. (Regulation 18)
- The trust must ensure patient care records including care plans and risk assessments are completed and updated. (Regulation 12)

Action the trust Should take to improve:

- The trust should ensure interview rooms have adequate soundproofing to protect people's privacy.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 1 other CQC inspector, 2 specialist advisors and an expert by experience. The inspection was overseen by an Operations Manager.

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing