CareQuality Commission

The state of health care and adult social care in England 2015/16

MENTAL HEALTH

STATE OF CARE

Mental health

Key points

- We have seen some excellent examples of good practice over the last year, with 16 NHS trusts rated as good as at 31 July 2016. We are pleased to have rated our first two NHS trusts as outstanding in September 2016.
- We have also seen good and outstanding practice in independent mental health providers, with 103 rated as good and seven rated as outstanding.
- Good leadership – both at a provider and ward level – is key to both providing a good service and helping organisations to improve.
- However, overall our ratings suggest that care for people with mental health problems is not good enough and needs to be improved.
- In particular, the safety of patients in NHS trusts remains an area of concern, with 40 rated as requires improvement and four rated as inadequate for the key question 'are services safe?'.
- Other areas of concern include:
  - the safety of ward environments
  - the safety of patients withdrawing from alcohol and opiates
  - long-stay patients in mental health wards
  - providers continuing to apply to register residential services that are not consistent with the new service model for people with a learning disability.

Introduction

The landscape of mental health care in England is complex, with organisations caring for people with a wide range of mental health needs in a variety of settings. We register and inspect mental health NHS trusts, independent mental health hospitals and substance misuse services. In addition, we monitor how providers are applying the Mental Health Act 1983 (MHA). We look at how the provider is fulfilling its duties overall through our comprehensive inspection programme and we publish these findings. We also monitor how it is being applied to individuals through our MHA reviewer visits, and use this information to inform our inspection activity.

A high proportion of mental health services are provided by independent mental health hospitals. Unlike other health sectors, independent hospitals provide a lot of the same services that are provided by NHS trusts, many of which are commissioned by the NHS.

Due to the size and spread of some NHS providers, we have identified 11 core services that, if they are provided, we will always include in an inspection. We rate small, independent providers by location rather than by core service. This means that we cannot always directly compare the quality of care between NHS and independent providers.

The findings from our inspections and ratings sit against a backdrop of wider developments and concerns relating to the sector. It is encouraging that mental health care continues to be high on the government's agenda. Analysis has suggested that commissioners have planned to shift some spending away from the acute sector towards community services, and to a lesser extent towards mental health, although there is substantial variation across the country, and we have yet to see these plans materialise fully.

A number of important reports were published during 2015/16, including *The Five Year Forward View for Mental Health and Winterbourne View – Time for Change* (Sir Stephen Bubb's final report). The reports highlight that there are still worrying inequalities that are putting lives at risk and preventing a large number of people from realising full mental health. They also show that there is more work to be done to improve the care of people with mental health problems, learning disabilities and/or autism.

Core services for specialist mental health services

The 11 core services that we will always inspect if they are provided include:

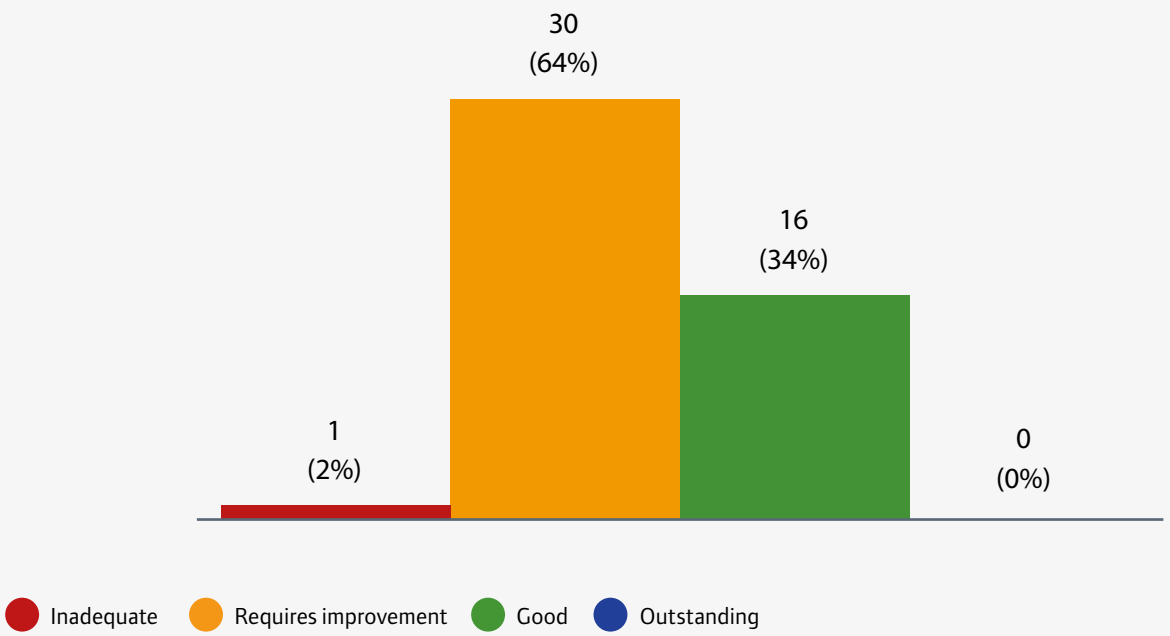
Mental health wards

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism.

Community-based mental health and crisis response services

- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism.

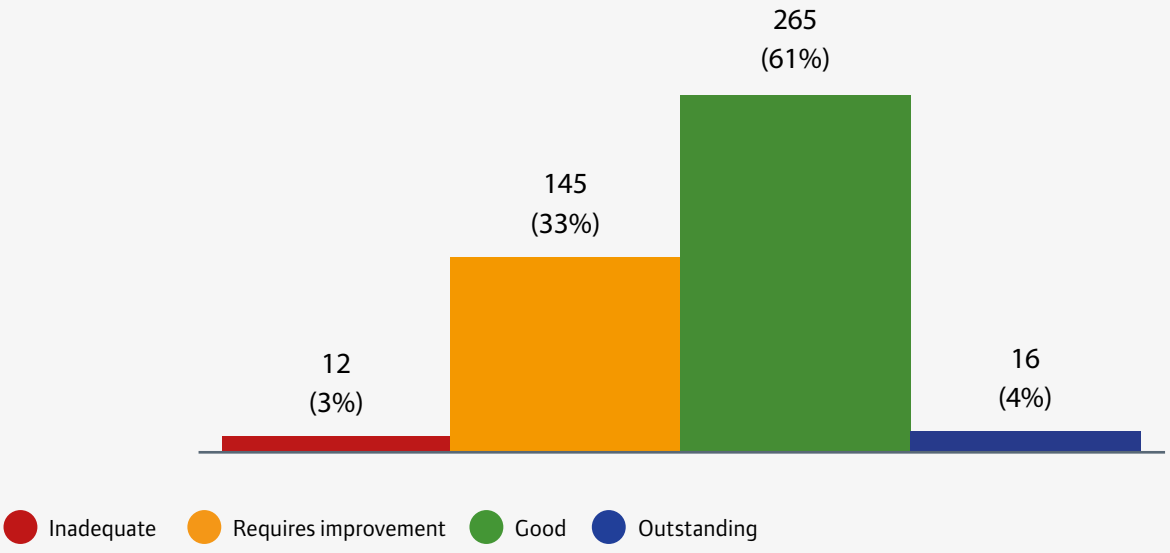
Figure 2.23 NHS mental health trusts current overall ratings, as at 31 July 2016



Source: CQC ratings data

Note: Since 31 July 2016, we have rated two NHS mental health trusts as outstanding.

Figure 2.24 NHS mental health trusts current overall ratings for core services, as at 31 July 2016



Source: CQC ratings data

Overview of quality

We have completed our comprehensive inspections of all 57 NHS mental health trusts. By July 2016, we had published the inspection reports and ratings of 47 trusts. Of these, 16 were rated as good (figure 2.23).

