Requires improvement

Bradford District Care Trust

Services 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)
Lynfield Mount Hospital	TAD17	Highfield assessment and treatment unit	BD9 6DP
Waddiloves Health Centre	TAD17	Learning disability	BD8 7BT

This report describes our judgement of the quality of care provided within this core service by Bradford District Care 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.

Where applicable, we have reported on each core service provided by Bradford District Care Trust and these are brought together to inform our overall judgement of Bradford District Care 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 learning disability services	Requires Improvement 
Are learning disability services safe?	**Good** 
Are learning disability services caring?	**Good** 
Are learning disability services effective?	**Requires Improvement** 
Are learning disability services responsive?	**Good** 
Are learning disability services well-led?	**Requires Improvement** 

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

Bradford District Care Trust provides care for people who have a learning disability. They have two registered locations, which are: Highfield Treatment and Assessment Unit at Lynfield Mount Hospital and Waddiloves Health Centre, which provides a range of community health services. There are also other, smaller community teams based around the local area.

Staff across the services were caring and compassionate. We saw that they worked positively with people and supported them well.

There were strong policies in place to make sure that people who used the service were safe.

We found that staff worked well together to meet people's needs and that they were able to respond to individual needs and preferences.

Staff said that they were supported by managers and senior managers, which helped them to feel valued.

Summary of findings

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

Are services safe?

Good

Staff had received safeguarding training and demonstrated that they knew how to protect people from harm.

There were enough staff on the assessment and treatment unit to provide safe care. The number of staff was increased to meet people's needs and ensure their safety.

Staff were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.

Ligature risks had been identified in the assessment and treatment unit and there were plans in place to reduce all of these.

There were strong policies in place about lone working to protect the safety of staff and people in the community.

Are services effective?

Requires Improvement

People's physical health needs were assessed and monitored to protect their health and wellbeing. However, we found that people's mental health needs were not always considered. People with complex needs, for example autism, did not always have these met.

Generally, staff had received the training they needed to meet people's needs. However, not all staff had received enough training on caring for people with autism.

Staff worked well together to meet the needs of people who used the service.

The Intensive Support Team needed to be developed to make sure that it met people's needs.

People knew how to access advocacy services. These services were effective in supporting people to make decisions about their care and welfare.

It was not clear how outcomes were measured . This meant that the service could not identify how or if a person's needs had been met to protect their health and wellbeing.

Although people's mental capacity was assessed, not all assessments were detailed. This meant that where people lacked the mental capacity to make decisions about their care and treatment, the decisions made may not be in their best interests.

Some staff needed more training about when to use the Mental Health Act and when to use the Mental Capacity Act, to make sure that people were being treated in the least restrictive way.

Summary of findings

Are services caring?

Good

Staff were caring and compassionate, and they were genuinely motivated to make sure that people were well supported.

People who used the service were also treated with dignity and respect. However, some people were not always involved in their care and treatment as information was not provided in a format they could understand.

Are services responsive to people's needs?

Good

Staff in the assessment and treatment unit worked with community teams to plan people's discharge from hospital.

The service met people's religious, cultural and gender-specific needs.

Staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.

We were told by staff that the trust had an open and transparent culture, so any concerns or complaints were dealt with and improvements made.

The assessment and treatment unit was closed to admissions because of the needs of the current inpatients. The community teams had responded to this in the short term, but this could not be a long-term solution because of staffing issues in those teams.

Are services well-led?

Requires Improvement

Staff felt well supported by their managers and by the senior management.

People who used the service were listened to and, as a result, improvements made.

Staff had opportunities to develop their skills and knowledge.

There was no visible leadership in some teams. This meant that the service was not always effective in meeting people's needs.

The psychology team leader only worked part time and was not a specialist in learning disability. This meant that the team had limited specialist input and were unclear of their objectives.

Summary of findings

Background to the service

Bradford District Care Trust provides care for people who have a learning disability from two registered locations, which includes one ward at Lynfield Mount Hospital. This is an assessment and treatment unit for up to six people who have a learning disability and who may be detained there under the Mental Health Act 1983.

The trust also provides a range of community health services. The teams are mainly based at Waddiloves Health Centre, but there are other, smaller community teams based around the local area. Community teams comprise nurse health facilitators, community support workers, psychologists, psychiatrists, dieticians, physiotherapists, speech and language therapists and occupational therapists.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair of the Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Hospital Inspection (Mental Health), Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: a Mental Health Act commissioner, a social worker, two support workers who support people who have a learning disability, and a consultant psychologist who specialises in working with people who have a learning disability and/or autism.

Why we carried out this inspection

We inspected this core service as part of our Wave 2 pilot 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 provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out an announced visit of learning disability services from 17 to 20 June 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, nursing managers and consultant psychiatrists. We talked with people who used services, carers and family members. We observed how people were being cared for and reviewed their care or treatment records.

What people who use the provider's services say

One relative told us that the care that the community team provided excellent care. Another said that they were very happy with the help and care they had from the community support worker.

However, one relative said that staff did not have the specific skills they needed to support their relative's needs.

