

Learning disability services inspection programme

National overview



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Foreword



Dame Jo Williams

In June 2011, the Care Quality Commission (CQC) stated that we would carry out a programme of unannounced inspections of services providing care for people with learning disabilities and challenging behaviours. This was in direct response to the BBC Panorama programme (May 2011) which exposed the abuses that had taken place at Winterbourne View hospital.

We set up external advisory and reference groups to provide support and challenge to the design, development and implementation of the inspection programme. I am grateful to the members of both groups for their rigorous commitment to the oversight and conduct of this review, and for their challenge and insightful questioning of our proposals. They have constantly reminded us that services need to deliver high-quality care that is based around the needs of the individual, acknowledging and involving family carers when appropriate and maintaining vigilance in the quality and safety of care delivery.

Each inspection included an expert by experience (someone who had experience of using services) and a family carer, as well as a professional advisor. The involvement of outside expertise alongside our inspectors has added significant value to the inspection programme, and brought with it an added depth to the process and judgements made about the quality and safety of care we observed. We have published an independent evaluation of the experiences of people with learning disabilities, family carers and professional advisors as members of the inspection team. The results show that it was a positive experience for all involved, views were taken seriously by CQC inspectors and, given the opportunity, all said they would be willing to engage in such inspections again.

I want to acknowledge the role played by Terry Bryan who blew the whistle on the abuses he observed at Winterbourne View Hospital. Furthermore, he has been a member of the CQC reference group and he has been on a number of the inspections as a professional advisor. His experience of working in learning disability services has been invaluable in the process.

CQC undertook an internal investigation regarding our response to whistleblowing information. We now have a specially trained whistleblowing team at our National Customer Service Centre. All whistleblowing concerns are tracked and chased through each stage of follow-up until completion.

Reviews of services for people with learning disabilities have taken place before in response to evidence of poor care and abuse in institutional settings. These include the irregularities at Ely hospital Cardiff in 1967, the Budock Hospital abuse in 2006, Sutton and Merton PCT investigation in 2006, and the learning disability national audit undertaken by the Healthcare Commission in 2007.

There is a good deal of evidence available as to what constitutes good care, and good commissioning. Our findings from this inspection programme show that there remains a significant shortfall between policy and practice. We found that nearly half the locations we inspected were not meeting the essential standards of quality and safety of care that people should expect. We found many people have been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people were in services away from their families and homes. Overall, there remains much to be done to ensure that people with learning disabilities are not discriminated against and that expectations are raised about the type of services that can be commissioned and provided for people and their families.

This national overview report provides an analysis of the findings of 145 inspections, as we have excluded the first five inspections in which we piloted the methodology. The report highlights the key areas of concern. One of the most significant findings is that in too many cases care was not person centred; people were fitted into services rather than the service being designed and delivered around them.

The majority of the locations we inspected were assessment and treatment or rehabilitation services, therefore we expected to see people being helped to live their lives with more independence and choice. Family carers on the inspection team described how they witnessed that people were kept occupied rather than having meaningful person-centred activities.

People are admitted to these services because they need help and support – for some this will have been at a time of crisis. They and their families need to be assured that they will be treated with care and respect. Our findings show that many people do benefit from good care from committed staff. However, this was far from universal with some locations failing to meet the individual needs of the people entrusted to their care.

The reports for the 150 locations have all been published and each details what our concerns were at individual locations. Where concerns were identified these are being followed up by the local inspection teams. Indeed, where we have carried out further inspections so far, the findings are encouraging.

Our findings demonstrate that services for people with learning disabilities still need to improve and that this requires a whole system response and approach from the policy makers, the providers, the commissioners and the regulators. There is no need for further guidance, but rather the purposeful will and effort to make sure that the policy vision is implemented for the benefits of people with learning disability and their families. There remains much to be done to ensure that people with learning disabilities are provided with care in community settings close to their homes and that they are only admitted to assessment and treatment services when clinically appropriate.

The results from the 150 inspections show that if the care system is to meet the needs of this group of vulnerable people it is vital to ensure that authentic person-centred care is commissioned appropriately and delivered. If this were to happen systematically people would be much more in control and able to exercise choice about how and where care is delivered that best meets their needs.

I want to acknowledge the part that the Learning Disability Public Health Observatory (LDPHO) has played alongside CQC in the analysis of the data. We welcomed the opportunity of having academic rigour and input to support the findings from the inspections. The LDPHO carried out all the statistical analysis, some of which has been used in the report.

The results from our inspections capture both the quantitative analysis and, importantly, the voice of the people using services, as well as the observations and judgements from the inspection teams. These are reported under each of the outcomes we inspected against. They all tell an important story about the quality and safety of care for some of the most vulnerable people in the care system. We have named those organisations in the extracts where the examples illustrate good care, since we want to be able to highlight the good practice we observed. It is practice that potentially can be shared more widely by the providers as part of their own quality improvement initiatives.

We have not named the providers in our analysis illustrating poor care and safety for two reasons. Since our inspections, the provider may well have improved the care in line with our requirements and we may also have been back on another unannounced inspection and published a second report. All the extracts are taken from the 145 inspections reports which we have already published, and we have listed all the locations we visited in Appendix C of this report.

The aims of this inspection programme included providing assurance to people using services, their relatives and the public that CQC would take appropriate action when we identified non-compliance with essential standards of safety and quality. Where we have had serious concerns we have taken prompt action and in those cases have already been back to inspect again and to be assured that improvements have been made. There is, however, an ongoing responsibility for the providers and commissioners to make sure that quality assurance systems are in place 24 hours a day, seven days a week. This includes having appropriate complaints procedures, access to and use of advocates, welcoming approaches to visitors and a fundamentally sound and appropriate support and supervision structure for all staff.

Dame Jo Williams
Chair, Care Quality Commission

Summary of key findings

We undertook this inspection programme in response to the serious abuse and appalling standards of care at Winterbourne View, which was a private hospital for people with learning disabilities. Of the 150 inspections we carried out, 145 reports were used for this analysis. The five pilot locations were excluded as we amended the approach on the basis of what we learned from the pilot work. The 145 locations in the sample were made up of:

- 68 NHS trusts providing assessment and treatment and secure services, including two services that were residential care homes.
- 45 independent healthcare services (IHC) providing assessment and treatment and secure services.
- 32 adult social care (ASC) services providing residential care.

We inspected all the services against two outcomes which were:

- Care and welfare of people who use services (outcome 4).
- Safeguarding people who use services from abuse (outcome 7).

For the purposes of the analysis, and in line with our approved methodology, locations are considered compliant with the outcome area if the judgement is either compliant or if there was a minor concern with an improvement action, that means they met the standard. Locations are non-compliant, that is they have not met the standard, if they have either a moderate or major concern with a compliance action.* The key findings from our judgements are:

- Overall levels of compliance with both outcomes were low. Forty-eight per cent of all locations inspected were non-compliant with care and welfare of people who use services and safeguarding people who use services from abuse.
- NHS locations were nearly twice as likely to be compliant with both of the outcomes compared to IHC providers (68% and 33% respectively).
- Less than half (47%) of the ASC services inspected were compliant with both of the outcomes.
- However, the majority of people (63%) were living in residential care homes that were compliant with both outcomes.
- The majority of assessment and treatment services were compliant with both outcomes (51%).
- However, there were more people (58%) in the services that were non-compliant.
- The range of length of stay in NHS and IHC assessment and treatment services and secure services ranged from six weeks to 17 years. Generally,

* For major concerns, in some cases enforcement actions will be made instead of compliance actions.

these were unacceptably long, and inconsistent with the descriptions of assessment and treatment.

- Assessment and treatment services and secure services run by the NHS were significantly less likely to have patients resident for longer than two and three years respectively (45% and 58%), compared to assessment and treatment and secure services run by IHC providers (75% and 88%).
- For outcome 4 (care and welfare of people who use services), NHS providers had the highest proportion of compliant locations (71%) compared to ASC providers (63%) and IHC providers (49%).
- Also for outcome 4, the highest levels of major concerns were identified in ASC providers (16%), while it was 6% for NHS services and 4% for IHC.
- The main concerns with non-compliance with outcome 4 across all care settings related to care planning (38%), meaning that people and their families were not involved in the design of the care and therefore were not in control of their own needs – a lack of person-centred planning was a significant feature.
- For outcome 7 (safeguarding people from abuse), NHS providers had the highest proportion of compliant locations (79%) compared to ASC providers (59%) and IHC (51%).
- Also for outcome 7, the highest levels of major concerns were found in ASC providers (12%), while it was 11% for IHC and 2% for the NHS.
- The main concerns with non-compliance with outcome 7 across all care settings related to the use of restraint (25%), meaning that restraint was not recorded and monitored appropriately. There were no systematic review and lessons learnt approaches taken to incidents where restraint was used.
- Although there were independent advocacy services at most locations, the quality of that provision needs to be reviewed given that advocacy was available in those services which were non-compliant with the standards.
- Providers were sometimes unclear about the use of deprivation of liberty and the safeguards needed, and those that were unclear did not have internal or external mechanisms in place to address that knowledge gap.
- We identified specific safeguarding concerns at 27 (18%) locations, which needed to be referred to the relevant local authority safeguarding adult team. In these cases we either requested the provider to make the referral (which we followed up to confirm was done) or made the referral ourselves. All these referrals have been monitored and will continue to be monitored until a satisfactory outcome is achieved.

Conclusions and recommendations

Conclusion relating to commissioners

Overall our inspections reveal that assessment and treatment services admit people for disproportionately long spells of time and that discharge arrangements take too long to arrange. People are more likely to have longer spells of care in independent healthcare service assessment and treatment services and secure services than in comparable NHS services. This raises important questions about the patterns of commissioning behaviour and practices across England.

Recommendations for commissioners

- Commissioners need to urgently review the care plans for people in treatment and assessment services and identify and plan move on arrangements to the next appropriate service and care programme.
- The emerging Clinical Commissioning Groups and the NHS Commissioning Board, as well as the local authorities in England need to work together to deliver innovative commissioning at the local level to establish person-centred services. This is much more likely to lead to people being able to stay in their local communities and so maintain important relationships.
- Commissioners also need to review the quality of advocacy services being provided, particularly in those locations where we identified non-compliance with the standards.

Conclusions relating to providers

For many of the locations in the sample of 150 this was their first inspection against the Health and Social Care Act 2008 regulations. We therefore cannot compare at location level against previous inspections under the previous regulations. However, whenever possible, we have made comparisons of our overall findings with the Healthcare Commission 2007 report, *A life like no other: A national audit of specialist in patient healthcare services for people with learning difficulties in England*¹ which audited both NHS and independent healthcare services. The report indicates that since the audit there has been improvement in the development of some policies and procedures, but there still remains a significant weakness in relation to person-centred planning and care and the use of restraint.

Restraint was not well understood in terms of what constituted restraint, the monitoring of the use of restraint or learning lessons following incidents of restraint and analysis of these. The use of seclusion was not always recognised as a form of restraint.

The use of deprivation of liberties and the safeguards needed are not well understood, reported and lessons learned.

Recommendations for providers

- Providers must ensure that people using services are routinely involved and 'own' their care planning and activities. These must be available in appropriate formats and must be accessible.
- There are still lessons to be learned by providers about the use of restraint. There is an urgent need to reduce the use restraint, together with training in the appropriate techniques for restraint when it is unavoidable. There also needs to be systematic monitoring about the use of restraint and ongoing analysis so that lessons can be learned and patterns of use better understood, which should all lead to less use of restraint. The use of seclusion needs to be recorded as a form of restraint.
- Providers must ensure that staff understand and can apply the deprivation of liberty safeguards.

Recommendations for providers, commissioners and CQC

- Providers and commissioners should ensure that there are appropriate quality assurance systems in place. This includes having appropriate complaints procedures, access to and use of advocates, welcoming approaches to visitors and a fundamentally sound and appropriate support and supervision structure for all staff.
- CQC should determine when it is most appropriate to visit and inspect services at weekends and evenings, rather than Monday to Friday between 09.00 and 17.00. Visits at these times can sometimes provide the additional evidence needed to assess visitor access, and judge the quality of care, staff, support and supervision.

Conclusion related to the Care Quality Commission

During 2011, CQC inspected 52 locations offering comparable services to those included in the sample of 150 locations for this inspection. The inspectors also assessed compliance against the same two standards in these 52 locations. In the inspection of those services we found three-quarters (73%) of locations to be compliant with the same outcomes, which is significantly higher than is the case with these thematic inspections.

Recommendation for CQC

- We acknowledge that the sample of learning disability providers inspected outside this thematic programme (52) was small by comparison. However, the differences in judgments about compliance and non-compliance warrant further evaluation, to help understand and explain the differences.

Background

The BBC's Panorama programme last year highlighted serious abuse and appalling standards of care at Winterbourne View, a private hospital for people with learning disabilities. Following this the Care Quality Commission (CQC) set out a programme of risk-based and random unannounced inspections of locations providing care for people with learning disabilities and challenging behaviour.