Since this data was collated, we have rated the first two mental health trusts – Northumberland, Tyne and Wear NHS Foundation Trust, and East London NHS Foundation Trust – as outstanding. However, our overall ratings for NHS providers also suggest that care for people with mental health problems needs improvement, with 30 rated as requires improvement and one rated as inadequate. Looking at the overall ratings for NHS trusts at core service level, 61% of services were rated good and 4% outstanding (figure 2.24).

By July 2016, we had rated 161 independent sector mental health hospitals. Of these, we rated seven (4%) as outstanding, 103 (64%) as good, 43 (27%) as requires improvement and eight (5%) as inadequate (figure 2.25).

Our inspections have given us a benchmark of the quality of mental health services in England, and examples of good practice in action.

Over the last two years, we have re-inspected seven trusts. We are pleased to report that two of these (Worcestershire Health and Care NHS Trust and Oxford NHS Foundation Trust, whose reports were published in August 2016) have improved their overall ratings from requires improvement to good. More generally, our inspectors have seen a broad range of improvements including changes to the physical environment, quality of staffing and restrictive practices.

Where our inspectors saw improvements, they found that leaders were properly engaged. This meant that not only were they more likely to spot problems themselves, but were also able to make improvements more quickly when they arose. In these trusts, our inspectors often found that teams worked well together – even if they were under-resourced – and that there was a culture of flexibility and delegation that empowered staff to make necessary changes.

Focused on recovery

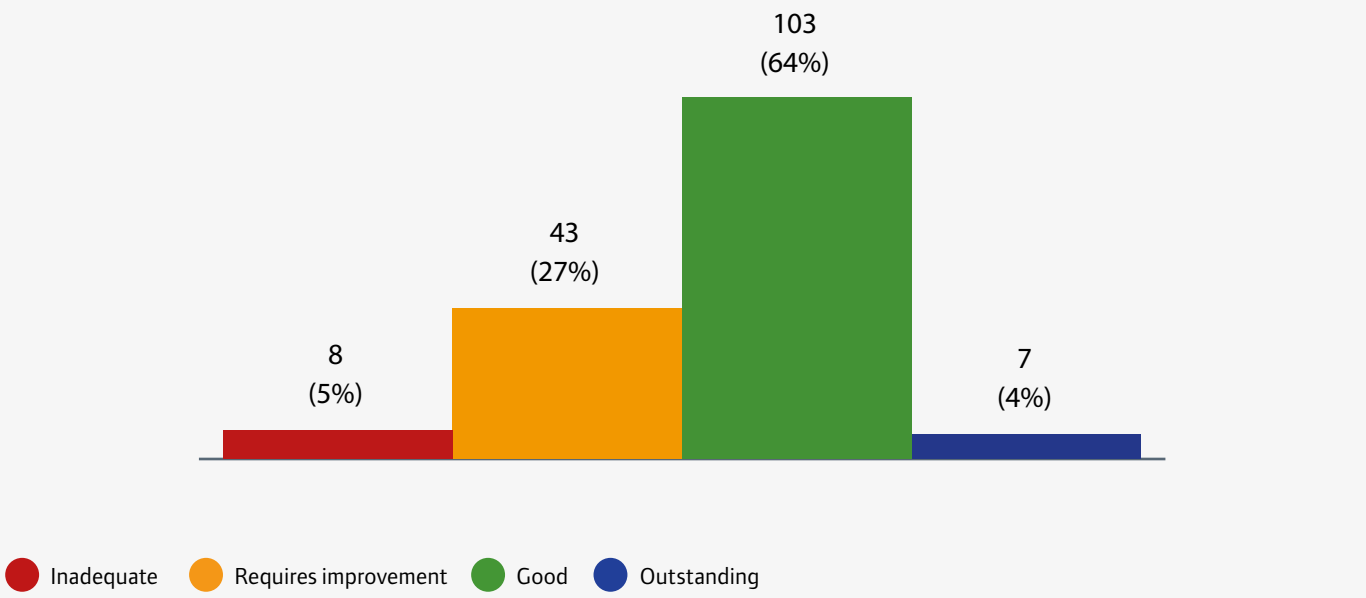
Turning Point Douglas House, Manchester

Turning Point is a national charity providing health and social care services for people with a learning disability, mental health needs and substance misuse problems. In March 2016 we visited Turning Point – Douglas House, a 12-bed independent mental health hospital in Manchester, and found that it was providing an outstanding service to its patients. Patients worked in true partnership with staff, and were both involved in decisions about their own care and in developing the charity's national policy and campaigning work.