Summary of findings

Good practice

- We saw several examples of good practice in relation to health screening and facilitation at Waddiloves Health Centre. For example, we saw the use of a screening tool that had been developed specifically for people who had Down's syndrome.
- People referred to Waddiloves Health Centre also had their respiratory rate measured. This was then monitored during the time they received the service. From this, staff were able to assess if a person was unwell with a respiratory disease and make sure that they received the care and treatment they needed.
- The community teams worked well with hospitals to make sure that people had a better experience when admitted to hospital, and that their physical health needs were better met.
- All staff were supported to attend training and conferences that would develop their skills and knowledge. Staff told us that this helped them to improve how they worked with people who used the service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should make sure that all ligature risks identified in the assessment and treatment unit are reduced promptly.
- The trust should make sure that moving administration staff to hub offices does not place other staff in smaller community offices at risk of harm.
- The trust should make sure that information about people's care and treatment is provided in a format that each person who uses the service can understand.
- The trust should make sure that each person's mental capacity is assessed for every decision made about their care and treatment.
- The trust should make sure that there are effective repair and maintenance systems in place to promote the wellbeing of people who use the service.
- The trust should make sure that all staff are clear as to their objectives and how these are measured, to make sure that the service meets people's needs.
- The trust should make sure that the Intensive Support Team is developed so that it meets people's needs.
- The trust should make sure that staff have the appropriate training so that they can meet people's needs.
- The trust should make sure that the community teams are able respond to the current need to close the assessment and treatment unit to admissions.
- The trust should make sure that all teams have clear leadership and objectives so that they are well-led and able to provide a quality service.

Bradford District Care Trust

Services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service(e.g. ward/unit/team)	Name of CQCregistered location
Highfield assessment and treatment unit	Lynfield Mount Hospital
Waddiloves Health Centre	Learning disability services

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

Records we sampled showed that staff had explained to people their rights under the Mental Health Act (MHA). However, this had not always been recorded on their records on the computer system on the assessment and treatment unit. This could mean that people were not read their rights as often as required to ensure they had understood these.

We saw that people who were detained under the MHA had access to an Independent Mental Health Advocate (IMHA). Records we sampled showed that the person's IMHA was invited to all meetings held about the person.

We saw that people who were detained there under the MHA had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent, because they did not have the mental capacity to do so, or had refused to, we saw that a second opinion appointed doctor (SOAD) had seen them and stated that it was appropriate for treatment to be given.

Records we sampled showed that people's forms for when they had section 17 leave from the assessment and treatment unit had been completed appropriately. However, some of the used section 17 leave forms had not been crossed out to show that this was no longer applicable. This could mean that staff were unsure what the current leave arrangements for the person were, which might impact on the person's safety and wellbeing.

Staff we spoke with told us that there was not an Approved Mental Health Professional (AMHP) who worked specifically in the learning disability service. They said this would

ensure that people with a learning disability, who have issues that affect their behaviour and mental health, are detained only when this is the least restrictive way of providing them with the care and treatment they need.

We saw that one person was on a Community Treatment Order (CTO) and that this had been applied appropriately and met the legal requirements of the MHA. We saw that the person had been supported by advocacy services and the community team to ensure they understood the conditions of the CTO and what they needed to do to comply with it.

Mental Capacity Act and Deprivation of Liberty Safeguards

Records we sampled showed that people's mental capacity to consent to their care and treatment had been assessed. These were generally detailed assessments, however, the community nurses assessments were brief. Staff had ticked whether an assessment had been completed and whether the person had mental capacity or not. They did not detail how the person's mental capacity had been assessed to make specific decisions about their care and treatment. This could impact on how decisions were made to ensure they were in people's best interests. We saw detailed best interest assessments that ensured that each decision made was in the person's best interests.

We found that staff needed more training about when to use the Mental Health Act and when to use the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) to ensure that people were being treated in the least restrictive way. Staff had received a briefing following the Cheshire West ruling and would be attending a one-hour training session. We saw that staff had the basis of the implications of the changes, however, they needed more support and training to enable them to have a greater knowledge and develop their skills.

Good

Are services safe?

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

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

Summary of findings

Staff across the learning disability service had received safeguarding training and demonstrated that they knew how to protect people from harm.

There were enough staff on the assessment and treatment unit to provide safe care. The number of staff was increased to meet people's needs and ensure their safety.

Staff across the learning disability service were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.

Ligature risks had been identified in the assessment and treatment unit and there were plans in place to reduce all of these.

There were strong policies in place about lone working to protect the safety of staff and people in the community.

Our findings

Highfield assessment and treatment unit

Track record on safety

All staff we spoke with demonstrated that they knew how to identify and report any abuse to ensure that people who used the service were safeguarded from harm. We saw that information was displayed to inform people who used the service and staff how to report abuse.

Learning from incidents and improving safety standards

We saw that all incidents were reported. The unit manager told us that an analysis of each incident was undertaken to ensure that any lessons could be learnt to improve safety for people who used the service and staff. Staff told us that they received feedback following incidents through meetings, handover and supervision and that lessons learnt were recorded.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the unit was clean and staff practised good infection control procedures.

Staff told us that the trust pharmacist visited the unit weekly to undertake audits of the medicine management systems and ensure that these were safe. During this inspection a pharmacy inspector from CQC visited the unit. They found that the medicine management systems on the unit were generally safe. They saw that the temperature of the fridge, where medicines were kept, needed to be reset to make sure that it was at a safe temperature. We saw that staff reported this immediately to the trust estates department to be rectified.

We saw that ligature risk assessments had identified the ligature risks in the unit. Some action had been taken to reduce these risks and further action was planned. In each shower room, toilet and bathroom there were curtain rails. However, we checked and saw that these were collapsible so that the risks of ligature were reduced. In each lounge area, there were wires trailing from the TV and DVD player. These had been identified on the ligature risk assessment as needing to be removed, but no action had been taken. We saw that a risk assessment was in place for the sensory room, which included the fibre optic lights. All the staff told us that people who used the service did not use this room without support from staff to reduce the risks to their safety.