Our plan to inspect 150 locations providing care for people with a learning disability was announced in Parliament on 7 June 2011. We brought together a broad range of stakeholders on 8 June 2011 to discuss early proposals and seek their feedback. This group was influential in shaping our work. We also formed a representative subgroup, the 'advisory group', to provide expertise and experience to inform the approach and scope of the inspection programme and to comment and provide a steer on the nature of the inspections in terms of focus and desired outcomes (see appendix A for terms of reference and group membership).

Definitions

*Valuing People*² defined people with a learning disability as having:

- A significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence).
- A reduced ability to cope independently (impaired social functioning).
- Evidenced before adulthood, with a lasting effect on development

Publication and follow-up

We published our inspection reports on all 150 locations on our website, along with details of what action services needed to take where they were either delivering poor care, or were at risk of delivering poor care if they did not make improvements. It took just over nine months from the decision to undertake the inspection programme to the conclusion of the individual inspections. Follow-up actions are now in place and we have already carried out follow-up inspections at some locations.

How we carried out the inspections

We carried out unannounced inspections at 150 locations in England, made up of 71 from the NHS, 47 from independent healthcare services (IHC) and 32 from adult social care (ASC). These inspections took place between September 2011 and February 2012. This inspection programme was undertaken in line with the judgement framework and enforcement policy in place at the time (see Appendix B).

Providers must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,³ and the Care Quality Commission (Registration) Regulations 2009.⁴ These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. Where a provider is not meeting the regulations we judge them as non-compliant and provide a level of concern. Being non-compliant increases the risk of poor quality care. Where this is the case we have acted swiftly to eliminate this risk.

We inspected against two 'outcomes' in each inspection. These were outcome 4 (care and welfare of people who use services) and outcome 7 (safeguarding people who use services from abuse). These relate to Regulations 9 and 11 respectively of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010³.

Planning of the project and recruiting suitable team members took place during June to August 2011, with training and piloting in September and then roll out in October 2011. A CQC inspector led each inspection, often assisted by a second CQC inspector. They were supported by a professional advisor and two experts by experience – one who was a person who had used services accompanied by their support worker, and a second expert who was a family carer. We trained a dedicated team of inspectors to lead the inspections, supported by a team of:

- 51 professional advisors
- 26 experts by experience who used services
- 27 experts by experience who were family carers.

We reviewed all the information we held about each provider. We carried out most inspections over two days between Monday and Friday. All inspections were unannounced. We typically arrived at a location at 9am and stayed until about 5pm. During the inspections we observed how people were being cared for, talked with people who used services and with staff, checked the provider's records, and looked at records of people who use services. As part of our inspection, telephone discussions were held with relatives and other professionals who were not able to meet with us during our visit.

During the inspections, our emphasis was on observing the quality of care provided to people with a learning disability and checking this against their care plans and other documents such as daily records and incident reports.

We used existing CQC methods and systems as well as specially adapted interview and observation tools to gain a greater understanding of activities relating to the two outcomes. To help us to understand the experiences people have, where possible we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time. Furthermore, it helped us observe the type of support people received and whether they had positive experiences.

We recorded our observations of the general environment and provision of care. We also checked personal records to look at how or whether care planning took account of people's wishes, preferences and choices, and how these were documented and monitored. Our inspections were designed to focus on outcomes, therefore placing the views and experiences of people who used services at the centre. All the published reports included views from people using the service and where possible their relatives.

Identifying the locations and services within those locations

Our primary selection criteria was to inspect NHS and IHC locations that offered services to people that were primarily defined as having a learning disability. We included:

- Assessment and treatment services
- Low and medium secure services
- Rehabilitation, step-down into the community services.

We excluded:

- Locations that had undergone a recent visit
- Locations with ongoing compliance actions
- Short break and respite services
- Community health services.

As we did not identify 150 NHS and IHC locations that met these criteria we responded to advice from the Advisory Group to include residential care home (RCH) locations.

Although we inspected 150 locations, five of these were undertaken as pilots and we revised our methodology following our learning from these. Therefore, the final analysis was on the remaining 145 locations.

Type of service provided by location

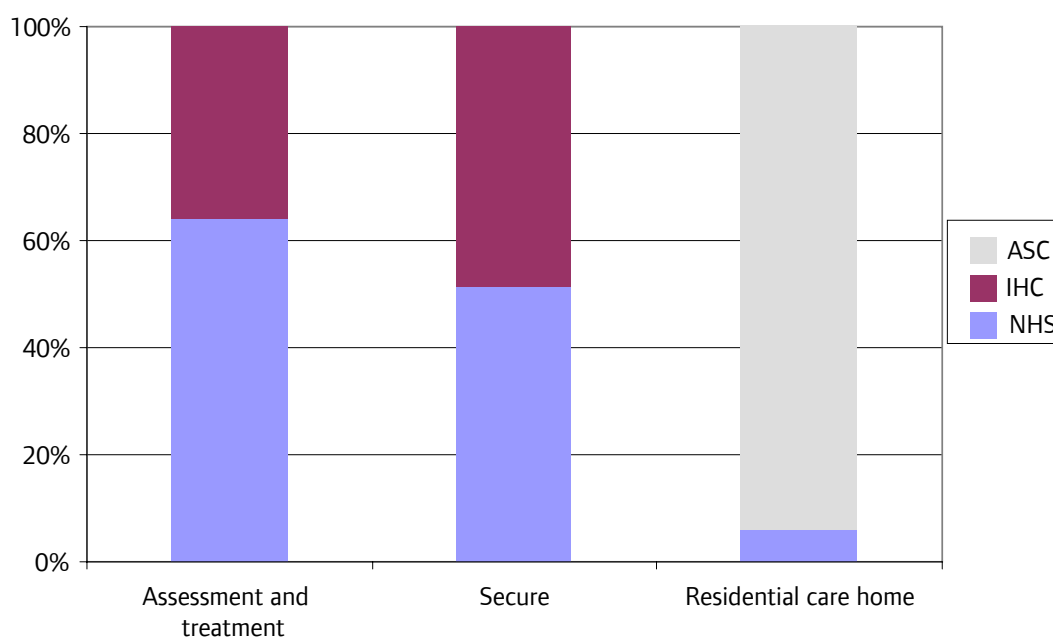
Over the course of the review we visited different types of services. For the purposes of analysis these were grouped as follows:

- 'Assessment and treatment' – this includes NHS and IHC locations that offer assessment and treatment; and/or rehabilitation.

- ‘Secure’ – this includes NHS and IHC locations that have a secure service at the location visited. A minority of these locations also had other services within the same location that offered services such as assessment and treatment and rehabilitation.
- ‘Residential care’ – this includes all the ASC locations including residential colleges within the Learning Disability Review and also two NHS locations that were offering a long-term service.

Proportionately there is a similar split of services inspected across the NHS and IHC as set out in Figure 1.

Figure 1: Type of service by location (n = 145)



How we analysed the data

The inspection reports, which reflected the data gathered by the inspections teams and from an analysis of relevant staff and service records, provided the themes by which the data was mapped and analysed. This approach also meant that the internal CQC quality assurance process delivered consistency with the judgements made across the services in England.

The data was mapped to themes and sub-themes under outcome 4 (care and welfare of people who use services) and outcome 7 (safeguarding people who use services from abuse) to help make the judgements and to analyse for this national report.

We also routinely collected data about the number of beds the service was registered for and the number of residents at the time of the inspection.

The Learning Disabilities Public Health Observatory agreed to work with us on the analysis of the data. Their independent analysis endorsed the themes and sub-themes as the units for judgements and analysis. They also provided a statistical analysis from the findings which we have been able to incorporate in our report.

Our key findings

Overall levels of compliance

Of the 150 inspections undertaken, 145 reports were used in the analysis. We have excluded the five pilot locations since we amended our approach after the pilot.

All locations were assessed against outcome 4 and outcome 7.

For the purposes of this analysis and in line with the approved methodology, locations are considered compliant with the outcome area if the judgement given is either compliant or there was a minor concern with an improvement action. Locations are non-compliant if they have either a moderate or major concern with a compliance action*.

- 35 of the 145 locations were fully compliant with no concerns for both outcome 4 and outcome 7 (24%).
- 41 of the 145 locations were compliant with minor concerns and improvement actions to address these across the two outcome areas (28%).

Overall, levels of compliance were therefore low, with 48% of all locations inspected being non-compliant with the essential standards of quality and safety. There is an increased risk of people using these services receiving poor quality care.

Although the overall percentage of services achieving compliance with both outcomes was 52%, there were more patients and people who use services in non-compliant assessment and treatment services, at 58%, than in compliant services.⁵

While there were more compliant secure units for both outcomes there were still disproportionately high percentages of people in these services – 57% compliant but 46% of patients in the non-compliant services.⁵

We found that less than half the residential care homes, 48%, were compliant with both outcomes, but significantly the majority of people using these services, 63%, were actually resident in the compliant services.⁵

It is noteworthy that during 2011, CQC had inspected comparable locations offering assessment and treatment and secure services that were outside this thematic inspection programme. These were inspections carried out at 52 locations as part of our 'business as usual' inspection activity. Although the number of locations was considerably smaller, inspectors judged the services to be compliant against the comparable outcomes in 73% of locations. CQC needs to understand the differences through making an evaluation of the processes,

* For major concerns, in some cases enforcement actions will be made instead of compliance actions

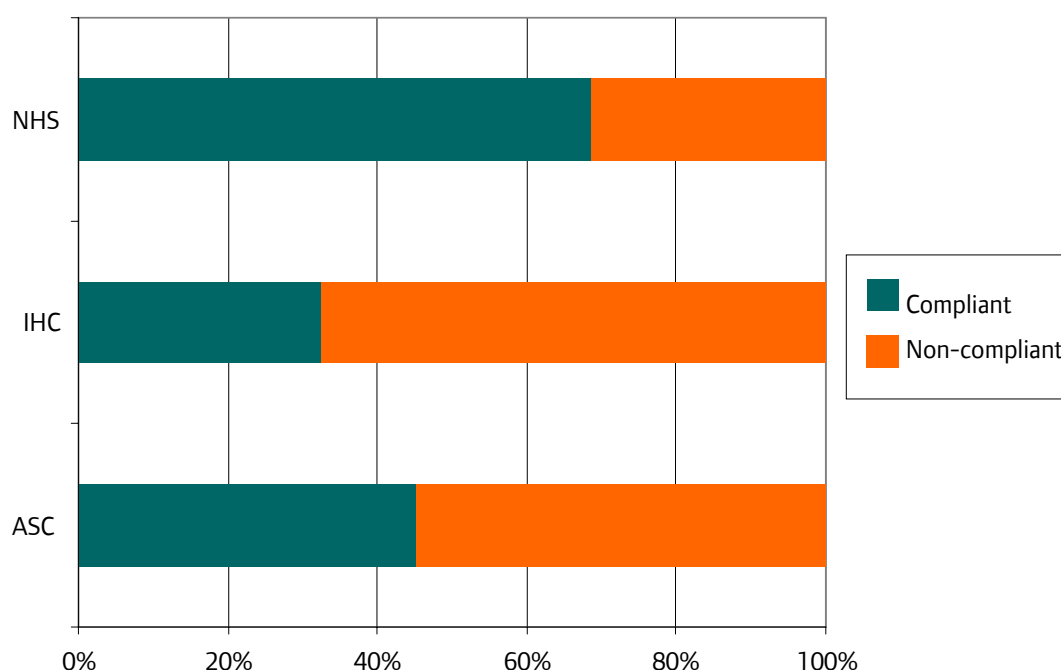
context and timing of the work and to find out to what extent the Winterbourne View Hospital exposé had an influence on the outcomes.

Overall levels of compliance by type of service provider

Of the three types of service provider inspected, NHS providers were twice as likely as independent healthcare service (IHC) providers to be compliant but with improvement actions required (figure 2):

- 46 of the 68 NHS locations were compliant but with improvement actions for both outcomes (68%).
- 15 of the 45 IHC locations were compliant but with improvement actions for both outcomes (33%).
- 15 of the 32 ASC locations were compliant but with improvement actions for both outcomes (47%).