The hospital was focused on recovery and used the mental health recovery star tool to develop support plans. In addition, staff encouraged, and were enthusiastic in supporting, patients to fulfil daily tasks such as planning and shopping for meals, cooking and tidying. There were good systems in place to make sure that the requirements of the Mental Health Act 1983 (MHA) were met. The MHA coordinator attended ward rounds on a weekly basis to monitor how the MHA was being implemented.

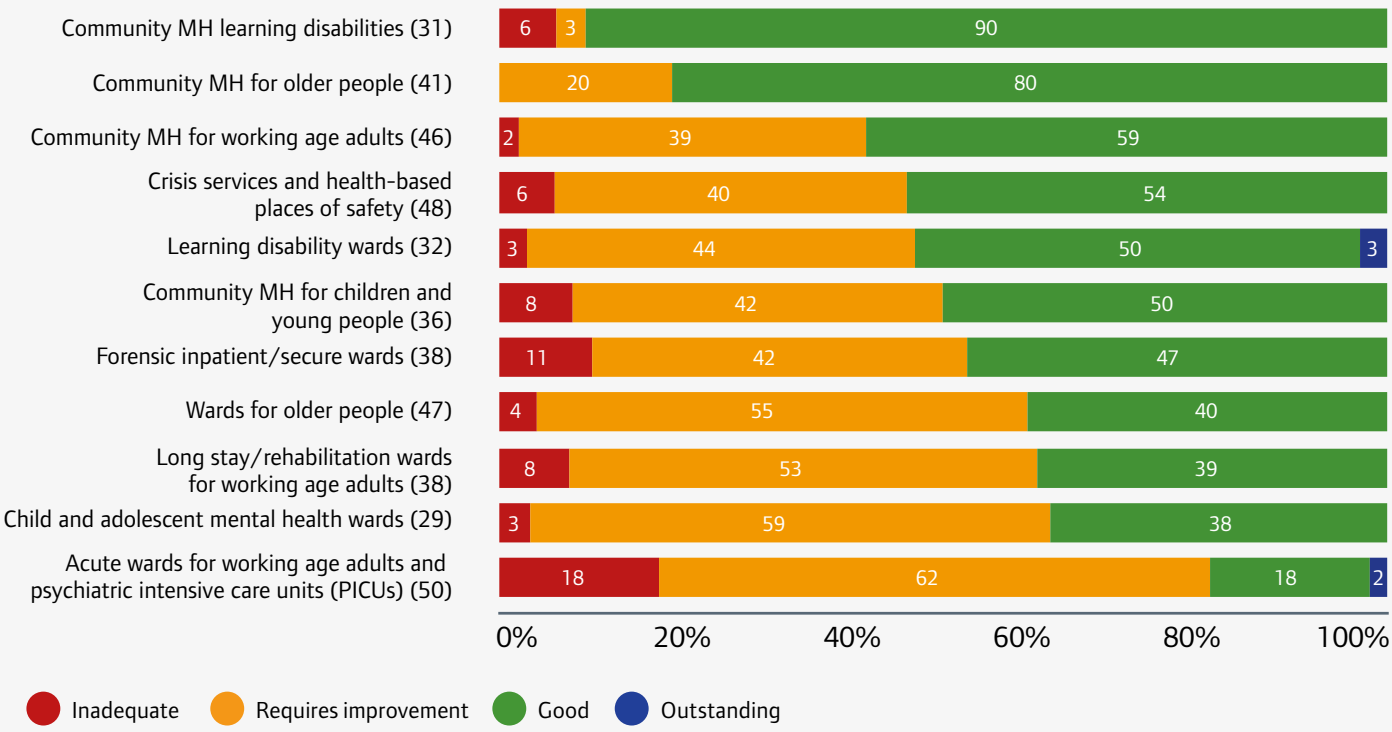
The hospital had strong management team that was person-centred, and was led by a well-respected registered manager. The service was focused on improvement. Staff had completed a range of clinical audits and made improvements as a result of these. Staff, patients and other stakeholders were told of all changes made at Turning Point Douglas House.