Staff records we sampled showed, and staff told us, that the appropriate recruitment checks were completed to make sure that staff were suitable to work with people who used the service.

Assessing and monitoring safety and risk

We saw that staffing levels were safe. Procedures were in place and used, where needed, to increase staffing levels to safely meet people's needs. We saw there was a high use of bank and agency staff to cover sickness and to meet people's needs. However, we found, and staff confirmed, that bank or agency staff employed worked there regularly and knew how to support people who used the service. The ward manager told us, and rotas sampled showed, that there were usually two qualified nurses on each shift during the day, and five or six health support workers. There were

Good

Are services safe?

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

also one or two occupational therapist support workers on each shift. At night there was one qualified nurse and five health support workers. Rotas showed, and staff told us, that staffing levels were adjusted according to the needs of people who used the service. We saw that where only one qualified nurse was on duty during the day, extra health support workers were on duty to provide safe support to people who used the service. The ward manager said that when they could not staff the unit with enough qualified nurses who had worked there previously, they used an extra health support worker who had worked there, so that people were safely supported.

Staff told us that restraint was only used as a last resort. We saw in restraint records, and staff confirmed, that recently they had used restraint more often to ensure the safety of people who used the service and staff. The unit manager told us that nine staff had been injured as a result of incidents involving a person who used the service. Staff told us, and we saw, that they were offered support from the psychology team, massage therapy and physiotherapy. They told us they felt supported and the risks to their safety and that of people who used the service had been reduced as much as possible.

Training records showed that all staff who were involved in using restraint had been trained in the physical intervention method used within the trust called Managing Violence and Aggression (MVA) and all staff we spoke with confirmed this. One member of staff who had not yet received this training told us that this training was booked and until then they were not involved in restraint techniques. MVA is not accredited by the British Institute of Learning Disabilities (BILD) to be used for people who have a learning disability. However, this does not mean that this is unsafe to use. Staff told us that the MVA trainers had visited the unit to train staff in how to use the techniques with each person who used the service, which would reduce any risks of it being an unsuitable method of restraint to use. Records we sampled included individual plans as to how staff should respond to people's behaviours to reduce the risks to their safety and that of others.

We saw that seclusion was not used at the unit and all staff we spoke with confirmed this.

Understanding and management of foreseeable risks

We saw that risks to the safety of people who used the service and staff had been identified and recorded on the risk register. Where action could be taken to reduce these risks, this had been done. We saw that where audits had identified that action needed to be taken to reduce safety risks these had been completed. This meant that staff identified risks and ensured action was taken to reduce these.

Staff told us that emergency equipment was kept on the ward opposite the unit. The unit manager told us that this equipment had not been used often but they had practised moving this equipment from the other ward to ensure they could do this safely if needed. They had moved the equipment in less than two minutes, which was within the National Institute for Clinical Excellence (NICE) guidance, to ensure that people who used the service would be safe.

Waddiloves Health Centre

Track record on safety

All staff we spoke with demonstrated that they knew how to identify and report any abuse to ensure that people who used the service were safeguarded from harm. Staff told us they had received training in safeguarding. We saw that information was provided to people who used the service about how to report abuse.

Learning from incidents and improving safety standards

Staff understood how to escalate concerns to ensure the safety of people who used the service. Staff gave us examples of how they had made referrals to the safeguarding team. They told us how they had learnt from these so that the safety of people who used the service could be improved.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the clinic where people received dental treatment was clean and staff practised good infection control procedures.

Staff records we sampled showed and staff told us that the appropriate recruitment checks were completed to ensure that staff were suitable to work with people who used the service.

Good

Are services safe?

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

Assessing and monitoring safety and risk

Staff in the Intensive Support Team told us that they had received training in breakaway techniques and restraint was not used by staff. However, one support worker told us they had received training in the Management of Violence and Aggression (MVA). This was to specifically support nursing staff when they needed to do blood tests on some people. It was identified that it was in the best interests of some people to be restrained so that tests could be done to identify their physical health needs. This was recorded and agreed by the team of professionals that worked with the person.

One of the physiotherapists told us how they had put research into practice to ensure people's safety. They had developed a respiratory policy which they were working with nurses to embed into their practice. They planned to measure the respiratory rates of all people referred to the service. From this they could identify when the person became unwell as they will know what the baseline is for that person. This should help to reduce the number of premature deaths in people who have a learning disability due to undetected respiratory illnesses.

Understanding and management of foreseeable risks

We saw that there were robust lone working policies and all staff we spoke to were aware of these. Staff told us that they did joint visits to people in the community where there were known risks or where they did not know the person and were unsure of any risks. This ensured the safety of staff and people who used the service. Some staff who were based in other areas than at Waddiloves told us how the recent move of administration staff from local offices to the hub offices had increased the risks of potential harm to community staff. This was because there were less staff based in the offices which meant that sometimes staff were alone there. Staff told us they had put their own systems in place to try to reduce risks but were concerned about the potential risks.

Are services effective?

Requires Improvement

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

People's physical health needs were assessed and monitored to protect their health and wellbeing. However, we found that people's mental health needs were not always considered within the assessment and treatment unit. People with complex needs, for example autism, did not always have these met.

Generally, staff had received the training they needed to meet people's needs. However, not all staff within the assessment and treatment unit had received enough training on caring for people with autism.

Staff worked well together to meet the needs of people who used the service.

The Intensive Support Team needed to be developed to make sure that it met people's needs.

People knew how to access advocacy services. These services were effective in supporting people to make decisions about their care and welfare.

It was not clear how outcomes were measured by the community teams. This meant that the service was could not identify how or if a person's needs had been met to protect their health and wellbeing.