Figure 2: Compliant and non-compliant services by type of service provider

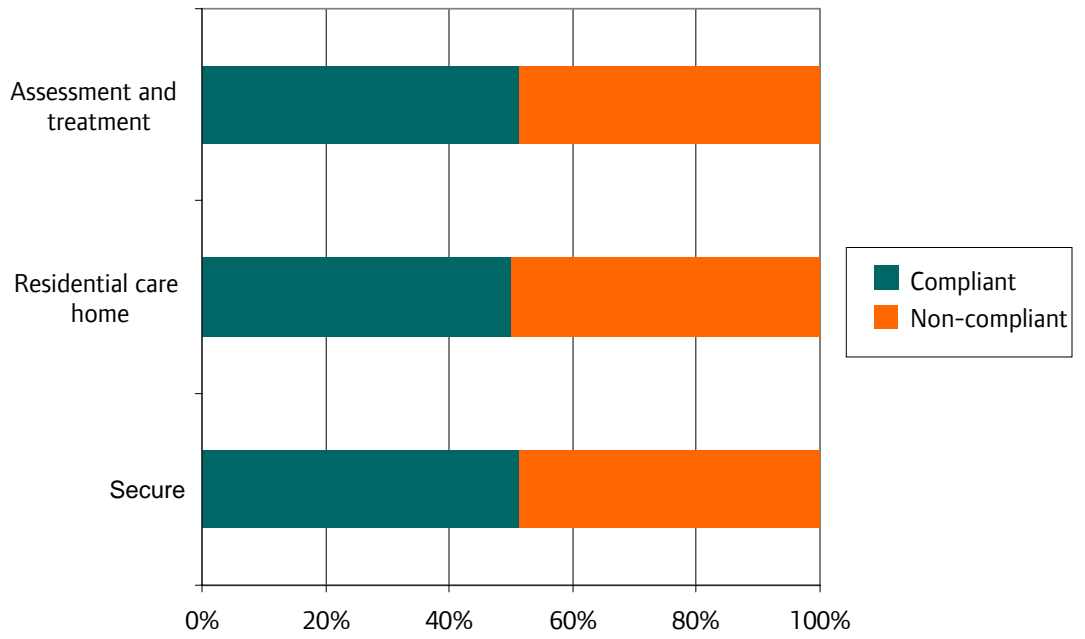


Overall levels of compliance by service type

Secure services had the highest level of compliance but with improvement actions required (figure 3):

- 37 of the 72 assessment and treatment services were compliant but with improvement actions for both outcomes (51%).
- 17 of the 34 residential care homes were compliant but with improvement actions for both outcomes (50%).
- 22 of the 39 secure services were compliant but with improvement actions for both outcomes (56%).

Figure 3: Compliant and non-compliant services by service type



Care and welfare

Outcome 4

Care and welfare of people who use services: Outcome 4 (Regulation 9)

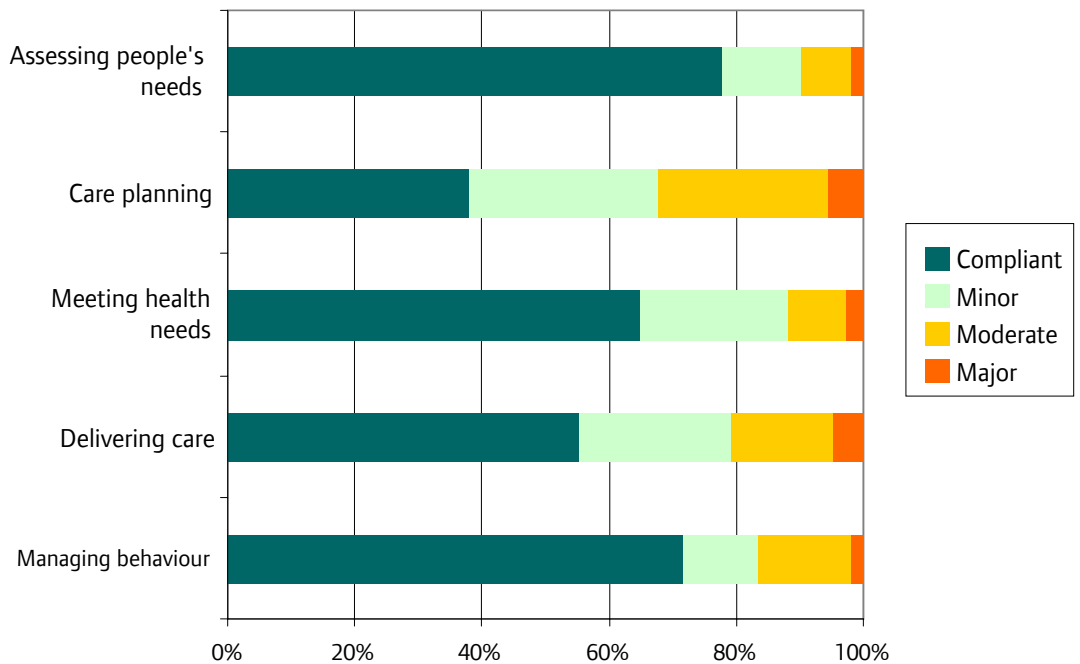
For the purposes of this inspection programme, we developed themes under each outcome based on the relevant regulation, in this case Regulation 9. This enabled us to ensure that the data and observations were consistently collected and mapped against the theme, which led to consistent judgements.

Outcome 4 was broken into the following themes:

- 4.1 Assessing people's needs
- 4.2 Care planning
- 4.3 Meeting people's health needs
- 4.4 Delivering care
- 4.5 Managing behaviour that challenges.

Each of these themes was given an overall level of concern. The highest level of concern in any of these areas set the overall level of concern for the outcome. Findings from the review showed that the highest levels of non-compliance for outcome 4 was 'care planning' followed by 'delivering care' (figure 4).

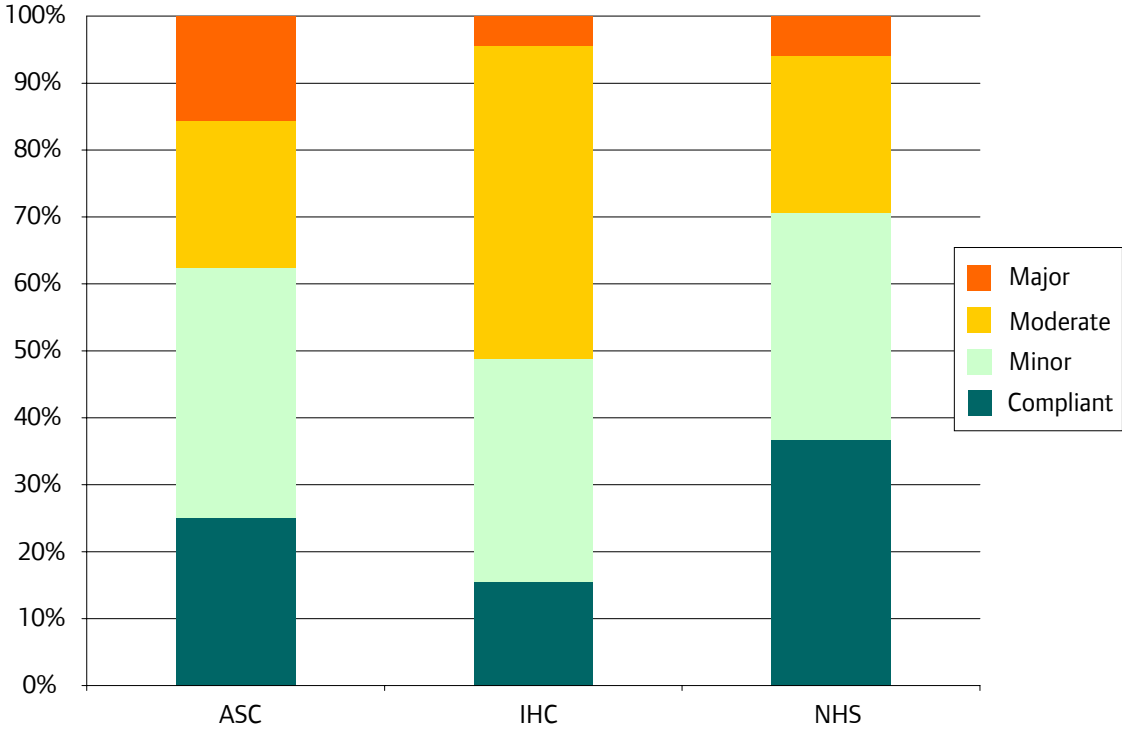
Figure 4: Outcome 4 – Level of concern by theme



Next we looked at compliance of these themes by location and by service type. The NHS has the highest proportion of compliant locations. Independent healthcare service (IHC) providers had the lowest proportion of compliant locations (figure 5).

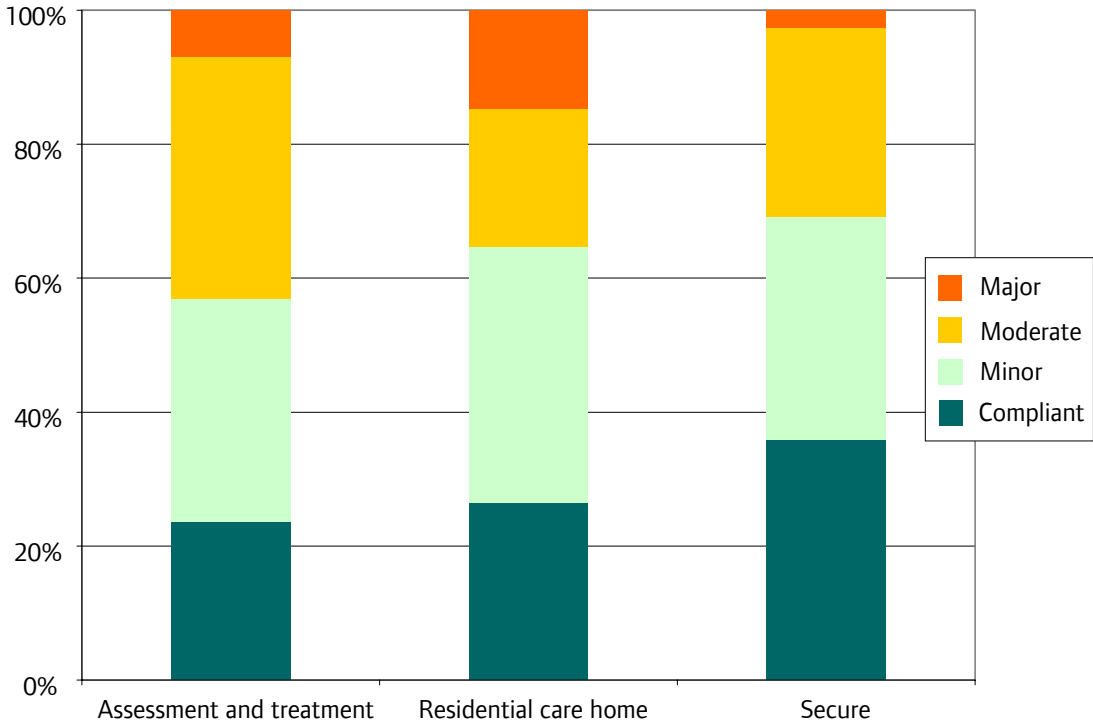
Care and welfare
Outcome 4

Figure 5: Outcome 4 – Levels of compliance by type of service provider



We found that the secure services, whether NHS or IHC, had the highest proportion of compliance for outcome 4 (figure 6) followed by the residential care homes, and finally assessment and treatment services – whether NHS or IHC. The secure services are generally subject to more external scrutiny and this may explain the highest proportion of compliance with care and welfare.

Figure 6: Outcome 4 – Levels of compliance by service type



Each of the five themes above was further divided into sub-themes. We did this to enable closer scrutiny of each theme. In doing so, we developed a richness in the information reviewed that helped us to evaluate compliance and assure consistency. The sub-themes and the qualitative narrative are shown below.

4.1: Assessing people's needs

For this theme we used the following sub-themes:

1. Was an assessment in place that clearly identified the person's needs?
2. Were people provided with information about the location before and during admission in a way they could understand?
3. Was suitable discharge planning in place (where appropriate)?
4. Average length of stay
5. Out of area placements.

1. Was an assessment in place that clearly identified the person's needs?

The regulation for this outcome and theme makes it clear that the registered person must ensure that an assessment of the needs of the person using the service is undertaken. In this inspection programme we focused on the initial assessments the person had prior to, and on entering, the service.

Overall, the majority of locations undertook good quality assessments that clearly identified people's needs. For example:

"The documentation we looked at showed that comprehensive assessments had been made and that some people whose needs could not be met or who were not compatible to the home had been refused admission." Shore Lodge, Leonard Cheshire Disability

However, assessments in some cases were poor and didn't contain sufficient detail to plan care:

"Staff informed us that they carried out a detailed assessment before anyone moved into the home. We asked for the pre-admission assessment records for two of the young people but staff were unable to provide these during the inspection or within the agreed time period after the inspection. They told us that the assessments may have been kept at their previous placement. This meant that staff did not have the information they needed to plan care effectively."

2. Were people provided with information about the location before and during admission in a way they could understand?

There were a range of ways a person could be admitted to a location: sometimes these were planned over a period of time, they could be transferred within the same provider from another location or site, but they could also be admitted due to an emergency situation. However, when someone was admitted we expected to see information provided to people in an appropriate manner and format for their communication needs.

The majority of services did provide people with information about the services before and during admission.

“Staff told us that once a referral had been received, senior staff visit prospective patients wherever they are living. They meet the prospective patient, look at all information relating to the person, speak to carers and then carry out their own detailed assessment. Where possible, patients visit Bigfoot for a day and then an overnight stay before admission; this was reflected in records seen and in talking to patients. A key worker is matched to the patient before admission so that they can start to get to know one another and to provide a familiar face on admission. Senior staff said the process usually took up to six months to complete, from initial contact but could be carried out more quickly.” Bigfoot Independent Hospital, Equilibrium Health Care Limited

However, in some cases people and their relatives had little or no information about the transition to the new service. For example:

“Two patients told us they had not been involved in deciding if they wanted to live at the service. Comments included, “I was just dumped here, and I am not near my family and in a locked place” and “No one told me, I was moving here, I don’t think it’s the right place for me”.