Figure 2.25 Independent mental health current overall ratings, as at 31 July 2016



Source: CQC ratings data

Figure 2.26 NHS mental health current safe ratings for core services, as at 31 July 2016



Source: CQC ratings data

Unsafe practices in managing withdrawal and detoxification from alcohol and opiates in substance misuse services

We began the roll out of our substance misuse inspection programme in October 2015. At the end of July 2016, we had published inspection reports for 58 substance misuse services. We found some serious and concerning issues:

- no written protocols for assisted alcohol or opiate withdrawal
- staff who were not trained and/or competent to provide safe care to people who were undergoing assisted withdrawal
- staff failing to create care plans that addressed the potential risks for people undergoing assisted withdrawal
- services not carrying out adequate physical health checks before starting assisted withdrawal and/or failing to carry out regular physical health checks.
- learning disability or autism.

As well as taking enforcement action where needed, we wrote to all providers of residential substance misuse services in January 2016 to alert them to our concerns. We then held a joint event with Public Health England in June 2016 about their responsibilities in relation to clinical care and governance, as part of our commitment to encouraging improvement.

Compromised privacy and dignity

We visited a ward at a mental health hospital in December 2015 as part of our comprehensive inspection. At the time of the inspection, plans were progressing for the redevelopment of the site, but the timescale for this work had not been confirmed.

This ward for female patients was one of three acute wards on the site. The layout of the ward did not meet the needs of the patients. Most of the bedrooms were shared, with up to four beds in one room separated only by curtains. This compromised the privacy and dignity of the patients. In addition, the ward shared a dining area with another ward. This meant that there was a timetable for meals, with patients from one ward using the dining room and then vacating it for patients from the second ward to eat. This affected the flexibility for mealtimes.

The communal lounge space on the ward was very small. If patients needed higher levels of observation, it would be very cramped for patients and staff to be in the lounge together. If staff needed to use the seclusion room for a female patient, they would need to escort the patient across a public corridor and through a male bedroom area to reach the facility. Although this did not happen frequently, it could again compromise the patient's privacy and dignity. The layout of the ward meant that the clinic room was through two locked doors. Emergency drugs and equipment was stored in this area, which meant they were hard to access by staff in an emergency.

The inspection made it clear in the report, and at the quality summit, that the physical environment at the hospital for the three acute wards was not fit for purpose. We expect the trust to work with commissioners to redevelop the ward quickly.

Ratings by key question

Looking in more detail at the ratings by key question, the picture is more mixed. While there are pockets of really good practice – which is reflected in the ratings for the key question 'are services caring' – other areas, such as safety, need to improve dramatically.

Safe

Last year, we highlighted the safety of mental health services as a key concern. We reiterate our concerns this year, with all but three NHS trusts rated inadequate or requires improvement overall for the key question 'are services safe?'.

Due to the size and complexity of NHS mental health trusts, and the variability between core services, it is possible that in some hospitals a few poorer performing core services may affect their overall rating. For example, only three core services out of 11 need to be rated as requires improvement for the whole trust to receive a rating of requires improvement for the key question 'are services safe?' Figure 2.26 shows the ratings for safety across the core services in NHS trusts.

It is important to note that mental health services place a different emphasis on some aspects of safety than acute hospitals. Problems with the physical environment frequently contributed to a rating of requires improvement or inadequate for inpatient core services. The most common problems mentioned in our inspection reports were:

- problems with the layout of some wards, meaning that staff had poor lines of sight and difficulty in observing some parts of the ward
- risks from potential ligature anchor points that staff had not adequately assessed or mitigated against
- failure to follow the guidance on getting rid of mixed-sex accommodation
- poor state of repair or decoration
- seclusion rooms that did not meet modern requirements.