Although people's mental capacity was assessed, not all assessments by community teams were detailed. This meant that where people lacked the mental capacity to make decisions about their care and treatment, the decisions made may not be in their best interests.

Some staff across the service needed more training about when to use the Mental Health Act and when to use the Mental Capacity Act, to make sure that people were being treated in the least restrictive way.

Our findings

Highfield assessment and treatment unit

Assessment and delivery of care and treatment

We saw that staff assessed and monitored people's physical health needs. Staff told us that this was completed on admission to ensure that people's physical health needs were met during their stay, and where referrals were needed, these could be made. We saw that one person had not had all their physical health checks completed since their admission. However, staff told us that these were delayed because the person continued to be distressed and would not allow staff to do this.

Records we sampled included detailed care plans. These showed staff how to support the person to meet their needs in the way the person wanted.

We saw that for most people who used the service, assessments of their mental capacity had been completed for each decision about their care and treatment. However, for one person we saw that an assessment of their mental capacity was completed on admission, but no further assessments had been completed. This meant that there was not an assessment that showed whether or not the person had the mental capacity to consent to their treatment there. This could mean that decisions were made about their care and treatment that are not in their best interests.

Staff rotas we sampled showed, and the ward manager told us, that some staff had attended training in how to work with people who used the service using positive behaviour support. The ward manager told us that staff discussed this training and approach in weekly staff sessions which helped to embed their training. This meant they were supported to use the skills and techniques to better meet the needs of people who used the service.

Outcomes for people using services

Some staff told us how they had used information from national audits and guidance to improve the effectiveness of the service. One member of staff told us how they had raised the need for services for people who have autism to be improved by the trust. They told us how this had resulted in them being contacted by a member of the trust board to ask how this could be developed. Staff told us about the monthly story that the trust had in the newsletter about the experience of a person who had used the service. They told us how this helped them to consider how to make the service more effective to improve the outcomes for people who used the service.

Staff, equipment and facilities

Most of the people who were admitted to the unit had a diagnosis of an autistic spectrum condition (ASC) in addition to their learning disability. The trust told us that they did not have a specific service for people who have ASC. All staff told us that they had received training in autism awareness and some staff had received further

Are services effective?

Requires Improvement

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.

training to develop their skills and knowledge. However, due to the needs of the current people admitted to the unit it was not possible to provide this further training to all staff. We received a comment from a relative who told us that staff did not have sufficient training in autism. They said this meant that staff were not able to support their relative to meet their needs. We saw that staff were unable to effectively engage this person in activities to stimulate and develop their skills.

There were a mix of qualified nurses, health support workers and occupational therapist support workers on each shift during the day. A qualified occupational therapist was based on the unit. We saw that there were a range of rooms and activities provided. These included a sensory room, music room, training kitchen, activity room, conservatory where there were a number of games and puzzles and two outdoor areas. However, we observed little evidence of activities taking place on the unit. Staff told us that this was because of the needs of one the people there and how difficult it was to engage with some people. This meant that the equipment and activities provided were not used effectively to meet people's needs. Staff told us that, due to the needs of the people who were currently at the unit, they were not able to provide the activities they usually did. Staff said that they usually recorded all activity that each person did in detail, how long the person participated in the activity and what the person's response was. This meant that they could support people to take part in activities they enjoyed and would benefit the person to develop their skills and independence. Staff we spoke with were frustrated that they were not able to provide activities in this way to the people currently placed there. This meant that the service was not effective in meeting the needs of some people placed there. The senior managers were however aware of the difficulties placed on the unit at the time and were actively seeking to address this.

We saw that the environment was arranged so that people had their own space and this reduced the impact from the behaviour of other people who used the service.

Multi-disciplinary working

We saw that weekly meetings were held with the multi-disciplinary team of professionals that worked there to discuss how they were meeting the needs of each person. Staff told us that these meetings were held more often if needed. We saw that the team worked well together to try to meet people's needs. We found that people's physical health needs were identified and action taken to meet these. However, we saw that staff were not always effective in meeting people's complex needs including their mental health needs and autism.

We saw that each person had two named nurses who were responsible for meeting with the person at least once a week to discuss how their needs were being met and what could be done to improve this. We saw that some people refused to engage in these but staff offered these at least once a week.

We saw that admissions to the unit were usually planned so that staff would have the information they needed about the person prior to their admission to help to meet their needs. Staff at the unit had weekly meetings with the Intensive Support Team in the community to ensure that the likelihood of emergency admissions occurring were reduced. This helped to ensure the wellbeing of people who used the service so that they had effective support in the community prior to admission and, where needed, after discharge from the unit.

We saw that, where appropriate, people had support from community staff that knew them during the time they were at the unit. For example, one person's community support worker visited them regularly to maintain contact with the person and enable staff there to effectively meet their needs.

Mental Health Act (MHA)

There were three people detained there under the Mental Health Act 1983. We saw that people had access to an Independent Mental Health Advocate (IMHA). Records we sampled showed that the person's IMHA was invited to all meetings held about the person. This meant that the views of the person could be considered.

We saw that information was available in two languages for people who were not detained there under the MHA. This stated that they had a right to leave the unit when they wanted to.

Records we sampled showed that people's forms for when they had section 17 leave from the unit had been completed appropriately. However, some of the used section 17 leave forms had not been crossed out to show that this was no longer applicable. This could mean that staff were unsure what the current leave arrangements for the person were which could impact on the person's safety and wellbeing.

Are services effective?

Requires Improvement

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.

We saw that people had been informed of their rights under the MHA. However, this had not always been recorded on their records on the computer system on the unit. This could mean that people were not read their rights as often as required to ensure they had understood these.