3. Was suitable discharge planning in place where appropriate?

The majority of locations we inspected were assessment and treatment or rehabilitation services; therefore in these services we expected to see people on a pathway towards a discharge to more independent living. In the Healthcare Commission report (2007), it was found that only in a minority of services were there efficient procedures for arranging discharge.¹ Several recommendations were made in the individual reports, which included ensuring people were not delayed and that appropriate services were found for individuals.

Some locations we inspected had a clear pathway for people from assessment to discharge. For example:

“The unit Edenwood uses a tool called Edenwood pathway, which sets out clear instruction for staff, by detailing each professional’s role and actions required in the assessment of patients. The pathway was provided to patients and their families so they know what to expect within certain timescales. Patients were given their pathway in a format they could understand; this was termed a hand held pathway. One patient showed us a copy of their pathway, and this set out how they were to be involved at each stage of their assessment, and stay while at Edenwood.” Carleton Clinic, Cumbria Partnership NHS Trust

However, at a number of services discharge planning was limited, with reports on five locations, four of which were for assessment and treatment, noting an absence of any discharge or rehabilitation planning⁵.

“There were no specific discharge plans about how the transition to another service or to independent living was to be achieved.”

4. Length of stay

We were unable to routinely capture the lengths of stay of patients and people in services as it was not always available. Sometimes where it was available it was not an accurate representation as the patient may have moved through different units within the same location. It was less relevant to those in the residential care homes as these services are expected to provide long-term stable home life.

We saw a range of lengths of stay across assessment and treatment and rehabilitation centres, which ranged from six weeks to 17 years; five to seven year stays were not uncommon. During inspections, some staff told our inspectors that there were difficulties in finding suitable alternative provision and this is why lengths of stay were longer than would be expected. The assessment of the availability of community-based provision is outside of our remit; however it is clearly an important issue that would benefit from further review by the relevant parts of the health and social care system.

Assessment and treatment services and secure services run by the NHS were significantly less likely to have patients resident for longer than two and three years respectively (45% and 58%), compared to assessment and treatment and secure services run by independent healthcare service providers (75% and 88%)⁵.

There were a number of examples where the actual service being provided to people did not appear to meet the service being offered on admission:

“The service is described as a rehabilitation unit, but at the time of our visit five of the six people using the service had been living there for longer than three years including one person who has been there since 1995. All of the people we spoke with including family members told us that when they moved to the service they believed it was for a period of rehabilitation and would give them time to learn new skills before moving on to more independent living.”

5. Out of area placements

There were a number of reports that highlighted people that were placed outside their local area, with one example of how technology could help people keep in touch with their families:

“At least two families lived over 50 miles away from the unit and said they found it difficult to visit. To try to help with this the unit had installed a video-conferencing facility, and access to local facilities nearer to where relatives lived to help families to be involved in meetings, and to keep in touch with their relative. A patient told us they had enjoyed talking to their family using this facility.” Carleton Clinic, Cumbria Partnership NHS Trust

It is acknowledged that such technology may not be suitable for all people. However, families in particular told us how they found it very difficult to get to see their family member.

“Four of the six people using the service are from other parts of the country, and the family members we were able to speak with all told us they find it very hard to get to the service as it is located in a very rural area.”

“Two patients told us that their families did not live locally and they were not happy because their families were unable to visit on a regular basis.”

4.2: Care planning

Care planning was the area of highest non-compliance within outcome 4 (care and welfare of people who use services). This particularly related to a lack of person-centred planning and appropriate levels of involvement from people using services.

We divided the theme of care planning into sub-themes as follows:

1. Did the care plans in place identify people’s needs and how care should be delivered? Were they person centred
2. Were care plans reviewed and updated regularly?
3. Were people involved in care planning and did they have a say in the care they receive?
4. Were care plans accessible to people and made available in a format they can understand?

1. Did the care plans in place identify people’s needs and how care should be delivered? Were they person centred?

The regulation for this outcome and theme makes it clear that the registered person must ensure that the planning of care meets the person’s individual needs and ensures their welfare and safety.

Care planning was routinely undertaken. However, care plans were variable in quality with some of the plans lacking clear details about how care should be delivered. For example:

“An example of the files that we looked at contained basic information such as date of birth, next of kin and the name of their GP. There was no information on the full assessment, no information on physical health and mental health needs and there was no information from specialist assessments such as speech and language therapy.”

Other services had detailed care plans in place:

“Care plans contained assessments made prior to and on admission to the service. The plans were person centred and patient’s needs, values and diversity were addressed. The service uses Recovery Star Care Plans which pictorially identify patient’s needs and goals, for example, social networks, addictive and inappropriate behaviour and managing mental health.” Burston House, Partnerships in Care Ltd

Person-centred planning can be simply described as a way of discovering what people want, the support they need and how they can get it.⁶ Person-centred planning is not a new concept, therefore we expected this to be embedded in practice. However, the most common issue of concern was a lack of person-centred planning with little information about people’s individual preferences, including likes and dislikes about how care is delivered. Many of the issues of concern that we found would have been managed better if decent person-centred planning had been in place.

Further work is required by commissioners and providers to understand why person-centred planning is not embedded into all care for people using services and to make sure that it is in place. We will continue to assess this as part of the inspections we routinely carry out.

“The care plans we looked at, however, did not cover information such as ‘Getting to Know Me’, likes and dislikes regarding choice of activities, food preferences and plans for ensuring hobbies and interests could be maintained. Without this information staff could not be sure that patients were supported in the way they preferred.”

2. Were care plans reviewed and updated regularly?

In order for care plans to meet the requirements of the regulation we expected them to continually meet people’s needs and ensure the person’s welfare and safety. They should be subject to regular review of their effectiveness, amended as required and kept up to date in recognition of the changing needs of the person using the service.

The majority of services routinely reviewed care plans and fed information from meetings into the care plans. For example:

“Regular multi-disciplinary team (MDT) and Care Programme Approach (CPA) meetings were held. Patients told us that they attended MDT meetings. Patients had weekly ‘catch up sessions’ with their support worker. This gave them the opportunity to talk about their care, treatment and support. Any issues or requests they had were then fed into their care plan via their weekly MDT meetings.” Woodside, Caireach Limited

However, lack of reviews of care plans at other services led to there being an increased risk of people not receiving care and support that meets their needs. For example:

“In some cases the care plans were not completed and where the risk assessments led to a plan this made reference to policy rather than individual needs. Where care plans had been completed, they had not been updated, although the running daily record showed that changes had been made to interventions. This poor organisation of care plans meant that people did not always receive the most effective care and support.”

“People’s needs were identified in care plans but there were a number of examples where they had not been reviewed and were out of date. This raises concerns about people’s needs not being met.”

A minority of services (this was in relation to the NHS locations only) were using or were transitioning to electronic care management systems. This had posed problems for staff and in some cases there was evidence of poor linkages between the electronic system and what was contained within the paper records.

“This service used an electronic system of care planning, although paper copies written in plain English and large print were available. We found the electronic care planning system to be complex. Staff

conducting reviews of care plans could not be confident that reviews had been satisfactorily completed without opening up every individual document and sub-site on the system. There was no flag system to indicate when reviews were due or when they had been completed. This had resulted in some care records not being updated when a person's needs had changed."

3. Were people involved in care planning and did they have a say in the care they receive?

Key to person-centred planning is the involvement of the person concerned. We expected to see evidence that plans had been developed with the person and/or those acting on their behalf. Often, people were not actively involved in the care planning process.

"None of the care plans we looked at showed evidence of patient, carer or relative involvement and none of the patients had a copy of their care plans. Staff said if a patient requested a copy of their care plan it would be made available."

One person told us: "I might have a care plan, but not sure. I don't know what's in it."

However, we did see some very positive examples of people being given control over the care planning process:

"The 'My shared pathway' workbooks we looked at supported patients to take control of their own journey to recovery, by having a shared input to their initial assessment, planning and treatment. ... Two patients showed us their workbooks, which they were in the process of completing. Both were very proud of the work they had done to complete these. They had written in the books in their own words reflecting their level of understanding and the reason for being in hospital. Both patients told us they felt much happier in themselves, since moving and explained how using the workbooks was helping them to achieve their goals to return to community life. One patient said their goal was to be home by next Christmas."
Little Plumstead Hospital, Hertfordshire Partnership NHS Foundation Trust

"People spoken with told us about their care plans and the things they enjoyed doing. One person told us, "I have a care plan, it says all about me and that I like going out, I like shopping and bargains." Another person said, "My care plans tells staff how I'm getting independent." Mansfield House, Four Seasons (Granby One) Limited

We expected to see evidence that people were involved in the development of their plans and care, treatment, options and alternatives with an explanation of the risks and benefits. We found evidence that consent was not always sought or documented to ensure that when people had capacity they agreed with the content of their care plans. For example:

"We found that care plans were not routinely being signed by patients to indicate that they had agreed to their treatment or if they had been involved in developing their plan of care."

4. Were care plans accessible to people and made available in a format they could understand?

Good services ensured care plans were accessible to people. They presented the care plan in alternative ways that were specific to people's individual communication needs. This may have involved the use of easy read plans with pictures. Staff spent time with people explaining the care plan and gaining people's views and consent. For example:

"Patients are able to have a copy of their care plan. This enables them to look at it and have more ownership of their care. When looking at patients' care plans we found that they had been written in a way that the patient could understand if they had a communication disability." Fieldhead Hospital, South West Yorkshire Partnership NHS Foundation Trust

**People told us: "I know what is in my care plan and I have a copy of it."
"If I struggle reading it my named nurse reads and explains it to me the best he can."**

"It tells about my needs and illnesses and how to look after me."

"They update my care plan now and again, it depends on how fast I improve, could be three to six months." Mary Dendy Unit (Alderley Unit) Cheshire and Wirral Partnership NHS Foundation Trust

Many people did not have access to a copy of their care plan. In some cases, we were told care plans were kept in a locked office, but people could see a copy if they specifically requested it. For example:

"Although some of the care plans were in an easy read format, all were kept in the main nursing office, which was kept locked. A separate folder summarised the care plans in a simpler form, written by the person themselves where they could, but these were again in the locked office. These were not accessible to people they related to."

People told us they were "not allowed to have a copy of their care plan."

Care plans were often task focused and written in a technical way for the staff team:

"They [the care plans] were written in a technical way for the staff to follow, and not written from the patients' perspective of how they would like staff to support them to meet their individual needs."

"Care plans were not written in accessible formats. There was an easy read picture on each care plan but the benefits of these were limited, as they consisted of one small picture at the top of each care plan. The pictures themselves were quite vague, for example there was a picture of two people pointing at each other, this was a care plan about mental health."

In the Healthcare Commission's report 2007, *A life like no other*¹, there was evidence that services had not adopted a formal person-centred approach to care planning. Plans often did not reflect the persons views; there was little evidence of people's full involvement; people did not always have a copy of

their care plan that was accessible and easy to understand; and there was little evidence that care plans were kept up to date. Five years on, it is difficult to understand why these actions are not now all embedded into practice

4.3: Meeting people's health needs?

Secure services, whether NHS or IHC, had the highest level of compliance, followed by assessment and treatment services for both the NHS and IHC. There was a higher proportion of major concerns within residential care homes.

We divided the theme of care meeting people's health needs into sub-themes as follows:

1. Was information available to staff that enabled them to meet people's health needs?
2. Were people's health needs met?
3. Did people have support to make positive choices about their health and wellbeing?

1. Was information available to staff that enabled them to meet people's health needs?

Overall, information on people's health needs was usually available. It is not a regulatory requirement for a provider to ensure that people have a health action plan in place as long as their health needs are assessed, planned for and met. However, a number of services were using specific tools such as health action plans and undertaking health assessments upon admission. For example:

"We saw that a clear and detailed physical health assessment was undertaken on the day following admission and action taken on any health issues. Health actions plans were in place and discussed with patients. This made sure that patients' health needs were managed appropriately." Mossley Hill Hospital, Mersey Care NHS Trust

"Health action plans were in place. They were in an easy read format and there was evidence that people using the service were involved in the process. The health action plan and information within care plans demonstrated people's health needs were being met. People received regular health reviews and appointments with health professionals as needed." Mansfield House, Four Seasons (Granby One) Limited

However, for some services, health planning was inadequate. In these cases, this could have negative consequences for people that affected their health and wellbeing. For example:

"Three of eight records sampled did not include a health action plan or evidence that the patient had an annual health check with their GP. This may mean that nursing and care staff do not know how to support the patient to meet their health needs."

"People's health care needs were not consistently well assessed, planned or met. People were not involved in a person centred way in managing their health."

The concept of health action planning, as a way of maintaining and improving the health of the individual, was originally introduced in the 2001 Valuing

People White Paper.² As can be seen from the quotes above services that were compliant generally had completed and comprehensive health action plans in place. There were, however, a number of services that had health action plans that, when we reviewed them, were blank.

“The HAP [health action plan] seen was devised using an accessible (pictorial) format. However, it was not fully completed. Large sections of the plan were left blank. The date on the plan was March 2011 and no review dates were recorded. There was no evidence that a medical professional had signed the HAP and there was no evidence that the patient had been involved in the process or had a copy.”

2. Were people’s health needs met?

People’s health care needs were met in the majority of cases. For example:

“Patients mental and physical health needs were responded to. The multi-disciplinary team of health professionals worked alongside care staff on the unit. Patients had appointments with community health professionals such as a dentist, or hospital appointments as needed. Each patient had an annual health check in October 2011.”
Hollybrook, 2Gether NHS Foundation Trust

However, in a minority of services people’s health needs had not been met. For example:

“We looked at how often blood glucose monitoring tests had been done for three patients with diabetes. The blood tests had been carried out at the required frequency for one patient but not for two other patients. This had not supported these patients to manage their diabetes properly.”

3. Did people have support to make positive choices about their health and wellbeing?

We saw some positive examples of people being supported to make positive choices that would promote their health and wellbeing:

“We saw that patients’ health needs were assessed and care plans were in place as necessary. For example, patients in both services had care plans to promote a healthy lifestyle to address their weight problems.” Mansfield House, Four Seasons (Granby One)

“For general healthcare, students were encouraged to engage with local primary healthcare professionals and to make appointments with the local GP. Sexuality and relationship sessions can be arranged i.e. well woman clinics can be accessed in the community. We saw examples of students being supported to take control of health issues such as healthy eating choices and exercise options.”
Beaumont College and Scope Inclusion North West, Scope

However, there were occasions when this wasn't achieved:

“Relatives commented on what they thought to be the poor nutritional value of the food and how they needed to supplement their relative’s diet, to ensure it was healthy.”

There were instances of restrictive practices around the implementation of healthy living programmes that were of concern. These particularly related to access to food and snacks and also to the ability to smoke. This is discussed further in 4.4 (delivering care) and 7.1 (preventing abuse).

4.4: Delivering care

For this theme we used the following sub-themes:

1. Was person-centred care delivered in line with the care plan and was the culture of the service positive?
2. Did people have access and adequate support (including sufficient staff) to participate in meaningful activities?
3. Were relatives and friends made welcome when they visited?
4. Was advocacy available to people using the service?

1. Was person-centred care delivered in line with the care plan and was the culture of the service positive?

The regulation for this outcome and theme makes it clear that the registered person must ensure that the delivery of care meets the person’s individual needs and ensures their welfare and safety.

Often the care people received was in line with their care plans. People using these services often commented on staff being kind and supportive.

“Staff were knowledgeable of patients’ care plans and treatment programmes and we observed how they delivered support to patients. Interaction between staff and patients was observed to be frequent, supportive and directed patients to meaningful activities.”
Mary Dendy Unit (Alderley Unit), Cheshire and Wirral Partnership NHS Foundation Trust

“Throughout, staff we spoke with showed great commitment, enthusiasm and understanding of how to better the lives of the people they were supporting. They were clear on their roles, clear on how to meet the needs of the people they were supporting, and felt well supported by the manager. From our discussion with staff and looking at care records it was evident that staff worked consistently and in line with care plans.” Lucy Glyn Residential Home, Lucy Glyn

However, for locations found to be non-compliant, care was often not delivered in line with the person’s care plan:

“We found that areas identified in two patients’ care plans had not been fully addressed, and implemented in a timely manner. For example one person was identified on admission as requiring specialist input for support with communication needs. Three months later this was only just being assessed, and in this person’s assessment the main cause for triggering challenging behaviours

was identified as frustration with not being understood or understanding other people. A visiting professional used a method to communicate with the patient, and felt a communication passport would assist in supporting this person. Staff told us they are not trained to use this method of communication and were awaiting advice from other professionals.”

Concerns were noted in a number of reports about locations having an ‘institutional’ culture. This included people being expected to follow rigid routines with meals, drinks and snacks only being available at set times, and people being expected to be in their bedrooms at certain times of the day.

“During our two-day visit we found that the delivery of care did not match the aims and objectives identified in patients’ behavioural management plans. It also did not match the service’s Statement of Purpose which tells us that the service aims to support individuals to achieve the highest quality of life in the least restrictive environment commensurate with their needs. We found the high security environment, noise levels from panic alarms and two way radios and strict adherence to perceived house rules created a highly charged atmosphere. Staff were task oriented and rigid in their approach with regards to access to drinks, smoking, daily living tasks and meals. With the exception of three staff, we observed that staff were direct and authoritarian when speaking with patients, giving orders such as ‘Go and wait outside for a minute’.”

“We were concerned that the confusion about the remit of the service affected care practice in the service, with staff unsure of the level of restrictions in the service and who the restrictions applied to. There were several restrictive and institutional rules and practices which were inappropriate in an assessment and treatment unit and even more so in a service suggesting that this was a person’s home for life. For example, written rules given to people showed that people were not allowed to converse over the fence with people in the service next door. People had to be in their bedrooms by 9.30pm and were not to come out between 9.30pm and 7.30am unless to use the toilet, in an emergency or to get help from staff.”

After observing staff interaction with people over a lunchtime period one of our experts by experience commented: “I felt and I observed institutional living.”

2. Did people have access and adequate support (including sufficient staff) to participate in meaningful activities?

In locations that were compliant, there was access to a variety of meaningful activities that met people’s needs and enabled them to gain life skills:

“There was an activity centre on site where patients accessed a range of leisure, sport and educational activities. Patients showed us their activity planners, which showed that activities were provided by ward staff at evenings and weekends. Links had been made with a local gym and a professional football club. Patients had their own

Care and welfare

Outcome 4

football team and trained at the club's training ground and also attended matches. Some people did voluntary work in the community and plans were made so that this continued when the patient was discharged." Tarentfort Centre, Kent and Medway NHS & Social Care Partnership Trust

One person told us "I have a full timetable, college, gardening, cleaning on the unit and shopping with support." Mary Dendy Unit (Alderley Unit), Cheshire and Wirral Partnership NHS Foundation Trust

In other locations, access to activities was limited or did not meet the needs of the people using the service. This can be linked to a lack of personalised care planning:

"During our visit we noted that planned activities were not taking place. People receiving treatment were either sat in the lounge or standing in the hallway. There were no staff with them or providing any stimulation. At one time, we observed people sitting in the lounge with no staff present for 25 minutes."

Across all types of services, staffing was, in some locations, insufficient to ensure people could undertake activities that met their needs:

"On the main service site there was a purpose built activity centre where patients could take part in a range of activities. We spoke to four patients who all told us that some of their activities were often cancelled due to staff shortages. The manager confirmed the main unit was short staffed due to staff vacancies and high sickness. The unit was in the process of recruiting new staff."

"From our observations during our visit and reading daily records staff support was not sufficient to meet each individual's activity needs both in the home and community. For example, on the second day of our visit people did not attend a day service but remained at home watching television or doing unorganised activities such as jigsaws or colouring. There were no planned activities for the days when we visited."

In other locations, including those defining themselves as 'rehabilitation' services, there was a lack of activities that enabled people to both retain and, or gain independent living skills needed to move onto a service that provided less support. For example:

"Staff and patients told us that social skills such as cooking, doing laundry and shopping were not maintained as it was against hospital policy."

"Although described as a rehabilitation service, all the activities observed were all leisure related. The facilities such as the kitchen were not suited to rehabilitation work, and care plans showed no evidence that any rehabilitation support was in place."

One relative commented, the staff take my son, "Here, there and everywhere" but without any real purpose.

3. Were relatives and friends made welcome when they visited?

Relatives and friends were, in the majority of cases, made to feel welcome when they visited people.

“Visitor records showed that family, friends and professionals visited people at the service at different times and at weekends. The visitors we spoke with felt they were free to visit when they wanted to and were made welcome when they came.” Home Farm, West House

However, in some locations visiting relatives did have restrictions placed on them. In such instances, this was sometimes related to a risk identified by the service. For example,

“...There was also an issue raised [by a relative] that they couldn't visit whenever they liked. We were told by the manager that this comment related to an occasion when they were unable to accept visitors due to the behaviour of one of the patients and the risk. They had therefore requested that the parent did not visit on the day planned.”

4. Was advocacy available to people using the service?

There is a wealth of evidence about the benefits of advocacy support for people with learning disabilities. Advocacy gives people a voice to express their thoughts and protects their rights. There is no legal requirement to provide advocates. However, there is a statutory duty to appoint an Independent Mental Capacity Advocate (IMCA) in limited situations⁷.

It was positive to find that advocacy was available at most of the locations we inspected as it provided an opportunity for people to speak out and express their views. For example:

“The manager told us that patients have access to advocates; this is provided by an independent local advocacy service. We saw that patients had access to someone who could advocate for them about their detention under the Mental Health Act 1983 and we saw that a specialist advocate for people with a learning disability attended the hospital to help with a patients meeting.” Atlas House, Oxleas NHS Foundation Trust

However, in some cases advocacy was not available. This could mean that people do not get adequate, impartial support to express their views:

“We were informed by the area manager that people using the service do not have access to an independent local advocacy service.”

In the Healthcare Commission report,¹ it was noted that the majority of services did not provide independent advocacy, so having advocacy in place at many locations we inspected should be positive. However, this included locations where we had moderate or major concerns. This raises the question about the quality of advocacy being provided and the engagement with advocates to ensure that comments and inputs were always taken account of.

In addition to advocacy, we found that some locations actively encouraged people to take a key role in developing their service through residents meetings. For example:

“On the first day of our visit we observed patients having a community meeting. These were attended by everyone living on the unit and extra support had been provided for patients through an independent advocacy service. We were told that these meetings took place weekly and were an opportunity for patients to highlight issues that they had on the unit. These included appointments, activities and ideas about the menu and anything else that they may have had concerns about. We also saw the minutes of the last three months’ ‘Residents Forum Meetings’ chaired by an independent advocate.” Cambian Fairview Hospital, Cambian Learning Disabilities Limited

4.5: Managing behaviours that challenge

This theme was not divided in sub-themes.

Were behavioural management plans and risk assessments in place that provided sufficient information to enable staff to recognise triggers and de-escalate situations positively?

We expected services to develop and implement behavioural management plans to support people effectively. These should document the triggers that may make a person start to feel agitated or distressed and how these can be managed to prevent this escalating to a situation where the person may lose control and require some form of restraint⁸.

The majority of locations did have behavioural management plans and risk assessments in place for people. For example:

“Records sampled included plans of how to manage the risks posed by behaviour described as challenging. They detailed the signs to look for that a patient’s behaviour may change and how to manage this safely. Staff spoken with knew how to manage each patient’s behaviour to ensure their safety and that of other patients and staff.” Sutton’s Drive, Black Country Partnership NHS Foundation Trust

“A risk assessment and review system was in place. Plans of how to manage the risks posed by behaviour described as challenging were present in all the records. All the risk assessments we checked had been regularly reviewed. A member of staff told us, ‘Risks are always explained and agreed with students and they were supported to take reasonable risks.’” Beaumont College, Beaumont College and Scope Inclusion North West, Scope

However, in other cases behaviour plans and risk assessments were not adequate or not being followed in practice.

“Challenging behaviour can be caused by a number of triggers; however the information in patients’ records did not adequately

detail either the signs to look out for or strategies for managing behaviour effectively. This meant that staff did not have clear guidance to ensure a consistent approach was used to support patients.”

There was evidence that in some cases behaviour management approaches were punitive and involved restrictions.

“We saw that behaviour plans were based around sanctions that included the patient losing the opportunity to go off the ward and removing activities due to the patient behaving in a way that challenged the service. These had not been formally agreed or planned and therefore impacted on the patient’s rights. There were little positive rewards and in one plan the incentive for the patient to behave in an appropriate way was not clear.”

“We saw that restrictions about smoking had been discussed and agreed with patients. For example, in one patient’s file we saw a smoking plan agreed and signed by the patient to support them to manage their smoking and finances. A second patient’s care plan contained a behaviour agreement. However, this had been written in a threatening and punitive way, in that it stated that, if this patient hits another person again, they will go back on section, and if they kept hitting others, they would have to go to another hospital. This agreement focused on negative behaviour rather than looking at a positive approach to support the individual to manage their aggression.”