We saw that a second opinion appointed doctor (SOAD) had seen people who had been prescribed treatment without their consent because they did not have the mental capacity to do so or had refused to. The SOAD had stated that it was appropriate for treatment to be given.

Waddiloves Health Centre

Assessment and delivery of care and treatment

In the community learning disability services we saw that people's care plans were developed with the person and centred on them and what they wanted. They were produced using pictures and in language that was easier to understand, which made them more accessible to people who used the service.

We saw several examples of good practice in relation to health screening and facilitation. For example, we saw that a screening tool was being used that had been developed specifically for people who had Down's syndrome.

Some people who used the service had been assessed as not having the mental capacity to make their own decisions about their care and treatment. We saw some good examples of best interest assessments completed by health facilitation nurses for these people.

We saw that a person who was on a Community Treatment Order (CTO) had an assessment completed of their mental capacity. We saw that staff across the learning disability service had worked together to support the person to make choices about their transition from hospital to the community.

We saw that health facilitation nurses worked with people who had a learning disability in the community to ensure that their physical health needs were met and people received their annual health checks.

It was not clear from psychology staff spoken with what the function of the psychology service was and who and when people would receive treatment from this service. We saw that psychology staff spent a lot of time completing assessments of whether or not a person had a learning disability and met the criteria for receiving the service. However, nurses spoken with told us how a checklist had been developed for nurses to be able to complete this assessment. They told us this was to reduce the psychology waiting list and through doing this only the complex assessments needed to be completed by the psychologists. This had reduced the psychology waiting list but was not yet effective in ensuring that the psychologist's role within the team was clear.

Outcomes for people using services

We saw that weekly clinics were held to meet people's physical health needs. There was good screening of people's physical health needs which ensured that each person had an annual health check.

We saw that community matrons were employed in the community team. They supported people who had complex needs and may have a range of professionals that worked with them. This meant that there was one professional who acted as the link to the person and their family or carers which helped to provide a more effective, consistent service.

The recent review of the Intensive Support Team (IST) showed that the team had prevented 20% of admissions to hospital from April 2012 to April 2013. We also saw that 49 high-risk admissions to hospital were prevented by intervention from the team. Staff told us that they thought there were a higher number of prevented admissions than this but not all outcomes had been measured as this was difficult to do on the current reporting system used. They said that they often offered support to staff in care homes which was not included as part of the numbers. This meant that it was not clear how effective the team had been in reducing admissions.

Staff showed us that care plans were focused on achieving the outcomes for people. We saw in one care plan that outcomes for the person were clearly stated. We saw that the transition team had a range of systems in place to evaluate the service. These included a questionnaire that was sent to families to ask for their views and experiences of the service provided.

Some staff spoken with told us that research was taking place in the learning disability directorate which they thought ensured that the organisation could be more effective in meeting people's needs.

Staff told us and we saw that the outcomes for people who used the service were not measured so it was not clear how effective the service was. Some staff told us they had

Are services effective?

Requires Improvement

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.

recently started using questionnaires that were accessible to people who used the service. They said they used this feedback to help improve the service provided. This was not consistent across all teams and most staff told us they did not know overall how the work they did improved outcomes for people who used the service. They told us how work with individuals had, in their opinion, improved the person's life but it was not clear how effective the service as a whole was in providing positive outcomes for people who used it.

Staff, equipment and facilities

Staff in community teams told us they received a week's induction when they first started working there, which included the mandatory training they needed to ensure people's safety. They shadowed another member of staff for a week and had three days training in the computer system before they had a caseload and were expected to support people who used services.

Staff spoken with told us that there were not enough staff in the Intensive Support Team (IST) to provide the service needed. We saw that there were high levels of sickness in this team, which meant that other staff had bigger caseloads. The role of this team was to support people in the community and prevent admission to hospital. One member of staff had been recruited and was due to start working there the following week. We saw that the staffing levels impacted on how effective the service could be in achieving their aims. For example, staff told us that they do not have the staff to be able to visit people as often as they would like and observe them where they are. This meant that they often relied on the information that the person's relatives or carers gave them and not on their own assessment. They said that this could make it more difficult to develop effective care plans. This could reduce the effectiveness of the service and result in people being admitted to hospital for care and treatment. The assessment and treatment unit was currently closed to admissions due to the needs of people placed there. The IST were working to negate the risks of this to prevent people needing to be admitted to hospital. However, they did not have sufficient staff to be able to do this on a long term basis. Staff in the IST told us that if they provided an out of hour's service and were based at the assessment and treatment unit the service could be more effective. Staff told us that behaviour therapists were now based in the psychology team which meant that this reduced how effective the IST could be in providing behavioural therapy for people who used the service.

Multidisciplinary working

Staff told us that the team was no longer integrated with social services and that people who they supported did not have allocated social workers due to local government budget constraints. They also told us that their computer system was not compatible with the social services system. This meant that sometimes community staff had to go out to visit people to assess what other services were providing because they did not have this information about the person. This meant that their ability to provide an effective service to meet the needs of people who used the service was reduced. Staff had regular meetings with social services teams to try and reduce the impact of this.

We saw that all teams worked well together, particularly in relation to meeting people's physical health needs. However, we found that community teams were less effective in meeting people's mental health and complex needs. This was because the objectives of some teams were unclear and the psychology service was not led by a clinician who was a specialist in learning disability. We saw that improvements were being made to this, for example, the manager of the IST team attended the mental health team governance meetings to ensure that issues that affected people who have a learning disability were kept on the mental health agenda.