Safeguarding people from abuse
Outcome 7

Safeguarding people who use services from the risk of abuse: Outcome 7 (Regulation 11)

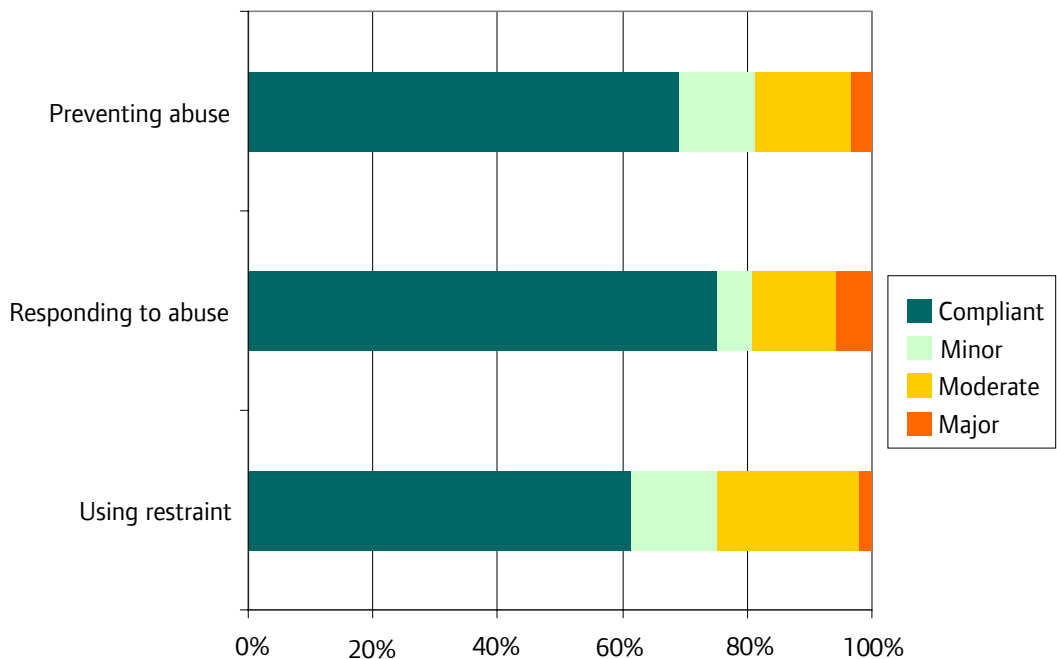
CQC’s function in response to safeguarding concerns is primarily to ensure that providers of care have adequate systems in place to ensure the safety of people whose circumstances make them vulnerable to abuse. All registered providers must comply with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010³. The regulation describes how the registered person must make suitable arrangements to ensure that people who use services are safeguarded against the risk of abuse by preventing it before it occurs; responding appropriately to any allegation of abuse; and where restraint or control is used in the carrying on of the regulated activity, suitable arrangements must be in place to protect the recipient from unlawful or excessive activities.

For the purposes of this inspection programme we developed themes under each outcome based on the relevant regulation – in this case Regulation 11. This enabled us to ensure that the data, information and observations were consistently collected and mapped against the theme, which led to consistent judgements. Outcome 7 was broken into the following themes:

- 7.1 Preventing abuse
- 7.2 Responding to allegations of abuse
- 7.3 Using restraint

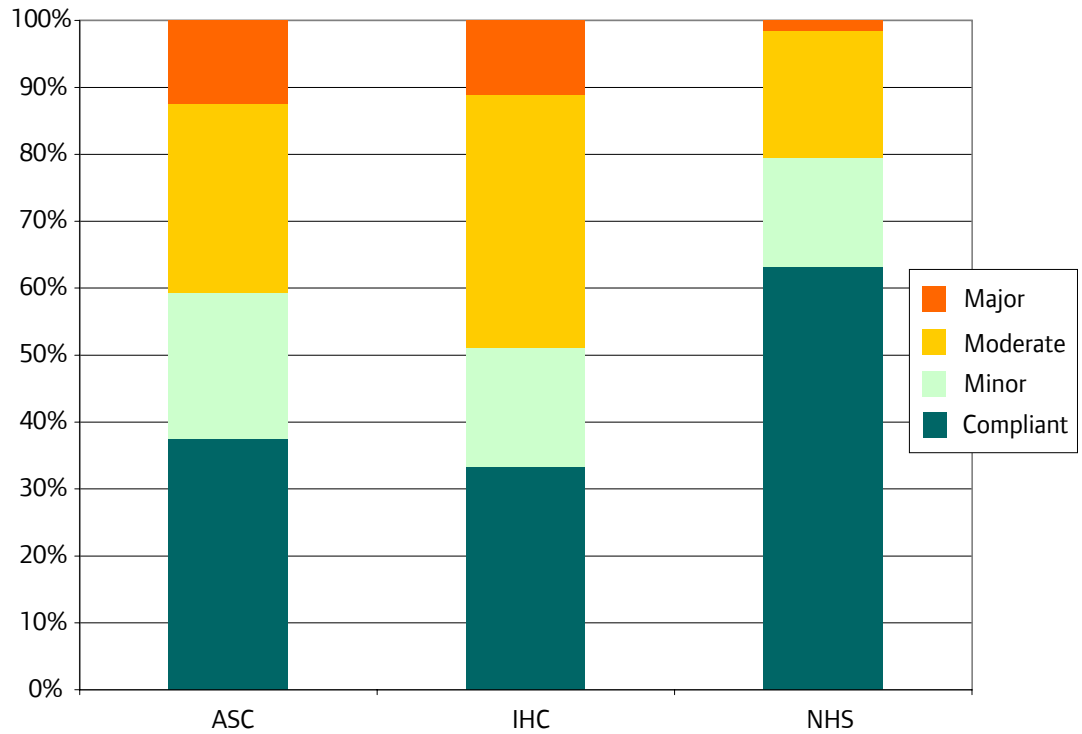
Each theme was given an overall level of concern. The highest level of concern in any of these areas set the overall level of concern. The key driver of non-compliance for outcome 7 was ‘using restraint’ (figure 7).

Figure 7: Outcome 7 – Level of concern by sub-theme



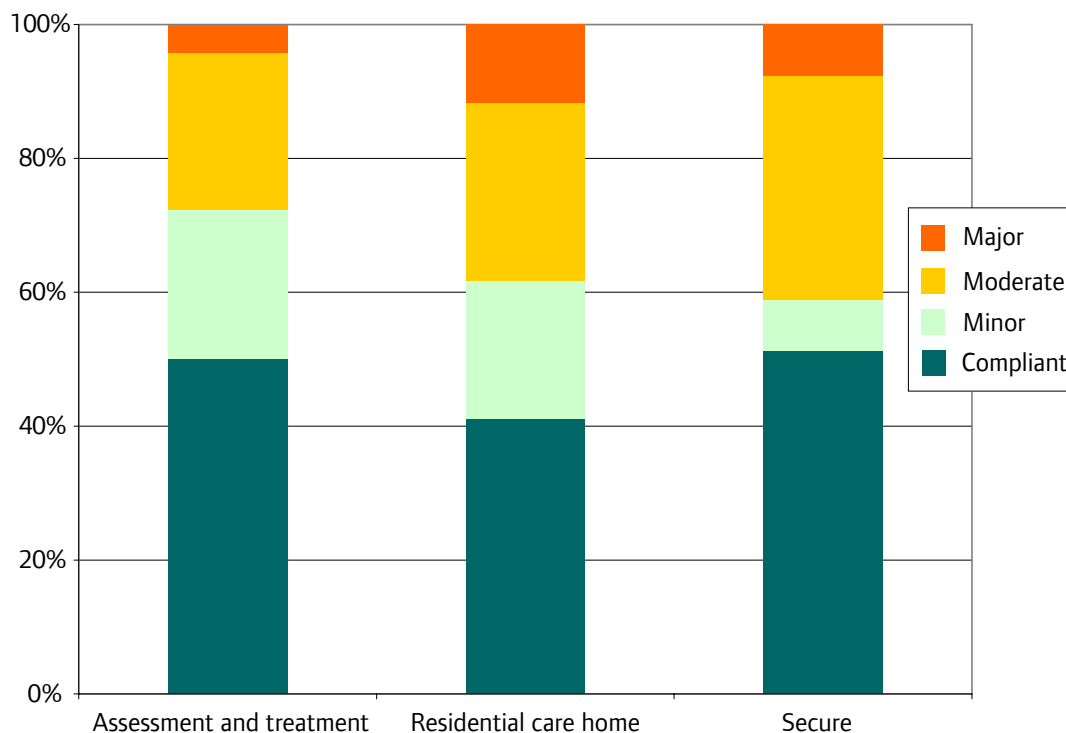
By location, the NHS has the highest proportion of compliant locations for outcome 7 and independent healthcare service (IHC) providers had the lowest proportion of compliant locations (figure 8).

Figure 8: Outcome 7 – Levels of compliance by type of service provider



Assessment and treatment services, whether NHS or IHC, had the highest level of compliance for outcome 7, while secure services, whether NHS or IHC, had the lowest compliance (figure 9). Although secure services had the highest rates of compliance for outcome 4 they have the lowest rates of compliance for outcome 7. It is possible that lessons to be learnt from the use of restraint are less likely to be considered in this care setting.

Figure 9: Outcome 7 – Levels of compliance by service type



Each of the three themes above was further divided into sub-themes. We did this to enable closer scrutiny of each theme, and to help ensure a depth of information for evaluating compliance and providing consistency. The sub-themes and the qualitative narrative are shown below.

7.1: Preventing abuse

For this theme we used the following sub-themes:

1. Were safeguarding and whistleblowing policies and procedures in place and did staff demonstrate an understanding of these?
2. Did people who use services and their relatives know how to recognise and report abuse and raise concerns?
3. Was the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards properly understood, implemented and documented?

1. Were safeguarding and whistleblowing policies and procedures in place and did staff demonstrate an understanding of these?

Nearly all locations had safeguarding policies and procedures in place. This was an area of improvement since the Healthcare Commission report of 2007¹ that had concerns regarding the availability of safeguarding policies and procedures. The majority of staff spoken with did have a good understanding of what safeguarding and whistleblowing was and also what they should do if they witnessed or suspected abuse or needed to whistleblow.

However in some cases, the knowledge and understanding of staff was inadequate:

“Two staff members we spoke with were not sure about safeguarding procedures; one staff member told us the provider

would investigate any safeguarding concern and not social services. Another staff member could not fully describe what constituted abuse; for example, when we asked what signs they would look for that might lead them to believe someone was at risk of possible abuse they could only give bruising as a sign. They did not give examples of a person being possibly withdrawn, changing their behaviour or not having any money.”

“We saw training records, which indicated that not all staff had completed safeguarding adults training and saw that some staff were in need of updates. For example, some people had last attended training in safeguarding vulnerable adults in 2009. The registered manager told us that they had recognised this and had prioritised staff for training, but was currently waiting for course availability. The service used a number of regular bank staff. We saw that bank staff had not always received up-to-date mandatory training and that their training was not monitored in the same way as permanent staff. This made it difficult to see if bank staff were appropriately trained in safeguarding adults. The lack of appropriate safeguarding training for all staff meant that people using the service could not be confident that they were always being supported by staff who were able to safeguard against the risk of abuse.”

On occasion there was also a failure to understand the potential negative impact of restrictive and institutional practices. When this occurred, choices for people who used services were sometimes restricted without evidence of an explanation of the restriction and involvement in and agreement of the person.

“While we observed positive interactions between staff and people during the inspection, we also witnessed restrictive and institutional practices that had not been identified as such by the service. This failure to identify the practices as restrictive and institutionalised raises concerns about the ability of staff to recognise practices that may be abusive and take appropriate action.”

“There was no evidence to demonstrate the patient’s choice regarding smoking had been undertaken...”

2. Did people who use services and their relatives know how to recognise and report abuse and raise concerns?

In a number of locations people and their relatives told us they did not know how to raise a concern. In some cases information was available but it hadn’t been shared with people in a way they could understand:

“People using the service told us that they did not have any information about abuse or what they should do if they saw something happen. The four people we spoke with did tell us they would speak to the lead nurse or to staff.”

“The provider’s safeguarding policy was in place and the acting manager had displayed leaflets on the wall, which were from the local authority and referred to safeguarding information. These may

have limited use for the people using the service as they were not provided in an easy read format but would be beneficial to staff and visitors.”

“The ward manager told us complaints were dealt with centrally. The manager advised that the ward had not received any complaints in the past year, from families, users of the service, or anyone else. The manager told us complaint forms were available, however we saw no evidence of information on the unit about making complaints. Relatives we spoke with spoke of having lots of concerns, but being unsure of raising them as complaints.”

One person told us: “When I first moved here I was bullied by other patients; this went on for six months, I was called names, they would ‘bang’ (speak disrespectfully about) my family”.

“There are ‘anti-bullying’ posters on the ward, been there for two weeks and no one has explained them to people who can’t read”.

3. Was the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) properly understood, implemented and documented?

In keeping with our regulatory role we asked staff about their knowledge of and experience with the MCA and DoLS. Responses were variable. We acknowledge the complexity of this area but, where there was confusion, we would expect providers to have more effective internal and external mechanisms to provide advice and support.

In some cases providers were able to show robust and supportive systems designed in the best interest of the person using the service. In these cases providers used guidance and worked closely with the person using the service to ensure individual support. For example:

“Where patients are ‘informal’, risk assessments had been carried out and restrictions had been discussed at multi-disciplinary meetings and other less restrictive options considered. An example of this had been the ward corridor doors being locked. These could only be opened by a sensor carried by the staff restricting the movement of patients. Staff looked at ways of letting some patients, where appropriate, have more movement within the unit. They made sure they had appropriate clinical reasons where they needed to restrict patient movement. All these measures ensured that patients’ rights were protected by the systems and practices in place on the ward.” Mossley Hill Hospital, Mersey Care NHS Trust

“We saw evidence that each patient’s capacity to consent was being assessed and that, where necessary, meetings were being held in their best interests. Multi-disciplinary meetings were recorded and the rationale for making decisions in a patient’s best interests was noted, along with family involvement and advocate input. The ward demonstrated a good working knowledge of the legislation to ensure that patient’s rights were safeguarded.” Carlton Clinic, Edenwood, Cumbria Partnership NHS Foundation Trust

In other cases there was a lack of understanding of what might constitute a restriction or deprivation of liberty. This included when and how it should or could be undertaken and the process of application, notification and documentation. For example:

“The care plans we looked at did not always show that capacity assessments had taken place; this was particularly in regard to decision making in risk assessments. This means that people using the service could not be sure decisions were being made in their best interests and that their views would be listened to.”

“There was little recognition of how to support people with diminished capacity. The service had not addressed people’s mental capacity to help assess whether people needed further support with making some decisions.”

In the 2007 report by the Healthcare Commission,¹ it was found that locked door policies were not flexible and may have been overly restrictive. We also saw examples of this lack of flexibility and individualised care:

“We noted that people did not have information in the service user guide about the policy of keeping all external doors locked. We advised the provider about the concerns expressed to us about the locked doors regarding accessing to the garden. Before we completed our visit information was being written for people using the service about the locking of doors so they could understand why this happened. The manager told us that they would be looking at how the garden could be made more secure so that people could go there when they wished.”

7.2: Responding to allegations of abuse

For this theme we used the following sub-themes:

1. Were safeguarding referrals appropriately identified and reported?
2. Was safeguarding routinely monitored and lessons learnt?

1. Were safeguarding referrals appropriately identified and reported?

In the majority of cases, locations reported safeguarding concerns appropriately in line with their safeguarding policies and procedures. For example:

“Records confirmed that the safeguarding policy and procedures were being followed. These records showed that two safeguarding referrals had been made to the local authority safeguarding team in the last 12 months.” Lothingland, Suffolk Mental Health Partnership NHS Trust

However, although policies and procedures were routinely in place they were not always effective. In some instances there was a failure of staff to recognise safeguarding issues or delays in reporting them. For example:

“.... one patient told us they had made a complaint about the injuries they received during a restraint in September 2011. They told us that they were dissatisfied with the way the complaint had been investigated. We checked the patient’s complaint, the

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hospital's response to them and other appropriate records. We found that the patient had raised their concerns with staff on the same day as the incident; staff had recorded the patient's allegations in their care records, but had not identified these as allegations of abuse."

"We found that where staff had recognised potential abuse these had been reported in line with the trust and local safeguarding guidelines. However we did find that delays were occurring in reporting. When looking in more detail at daily notes, patients' plans and discussing specific incidents with staff, it was clear that in practice staff were not always recognising what may constitute abuse. This had led to two allegations and incidents of possible abuse having significant delay in being reported to the local authority safeguarding team responsible for investigation. This included a five day and a twenty six day delay in reporting potential incidents of abuse. Both of these incidents are now being investigated but the delays have slowed up the review and any possible recommendations to improve patient care and treatment within the service during this time."

There were also instances where incidents that should have been referred had not been:

"We saw records kept in the home relating to incidents of violence or aggression. During September and October 2011 there were six incidents that should have been reported to safeguarding authority but were not."

IHC providers were significantly less likely to raise safeguarding referrals than NHS providers.⁵

At 27 locations we either had allegations of abuse disclosed to us or we identified safeguarding concerns through the course of the inspection. In these circumstances, we either requested that the location referred these to the relevant local authority, and we checked that they had, or we did so ourselves. We were satisfied that the local authority was dealing with these.

2. Was safeguarding routinely monitored and lessons learnt?

In many, but not all cases, locations did monitor all alleged safeguarding incidents. Where a safeguarding referral was made many locations did look to see what lessons could be learnt to minimise future risks of reoccurrence. For example:

"All untoward incidents were reviewed by the management team to make sure that any lessons were learned. We talked with the manager about what happened after an incident and they told us that people using the service had a chance to talk about what had happened and de-briefings took place with the staff who had been involved. This included all incidents of aggression or violence involving people using the service and all incidents when people had been restrained by staff. The reports were analysed and audited and any patterns or themes were noted and acted upon, to make sure

people using the service were kept safe. Annual reports about people's progress and wellbeing were produced by the staff and sent to people's social workers, and they included a record and analysis of any untoward incidents." Whitwood Hall, Whitwood Care Limited

However, in some locations that were non-compliant, safeguarding was not routinely monitored or changes implemented, which could place people at unnecessary risk:

"Although incidents were recorded the records did not clarify the outcomes of these incidents so we were unable to see what happened after the incidents or what actions were put in place to reduce the risk of further incidents occurring. The records of incidents for one person had taken place on three separate occasions since September 2011 but nothing was recorded to demonstrate how they had been dealt with."

"We asked to look at information about safeguarding referrals, the action taken, what follow-up actions had been put into place to protect people in the future and what lessons had been learned; however we were informed these were not held on site. We found that they do not record, act on, follow up or learn from allegations of abuse."

7.3: Using restraint

For this theme we used the following sub-themes:

1. Did staff understand what restraint was? Had they received sufficient training to use restraint appropriately?
2. Did staff use information from behaviour management plans and risk assessments to minimise the likelihood of restraint occurring?
3. Was the use of restraint routinely monitored and lessons learnt?

The following highlights our findings on the key areas for the theme of using restraint.

1. Did staff understand what restraint was and had they received sufficient training to use restraint appropriately?

In many cases, restraint was understood. Staff in many services said the focus was on positive intervention strategies, where situations were de-escalated and restraint used as a last resort. For example:

"The unit manager told us that the service had recently changed to a new training provider for the purpose of physical restraint. The manager said that the new system is still focused on positive behaviour management and physical restraint is only used as a last resort. We asked the reason for this change and we were told that this was due to changes in the needs and dependency levels of people now using the service. This demonstrates that the service responds to the changing needs of patients and makes changes where necessary." Ashford Unit, Southern Health NHS Foundation Trust

However, there were examples of staff not recognising that what they were doing constituted restraint. These cases were concerning as it could mean restraint being used inappropriately, putting people at risk of harm or abuse:

“We were advised by the registered manager that figure of four and thumb holds are used. These techniques are applied by holding one or both of the patient’s arms, which restricts their movement. These methods of restraint were being used by the staff. However, the registered manager did not recognise this as restraint. The manager confirmed there is no separate record being kept of the number of occasions restraint is being used, the type of restraint, the number of staff involved, the duration or reason of why restraint was deemed necessary. From discussion with the registered manager and staff members it was evident there was not a clear plan or understanding of when restraint would be appropriate for individuals, what constituted restraint and what was reportable as restraint.”

2. Did staff use information from behaviour management plans and risk assessments to minimise the likelihood of restraint occurring?

Staff often delivered care in line with behavioural management plans to de-escalate situations where possible:

“Staff spoken to understood that physical restraint should only be used when patient safety was put at risk. Staff were able to explain what forms of restraint would be used with individuals. Care plans and risk assessments clearly identified the appropriate restraint technique to be used with each individual. Where the patient had a particular health risk that could be adversely affected by the use of restraint this was highlighted and an appropriate restraint method was recommended.” Constance House, Curo Care Limited

“We looked at a range of documentation relating to incidents and the use of restraint. This included statutory notifications, incident records, daily care records, support plans and risk assessments. The records we looked at demonstrated that policies, procedures and patient guidelines had been followed consistently.” Penhayes, Modus Care Limited

3. Was the use of restraint routinely monitored and lessons learnt?

Many of the locations that were compliant did record information about incidents of restraint and analyse these to look for trends. These locations learned from this and fed information back into people’s care plans to reduce the chances of restraint being needed in the future. For example:

“During the inspection we looked at a range of documentation and information relating to the use of restraint within the service. The provider logged all incidents on its computer system which recorded the cause, the duration and the type of restraint used. We examined the incident reports of the young people who used the service. We found evidence that the records were adequate to demonstrate that the local policy and procedures had been followed consistently. The care plans we looked at showed us that incidents of challenging

behaviour had been reviewed and analysed at each weekly meeting. When triggers to a young person's challenging behaviour were identified, the care plan was amended and this was confirmed by the young people we spoke to." Ferndene, Northumberland, Tyne and Wear NHS Foundation Trust

However, we saw many examples where restraint was not being effectively monitored or lessons learnt:

"The figures for restraint and seclusion are not being used effectively to monitor patterns or used as a quality indicator for the unit. This meant that learning from incidents is not always taking place and opportunities to reflect on practice, such as the build up to, and triggers for requiring restraint were not being fully investigated."

"We found that the monitoring of incidents involving restraints was not adequate. Incident reports were not always completed appropriately with a lack of evidence of review and learning from the incident. There was no evidence that the poor recording of incidents was picked up at any level in the organisation. Patients were therefore at risk of being inappropriately handled during an incidence of restraint."

In our review of people's care plans and incident records we found a number of incidents where seclusion had been used and not recognised as a form of restraint in accordance with national guidance on restraint⁹. For example:

"When we visited a unit for women with the most challenging behaviour, we saw that a patient was being cared for separately by two staff in the management suite. This patient's care had been managed this way for the previous 24 hours. While it was clear that this patient needed to be cared for in segregation due to the threat she posed to other patients and staff, the service was not managing this as seclusion. The service stated that the patient was in 'therapeutic segregation' but the challenging behaviour policy did not define or describe how or when segregation could be used or the safeguards that should be in place when a patient was managed in segregation."

Conclusions

While progress has been made to improve the lives of people with learning disabilities, challenges still remain in making further positive changes that give people back their independence and control. Good quality commissioning and provision of care are central to ensuring people's wishes, needs and aspirations can be met so they can live fulfilling lives.

Our inspection of 150 locations found that there is still a need to make sure that care planning and care delivery need to be highly individualised with clear objectives that help people manage their complex needs over time.

Challenging behaviour is complex, and poorly organised services can pose risks to individuals and the staff providing services. One of the management interventions with challenging behaviour is the use of restraint. We found through the inspections that there is poor staff understanding of restraint, a lack of monitoring of the usage of restraint leading to increased risk of restraint being used inappropriately.

The poor care and abusive practices witnessed at Winterbourne View Hospital have once again placed services for people with learning disabilities, mental health needs and challenging behaviours into the spotlight. The results of this inspection programme lead to the conclusion that public policy planning is being inconsistently implemented. Commissioners need to collaborate at a local level. They need to involve family carers in defining need. They must commission innovative and locally based services that are developed with clear measures of success and represent the needs and aspirations of people with learning disabilities.

Follow-up inspections

We published inspection reports on each of the 150 inspections between December 2011 and May 2012. The lead inspector gave immediate feedback to the staff at the location at the end of each inspection and the reports were shared with the providers in advance of publication.

Of the 150 inspections, 35 locations were fully compliant. No further action was required for these services. Forty-four locations were compliant but had minor concerns. These locations were required to submit an action plan to demonstrate how they would maintain compliance against the essential standards. Seventy-one locations were non-compliant with either moderate or major concerns. These locations were required to submit an action plan to show how they would become compliant within an appropriate timescale.

We dealt with each case in the context of the location, so there were no standard actions put in place. Details of the actions that individual locations had to take were set out in the reports published on our website. We will update these actions regularly as and when we carry out follow-up inspections, so they are not recorded here.

By the end of May 2012 we had undertaken 34 follow-up inspections of non-compliant locations. Of these, 24 locations were found to be compliant; the evidence for ten locations is still being examined. Where we served warning notices we have been back and found the locations to now be compliant. Further follow-up action is planned at every location where improvement or compliance actions were put in place. Decisions on when and how to follow up on improvement and compliance actions is based on the levels of risk (in terms of potential impacts on patients) associated with our judgements.

We identified specific safeguarding concerns at 27 (18%) locations, which required referral to the relevant local authority safeguarding adult team. In these cases we either requested the provider to make the referral (which we followed up to confirm was done) or made the referral ourselves. All these referrals are being monitored and we will ensure we are satisfied that an appropriate outcome has been reached.

Appendix A: Terms of reference for advisory group

Learning Disability Review: Advisory Group

Terms of reference

Overview and purpose

These terms of reference describe the arrangements for the Advisory Group set up regarding the CQC Learning Disability review.

The purpose of the group is to:

- Provide expertise and experience to inform the approach and scope of the programme.
- Comment and provide a steer on the nature of the inspections in terms of focus and desired outcomes.

The outputs from the group will be reported to the CQC virtual advisory network, and the CQC Executive Team and Board.

The advisory group has no decision making authority regarding CQC's regulatory activity.

The conclusions of the advisory group will be aligned with what is happening in the wider environment.

Responsibilities and membership

The group is scheduled to meet monthly in London; in person or by a virtual meeting via teleconference or other remote working meeting technology.

Nomination of a deputy is requested to cover inability to attend.