We saw that IST referred people to other professionals to ensure their needs were met. Staff in the IST told us that they had recently started to attend weekly meetings with the psychiatrist. They told us this helped to make the service more effective for people who used it. They also worked with the psychology team which had helped to reduce the psychology waiting list and gave each team a greater understanding of each other's pressures. They said this made the service more effective in meeting the needs of people who used it.

We found that staff worked well with staff in general hospitals to ensure that when a person with a learning disability was admitted they would receive the care they needed. Staff worked with the teams on the ward during their admission and ensured they also had a safe discharge. For example, staff told us that they worked with the discharge team at the general hospital. This ensured

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that hospital staff and the carers, relatives or staff that worked with the person at home understood their role in supporting the person to meet their needs. This meant that the person was supported throughout their time in hospital and when they returned home.

We observed good working relationships between staff working in children's and adult services to ensure that people were supported in their transition across these services.

Mental Health Act (MHA) 1983

We saw that one person was on a Community Treatment Order (CTO) and that this had been applied appropriately and met the legal requirements of the Mental Health Act (MHA). We saw that the person had been supported by advocacy services and the community team to ensure they understood the conditions of the CTO and what they needed to do to comply with it.

We found that staff needed more training about when to use the MHA and when to use the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) to ensure that people were being treated in the least restrictive way. Staff had received a briefing following the Cheshire West ruling and would be attending a one-hour training session. We saw that staff had the basis of the implications of the changes, however, they needed more support and training to enable them to have a greater knowledge and develop their skills.

Records we sampled showed that people's mental capacity to consent to their care and treatment had been assessed. These were generally detailed assessments, however, the community nurses assessments were brief and staff had ticked whether an assessment had been completed and whether the person had mental capacity or not. They did not detail how the person's mental capacity had been assessed to make specific decisions about their care and treatment. This could impact on how decisions were made to ensure they were in people's best interests. Detailed best interest assessments seen helped to ensure that each decision made was in the person's best interests.

Staff told us that there was not an Approved Mental Health Professional (AMHP) who worked specifically in the learning disability service. They said this would ensure that people with a learning disability, who have issues that affect their behaviour and mental health, were detained only when this was the least restrictive way of providing them with the care and treatment they needed.

Good

Are services caring?

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

Summary of findings

Staff were caring and compassionate, and they were genuinely motivated to make sure that people were well supported.

People who used the service were also treated with dignity and respect. However, some people in the assessment and treatment unit and in community teams, were not always involved in their care and treatment. This was because information was not provided in a format they could understand.

Our findings

Highfield assessment and treatment unit

Kindness, dignity and respect

We observed that staff were compassionate and caring towards people who used the service.

All staff spoken with demonstrated an understanding of the individual needs of people who used the service. Staff told us how they supported people to attend their chosen places of worship, if they wanted this, to meet their religious needs.

People using services involvement

We saw that a lot of good information about the service and advocacy services was provided on a notice board in the unit. However, this was all provided in English. The needs of the local population are diverse. Staff spoken with told us that if people could not understand English, staff would contact an interpreter or a member of staff who spoke the first language of the person who would translate it to them. We saw that some signs were provided on the unit in other languages to support people to understand.

We saw that each person had an information pack in their bedroom. This told people what they needed to know about the unit, mealtimes, what care they would receive there and how to make a complaint. We saw that a lot of the information had been photocopied several times which made some of it difficult to see.

The ward manager told us that when a person was admitted to the unit a referral was made for them to the advocacy service. Records we sampled showed that each person had access to an advocate to ensure their views were expressed about the service they received.

Records we sampled showed that care plans had been written in a way that was easy to read to make them more accessible to the person who it was about. We saw and staff told us that people and their family or advocates were invited to their reviews and all meetings about them.

Emotional support for care and treatment

We observed positive and respectful interactions between staff and people who used the service.

We saw that people were supported to maintain contact with their family and continue links with their local community. Staff spoken with told us that visiting times were flexible as they recognised it was important for people to maintain contact with and see their family regularly.

Waddiloves Health Centre

Kindness, dignity and respect

We observed that staff treated people who used the service with dignity and respect. We saw a member of staff talking with a person who used the service and their family. Although staff spoke more with the person's family, all the conversation was centred on the person and what they wanted to meet their needs.

People using services involvement

We observed an outpatient appointment and the person was asked if they agreed to this. The person had been sent a letter about this appointment but it was not in an accessible format, which would help them to understand. We observed that they were not involved in the discussion about their care and treatment, but were talked about by the professionals at the meeting. The only questions they were asked were presented in a way that did not seek their view or make it possible for them to understand.

At other appointments we observed, we saw that staff communicated well with people who used services, so they understood their care and treatment and could have a say in this. Staff gave people time to respond to any questions they asked and ensured they understood what was being

Good

Are services caring?

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

discussed. We saw that a community nurse wrote an appointment date on a person's calendar to help them understand and remember when their next appointment was.

We observed staff clearly explained to a person why they had visited and went through their health plan with them. This involved the person throughout and staff gave the person an opportunity and time to respond to questions asked.

We attended a meeting with staff from the transition team. This is a team that works with people who are making the transition from children to adult services. The person did not attend the meeting but all the meeting was focused on them, all their needs were considered and action taken where further input was required. We saw that the transition team asked parents and carers for their views about the service provided in a questionnaire. These were used to make improvements to the service to benefit people who used it.

Records we sampled included care plans that were in formats accessible to the person to enable them to be involved and understand how they were supported. We saw that people were offered choices about their care and treatment and empowered to make these.