The meeting will receive a verbal briefing and written papers if relevant and provide expert opinion on the progress of the inspection programme at each meeting.

The group is chaired by Jo Williams, CQC Chair, or by her nominated deputy.

The group members are shown in Table 1.

Table 1

Organisation	Title of member
VODG	General Secretary
Royal College of Psychiatrists	Consultant Psychiatrist
St. George's Healthcare NHS Trust	Consultant Nurse Learning Disability
NHS London	Head of LD Development
Local Government Group	Strategic Lead, Adults and Health Services
National forum for people with learning disability	Co chair of the forum
Association of Directors of Social Services	Director, Directorate of Adult Community and Housing Services
Worcestershire Mental Health Partnership NHS Trust	Associate Director
Nursing and Midwifery Council	Director of Nursing and Midwifery Policy and Standards
National Valuing Families' forum	Carers lead
Independent Healthcare Advisory Services	Representative from private location
Care Quality Commission	Project Lead Learning Disability Review
Care Quality Commission	National Advisor on Adult Social Care
Care Quality Commission	Special Policy Lead to CEO
Care Quality Commission	Administrator

Learning Disability Review: Reference Group – Organisations represented

Association of Directors of Adult Social Services	National Valuing Families Forum
British Institute of Learning Difficulties	National Valuing People Forum
British Psychological Society	NHS Confederation
Care Management Group	NHS London
Centre for Health and Social Care, Leeds University	Nurse – independent
Department of Health	People First
Equality and Human Rights Commission	SCOPE
Her Majesty's Inspectorate of Prisons	Sense
House of Lords	South Essex Partnership University NHS Foundation Trust
Learning Disability Coalition	The Challenging Behaviour Foundation
Local Government Group	Turning Point
Mencap	Voiceability
National Autistic Society	Voluntary Organisations Disability Group
National Family Carers Network	

Appendix B: Are locations meeting the standards people should expect?

When a location meets the standards the law says people should expect, we say the location is 'compliant'. When a location is failing to meet those standards, it is 'not compliant'. There are a number of decisions we can make as a result of our inspections and in this programme of inspections we used four:

Compliant – this means the location is meeting the standards and no action is needed to improve.

Compliant, minor concern – this means the location is meeting the standards we expect but needs to take action to make sure they keep meeting the standard. In this case, we set the location an 'improvement action' to try to prevent them falling below the bar. We will check later to see if they have done this.

Non-compliant, moderate concern – this means the location is not meeting the standards we expect and although people are generally safe there some are unacceptable risks to their health and wellbeing. In this case, CQC puts a 'compliance action' in place for the location. They must carry out the action we tell them by a set date or face further action.

Non-compliant, major concern – this means the location is not meeting the standards we expect, and people are not protected from unsafe or inappropriate care. In this case, we also use a 'compliance action' but may use one of our most serious powers – which can include suspending or even closing services – to protect people from harm.

When a location is non-compliant, it does not mean everyone who uses that location will experience poor care. It means there is an increased risk of people receiving poor care. Given the size and complex nature of the care delivered in locations, you will always find examples of good care in non-compliant locations, and occasional poor care in compliant locations. CQC's judgements try to capture the overall quality of care at location-wide level. We try to tackle problems that make the risk of poor care in any given case more likely.

Appendix C: Locations inspected in this programme

Locations where we had a major concern (for outcome 4 and/or 7)

Please note we are undertaking follow-up inspection at these locations and more recent judgements and reports may be available on our website.

Name	Provider
9 Victoria Street	Derbyshire County Council
Assessment and Intervention Service (Birling Centre)	Kent and Medway NHS and Social Care Partnership Trust
Beech House	Four Seasons (Granby One)
Bloomfield Court and 5,6 Ivy Mews	Curo Care Limited
Chaseways	Cambian Learning Disabilities Limited
Cheswold Park Hospital	Riverside Health Care
Elmsmead	Voyage 3 Limited
Harkstead Barns	United Response
Hennel Lane	Scope
Kent House	Cheshire and Wirral Partnership NHS Foundation Trust
Langdon Hospital	Devon Partnership NHS Trust
Melling Acres	Parkcare Homes (No 2) Limited
Newsam Centre	Leeds Partnership NHS Foundation Trust
North Lodge	Calderstones Partnership NHS Foundation Trust
The New Barn	Claremont Care Limited
Townend Court	Humber NHS Foundation Trust
Walkern Lodge	Cambian Learning Disabilities Limited
Willes Road	Turning Point

Locations where we had a moderate concern (for outcome 4 and/or 7)

Please note we are undertaking follow-up inspection at these locations and more recent judgements and reports may be available on our website.

Name	Provider
Ashley House	Four Seasons (Granby One)
Brooklands	Coventry and Warwickshire Partnership NHS Trust
Caludon Centre	Coventry and Warwickshire Partnership NHS Trust

Cambridge House	Cambridge Care Homes Limited
Carleton Clinic (Edenwood)	Cumbria Partnership NHS Foundation Trust
Cedar Gardens	Nigel Hooper
Doulton Lodge Independent Hospital	Doulton Lodge Limited
Ferme Park House	Curo Care Limited
Field House	Growing Older with Learning Disabilities Limited
Foresters	Dorset Residential Homes
Fox View	South West Yorkshire Partnership NHS Foundation Trust
Gisburne Lodge	Calderstones Partnership NHS Foundation Trust
Granby Place	DSGM Choice
Greenways	Cheshire and Wirral Partnership NHS Foundation Trust
Hazelwood House	Partnerships in Care Limited
Heath Lane Service	Black Country Partnership NHS Foundation Trust
Highbury Hospital	Nottinghamshire Healthcare NHS Trust
Jubilee Court	Autism Support and Care Ltd
Kings Delph Lodge	Four Seasons (Granby One)
Lansdowne House/Blackberry Hill	Avon and Wiltshire Mental Health Partnership NHS Trust
Linden House	Four Seasons (Granby One)
Lombard House	Partnerships in Care Limited
Mansfield Community Hospital	Nottinghamshire Healthcare NHS Trust
Old Leigh House	Mild Professional Homes Limited
Olive Eden Hospital	Curo Care Limited
Orton Mere	Four Seasons (Granby One)
Penhayes	Modus Care Limited
Phoenix House	Nigel Hooper
Pond Lane	Black Country Partnership NHS Foundation Trust
Rainham-Farm Lodge	Cambian Learning Disabilities Limited
Rhodelands	Voyage 1 Limited
Richmond House	Partnerships in Care Limited
Ridge Hill	Black Country Partnership NHS Foundation Trust
Rowan House	Four Seasons (Granby One)
Shear Meadow	Cambian Learning Disabilities Limited
St Andrew's Healthcare - Women's Service	St Andrews Healthcare
St John's House	Partnerships in Care Limited
St Luke's Hospital	Mild Professional Homes Limited
St Lukes Rosebury Park	Tees, Esk and Wear Valleys NHS Foundation Trust
St Mary's Hospital (Woodland Square)	Leeds Partnership NHS Foundation Trust
Stepping Stones	Stepping Stones Resettlement Unit Limited

The Manor	Cambian Learning Disability Midlands Limited
The Views	Cambian Learning Disability Midlands Limited
The Woodhouse Independent Hospital	Acorn Care Limited
Thingwall Hall Nursing Home	Brothers in Charity
Tynedale	Autism North Limited
Vista Healthcare Independent Hospital	Fairhome Care Group (W.L.) Limited t/a Vista Healthcare Independent Hospital
Warrington (Hollins Park Hospital)	5 Boroughs Partnership NHS Foundation Trust
Watcombe Hall Annex	Four Seasons (Granby One)
Westridge Assessment and Treatment Service	2Gether Trust
Whipton Hospital (Knightshayes)	Devon Partnership NHS Trust
Willis House	5 Boroughs Partnership NHS Foundation Trust
Yew Trees	Mild Professional Homes Limited

Locations where we had minor or no concerns (for outcome 4 and/or 7)

Name	Provider
1 Whitehorse View	North Yorkshire and York PCT (now transferred to Leeds and York Partnership NHS Foundation Trust)
15 - 16 Daisy Banks	Calderstones Partnership NHS Foundation Trust
163 Durham Road	Tees, Esk and Wear Valleys NHS Foundation Trust
Agnes Unit	Leicestershire Partnership NHS Trust
All Saints Vicarage	Autism North Limited
Ash Green	Derbyshire County PCT
Atlas House	Oxleas NHS Foundation Trust
Badsley Moore Hospital	Rotherham, Doncaster and South Humber NHS Foundation Trust
Bankfields Court	Tees, Esk and Wear Valleys NHS Foundation Trust
Beaumont College and Scope Inclusion North West	Scope
Berrywood Hospital (Vale)	Northamptonshire Healthcare NHS Foundation Trust
Bewick House	Voyage Limited
Bigfoot Independent Hospital	Equilibrium Healthcare
Bostall House	Mild Professional Homes Limited
Bradley Woodlands Low Secure Hospital	Healthlinc Individual Care Limited

Bucknall Hospital	North Staffordshire Combined Healthcare NHS Trust
Burgess Care	Burgess Care Ltd
Burnside Care Limited – Holme Road	Burnside Care Limited
Burston House	Partnerships in Care Limited
Calderstones (Main Site)	Calderstones Partnership NHS Foundation Trust
Cambian Fairview Hospital	Cambian Learning Disabilities Limited
Cedar House	Four Seasons (Granby One)
Chilterns Assessment and Treatment Unit	Oxfordshire Learning Disability NHS Trust
Church View	Tees, Esk and Wear Valleys NHS Foundation Trust
Constance House Hospital	Curo Care Limited
Education & Life Skills Warford	David Lewis Centre
Evenlode	Oxfordshire Learning Disability NHS Trust
Fairmead (Bramdean)	Surrey and Borders Partnership NHS Foundation Trust
Farmfield	Surrey and Borders Partnership NHS Foundation Trust
Ferndene	Northumberland, Tyne and Wear NHS Foundation Trust
Fieldhead Hospital	South West Yorkshire Partnership NHS Foundation Trust
Hallam Street Hospital	Black Country Partnership NHS Foundation Trust
Healthlinc House	Healthlinc Individual Care Limited
Heath Close	South Essex Partnership University NHS Foundation Trust
Hob Meadow	Accord Housing Ltd
Hollybrook	2Gether Trust
Home Farm	West House
Hungate Road	Four Seasons (Granby One)
Ivers	Iver House Limited
James House	Four Seasons (Granby One)
John Charrich House (Slade)	Oxfordshire Learning Disability NHS Trust
Kingswood Centre	Central and North West London Foundation Trust
Knightsbridge House	Mild Professional Homes Limited
Lanchester Road Hospital	Tees, Esk and Wear Valleys NHS Foundation Trust
Little House	Berkshire Healthcare NHS Foundation Trust
Little Plumsted Hospital	Hertfordshire Partnership NHS Foundation Trust
Littlebrook Hospital	Kent and Medway NHS & Social Care Partnership Trust
Long Leys Road	Lincolnshire Partnership NHS Foundation Trust

Lothingland	Suffolk Mental Health Partnership NHS Trust
Lucy Glyn Residential Home	Lucy Glyn
Lynfield Mount Hospital	Bradford District Care Trust
Mansfield House	Four Seasons (Granby One)
Mary Dendy Unit (Alderley Unit)	Cheshire and Wirral Partnership NHS Foundation Trust
Mossley Hill Hospital	Mersey Care NHS Trust
Northern General Hospital- Assessment & Treatment Unit	Sheffield Health & SC FT
Oaklands	Surrey and Borders Partnership NHS Foundation Trust
Orchard Hills	Black Country Partnership NHS Foundation Trust
Pathways & Community Warford	David Lewis Centre
Postern House	Oxfordshire Learning Disability NHS Trust
Prospect Park	Berkshire Healthcare NHS Foundation Trust
Rose Lodge	Northumberland, Tyne and Wear NHS Foundation Trust
Scott House	Calderstones Partnership NHS Foundation Trust
Seacole Centre	Central and North West London Foundation Trust
Shore Lodge	Leonard Cheshire Disability
St Andrew's Healthcare – William Wake	St Andrew's Healthcare
Stockton Hall	Partnerships in Care Limited
Sunflowers Court (Moore Ward – Goodmayes)	North East London Foundation Trust
Sutton's Drive	Black Country Partnership NHS Foundation Trust
Tarentfort Centre	Kent and Medway NHS & Social Care Partnership Trust
Tarry Hill	HC-One Limited
The Glades (The Coppice)	South Essex Partnership University NHS Foundation Trust
Trust HQ (Ashford Unit)	Southern Health NHS Foundation Trust
Trust HQ, Doncaster (Sapphire Lodge)	Trust HQ, Doncaster (Sapphire Lodge)
Wensley Street	South Yorkshire Housing Association
Westbrooke Grange	Modus Care Limited
Whitwood Hall	Whitwood Care Limited
Woodbury Ward, Wolfson House	East London NHS Foundation Trust
Woodside	Caireach Limited
Wycar Leys The House	Wycar Leys Limited

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Please contact us if you would like a summary of this document in another language or format.



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