Emotional support for care and treatment

We observed positive and respectful interactions between staff and people who used the service. It was evident that staff had worked with people in a way that enabled them to trust the staff member. This helped to ensure that the person's needs could be met.

Are services responsive to people's needs?

Good

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

Summary of findings

Staff in the assessment and treatment unit worked with community teams to plan people's discharge from hospital.

The service met people's religious, cultural and gender-specific needs.

Staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.

We were told by staff that the trust had an open and transparent culture, so any concerns or complaints were dealt with and improvements made.

The assessment and treatment unit was closed to admissions because of the needs of the current inpatients. The community teams had responded to this in the short term, but this could not be a long-term solution because of staffing issues in those teams.

Our findings

Highfield assessment and treatment unit

Planning and delivering services

All staff spoken with told us that interpreters were always available to use when needed and they provided a good service. They said this helped people to understand their care and treatment.

We saw that the unit had been divided to ensure that men and women had separate areas where they could be cared for to ensure their individual specific needs could be met.

We saw that facilities were provided, which included a training kitchen and laundry equipment, to help maintain and promote people's independence. Staff told us that the people who currently used the service did not use these often due to their needs, however, these had been used regularly in the past.

Staff told us that the unit had previously been used for a large number of people and this had been gradually reduced over the years. This meant that there were several bedrooms that were no longer used and several staff were needed to be able to safely support people. We saw that one person had broken the glass in a door which had been boarded up to make it safe. The ward manager told us that this happened about two weeks ago and, although it had been reported, there was often a delay in work being completed by specialist contractors. The ward manager told us that this did not benefit the wellbeing of the person who had broken this, as it served as a constant reminder to them about how they had behaved.

Right care at the right time

The unit was currently closed to admissions due to the needs of the people placed there. There were four people placed there, one of whom was ready to be discharged. This meant that the unit could not respond to meet the needs of people who needed to be admitted.

Care pathway

Staff gave us examples of how they had worked with people to ensure the person's individual needs were met. For example, they told us how they had adapted one person's care plan with the help of an interpreter to ensure the person and their family could understand it. They also told us how they found out what interests a person had and developed the person's activity plan around these to help the person to engage.

Staff told us that they supported people to attend their chosen place of worship if they wanted to. They also showed us that facilities were provided to meet individual's religious needs if people wanted to use these.

We saw that staff planned for the person's discharge from the time they were admitted to the unit. Staff worked with community teams to ensure that people's needs were met on their discharge. Some people were at the unit longer than they needed to be and their discharge was delayed. This was due to social service teams not being able to allocate a social worker to be able to move the person to an alternative placement. Staff told us that this had a negative impact on people's wellbeing. Staff contacted social services teams regularly to ensure that they were aware of the need to move the person to a more suitable placement.

A relative told us that staff did not communicate well with them which meant that staff were unable to be responsive and meet their relative's needs. We saw in the person's records and from talking with staff that staff had tried to respond to the person's needs but they did not always have the skills and training to be able to develop this.

Are services responsive to people's needs?

Good

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

Learning from concerns and complaints

One relative told us they had made a complaint about the service provided and since they had done this they had received regular communication from the senior management of the trust.

Staff told us that there was an open culture in the service and that if they raised a concern or complaint this would be listened to. They said that they would not need to make a formal complaint as improvements were made if they raised any concerns informally.

Waddiloves Health Centre

Planning and delivering services

All staff told us that good interpreting services were provided, which were easy to access, reliable and consistent and helped support staff to meet people's individual needs.

We saw that the community teams worked well together and with other services that the person accessed, for example, general health care, schools and day centres. This ensured that the services could respond to the person's individual needs.

We observed that staff prepared for visiting people before they went out. This helped to ensure that the person's individual needs were met.

Staff told us how some of the mental health services had expected that all of the person's needs would be met by the learning disability teams so that people were referred to teams to meet them all. They told us that this meant that people's needs might not be responded to appropriately. We saw that a plan was developed to reduce the risk of this happening and improve the working relationship between the services.

Right care at the right time

We saw and staff told us, that some teams worked flexibly, to suit the needs of the person. This meant that they visited people at a convenient place to them, for example, at their work placement, school or day centre. Staff also told us that they would visit a person later in the day if needed, so that they did not have to miss going to their day centre.

Staff told us how they had worked with a person when they were in the assessment and treatment unit to develop a relationship with them and prepare the person to move back into the community. They increased the time they spent on each visit gradually and when the person was discharged they were comfortable enough for the community nurse to visit and give them their regular injection. This helped the person to feel in control of their care and treatment and reduced the need for further hospital admission.

Staff told us how there was a learning disability champion on each mental health acute ward in the trust. This helped staff to respond to the needs of people with a learning disability if they were admitted there. They also told us that learning disability and autism awareness training was being provided to all staff working in the trust mental health services.

We saw that when staff visited people in the community they ensured that all their physical health needs were met. Where needed they arranged appointments for them with the dentist and podiatrist. A specialist dentist and podiatry service was provided at Waddiloves for people who were unable to access local community services. A health facilitation nurse worked in the clinic and ensured people were supported to reduce their anxieties and get the physical health treatment they needed.

There was a waiting list of about 15 months for psychology services and team members spoken with were not clear what they needed to do to reduce this and provide the service they wanted to provide.

Care pathway

We saw that a clear criterion was in place as to how most teams responded to people's needs. We saw that the transition team had a clear pathway as to what care and support people who used the service would receive. Staff were clear as to this and we observed that people who used services were cared for in the way they needed. The Intensive Support Team (IST) duty nurse took referrals and these were allocated to appropriate staff who would visit the person. We saw that urgent referrals were always responded to, which helped to prevent people's admission to hospital as much as possible.

Learning from concerns and complaints

We saw that information was provided for people who used the service and their relatives as to how to make a complaint about the service.

Are services responsive to people's needs?

Good

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

Staff told us that there was an open culture in the service and that if they raised a concern or complaint this would be listened to. They said that they would not need to make a formal complaint as improvements were made if they raised any concerns informally.

Are services well-led?

Requires Improvement

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

Staff felt well supported by their managers and by the senior management.

People who used the service were listened to and, as a result, improvements made.

Staff had opportunities to develop their skills and knowledge.

There was no visible leadership in some community teams. This meant that the service was not always effective in meeting people's needs.

The psychology team leader only worked part time and was not a specialist in learning disability. This meant that the team had limited specialist input and were unclear of their objectives.

Our findings

Highfield assessment and treatment unit

Vision and strategy

It was not clear from all our discussions with staff that the vision of the trust had been clearly communicated to them to help them understand their role and, if changes were made, the reasons for these.

Responsible governance

Some staff we spoke with, were not clear which individual leader was specifically responsible for the learning disability service. The trust's structure showed where the learning disability service fitted. Staff did not refer to this structure but to their line manager who they told us led them well. Some staff told us how they had tried to raise the profile of meeting the needs of people with autistic spectrum conditions (ASC). Most of the current people in the unit had this diagnosis but the trust told us that they were not commissioned to provide these specific services. However, staff told us that recently experts in ASC had been appointed to the trust planning committee and in children and adolescent mental health services (CAMHS) to help develop these services so they could be provided to meet people's specific needs locally.

Leadership and culture

Staff told us that the ward manager was very supportive and led the unit well. Staff told us that they felt valued by the trust for the work they did and senior managers had visited the unit and told them this.

Staff told us about monthly culture conversations that were held within the trust. They said these conversations were open and honest and gave them an opportunity to discuss staff morale and how improvements could be made to benefit people who used the service.

Engagement

Staff told us they received regular supervision with their manager and were also encouraged to have clinical supervision or meet regularly with another staff member in the same role. This meant that each member of staff was given an opportunity to develop the skills for their job role and profession.

Some staff spoken with told us that they thought the trust board had learnt from the Francis Inquiry. They thought that the board wanted to engage with staff and people who used services as a result of this and ensure this was used to develop an open and transparent culture.

Staff told us and we saw that the trust invited stories from people who used the service about their experiences of the service provided. Each month these stories were published in the trust newsletter to ensure that all staff knew what they had done well, what could be better and how things were to be improved as a result of listening to people who used the service.

Performance improvement

Staff told us they received an annual appraisal to assess how well they were performing in their role and what they needed to do to provide a better service to people who used it.

Waddiloves Health Centre

Vision and strategy

Some staff told us about the changes that had been made within the trust. They were particularly concerned about the negative impact of administration staff moving from local offices to work in hubs. It was not clear from all our discussions with staff that the vision of the trust had been clearly communicated to them to help them understand the reasons for any changes that were made.

Are services well-led?

Requires Improvement

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.

Responsible governance

Some staff we spoke with, were not clear which individual leader was specifically responsible for the learning disability service. The trust's structure showed where the learning disability service fitted. Staff told us that there used to be a team leader but there was not one now. They said that as small teams they were well led but did not think that the services worked as well together as they used to, which could impact on how the service met the needs of people who used it.

We saw that locality governance groups had been set up and staff told us that learning disability services had recently been represented on these. These provided good networking opportunities for colleagues of different disciplines across the service to help the service to become integrated and benefit people who used the service.

We found that some teams did not have clear objectives and as a result of this did not measure the outcomes for people who used the service. This meant that it would not be possible to assess the quality of the service they were providing. We spoke with several motivated staff and we observed that staff worked hard to provide a good service for people who used it. However, without clear objectives and direction, the service could be at risk of not providing a quality, safe service for people who used it.

Leadership and culture

We observed, and staff told us, that there were some good team leaders and this resulted in staff feeling valued and positive about their work. Several staff told us that they had met senior trust managers and thought that they valued the work they did.

Staff in the psychology service told us they were managed by a part time consultant psychologist who worked in mental health but not the learning disability service. The psychology team consisted of junior staff who had recently qualified and, all but one of the team, was employed part time. We found that the team were not clear as to their objectives and their priorities, which affected the service provided. We saw that psychologists spent a lot of time promoting the wellbeing of other staff in learning disability services, for example, counselling and reflective practice sessions at the assessment and treatment unit and 'mindfulness' sessions for community staff. However, psychology staff were not themselves supported in this way which could reduce the effectiveness of the service they provide.

Engagement

Several staff told us about the 'Involving You' group that involved people who used the service and their relatives. Staff said that some of these meetings had been too formal, which excluded some people. However, they had been changed to make them more accessible ensure people's views could be better expressed. They also told us about a sub group from this, run by people who used the service, called 'Healthier Lives'. They said that people who used the services did 'mystery shopping' in the trust services and the results of this were used to improve services.

Most of the staff spoken with told us that they were well led by their managers. Staff told us they received regular supervision with their manager and were also encouraged to have clinical supervision or meet regularly with another staff member in the same role. This meant that each member of staff was given an opportunity to develop the skills for their job role and profession. Several staff told us how they received positive feedback from their manager, which helped to make them feel valued.

Some staff told us that they were they were listened to by the trust managers and their team resources were increased as a result of this.

Performance improvement

Staff told us they received an annual appraisal to assess how well they were performing in their role and what they needed to do to provide a better service to people who used it.