During 2015/16, we issued Warning Notices to four NHS trusts relating to concerns with the environment of the service. In three cases, we specifically noted that there was a lack of governance or that governance was not effective in identifying environmental issues.

In a number of reports, inspectors explicitly linked the problems they found with the fact that the wards were housed in old or unsuitable buildings.

In the long term, there needs to be greater investment in purpose-built wards that are more suitable for mental health care. However, in the medium term, providers must manage the risks posed by older buildings to improve patient safety. Through our inspections, we have found examples where providers have made changes to the environment, which enabled people to use the services more safely.

This year, we began inspecting specialist substance misuse services using our new approach. After completing the first 16 inspections of residential substance misuse services, we found an alarming

Long-stay patients

An area of concern that we have seen across a number of providers, largely in the independent sector, is people with severe mental health problems staying in hospitals for months and years at a time. We are particularly concerned that some long-stay units are not focused enough on people's recovery.

This is reflected in:

- poor discharge planning
- a lack of motivating and recovery-oriented activity for patients
- patients not being involved in developing their treatment plans, or care that is not person-centred or holistic
- poor assessment and/or treatment of physical health problems.

number of services with inadequate practices that were putting people at significant risk of harm.

When things go wrong, it is important for healthcare professionals and organisations to learn lessons and make sure the same mistakes are not repeated. Nowhere is this more important than when someone dies. Following the NHS England commissioned report on the investigation of deaths at Southern Health, we are looking at how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations. We also want to assess whether opportunities to prevent deaths have been missed. Findings from our review are due to be published later this year.

Problems with staffing also contribute to the poor ratings for trusts in terms of safety. National figures show a continuing decline in the number of mental health nurses. At the same time, the number of staff reporting that they are working extra hours remains high, at almost three-quarters, in the 2015 NHS staff survey. Our inspectors have also flagged a problem with experienced staff reaching retirement age, and not enough nurses being trained or retrained.

Despite this, feedback from inspectors flagged staffing as an area in which they had found examples of improvements over the last year. Solutions to some of the problems identified included moving staff to where they are most needed and recruiting from abroad.

Effective

To assess the effectiveness of services, we check whether people receive care, treatment and support that follows good practice, achieves good outcomes and promotes a good quality of life. At a provider level, our data suggest that services need to improve in this area, with 28 NHS trusts rated requires improvement for the key question 'are services effective?'. However, as we highlighted in the section on safety, the complex nature of NHS mental health trusts means that the picture is both different and variable at a core service level, with 67% of core services (293 out of 436) rated as good or outstanding.

Of the 162 independent hospitals inspected and rated, 105 (65%) have been rated as good and outstanding for this key question. Where we rated services as good or outstanding, we found that care plans were kept up-to-date and reviewed regularly, patients had good access to psychological therapies, and there were comprehensive multidisciplinary teams (including medical staff, nursing staff, social workers, psychology staff and occupational therapists) who worked well together to care for and support patients.

Under this key question, we also check that people who are subject to the Mental Health Act 1983 (MHA) are assessed, cared for and treated in line with the MHA and Code of Practice. Through our monitoring activities we have found that services across England are striving to provide innovative, caring services for patients subject to the MHA despite resource pressures. However, we are

Staffing improvements

St Andrew's Healthcare, Nottinghamshire

On our initial inspection of St Andrew's Healthcare, we raised concerns about the number of staff and skill mix on the wards. When we went back, we found that the hospital was using a risk-based safer staffing tool to evaluate the required number of staff and grades of staff per shift. This was reviewed daily in response to requirements such as a patient's condition getting worse, sickness, training needs and section 17 leave under the Mental Health Act 1983. Wards were running above the base numbers due to increased observation levels and the adoption of new working models, in particular Newstead and Thoresby wards.

Tailored for individual patients

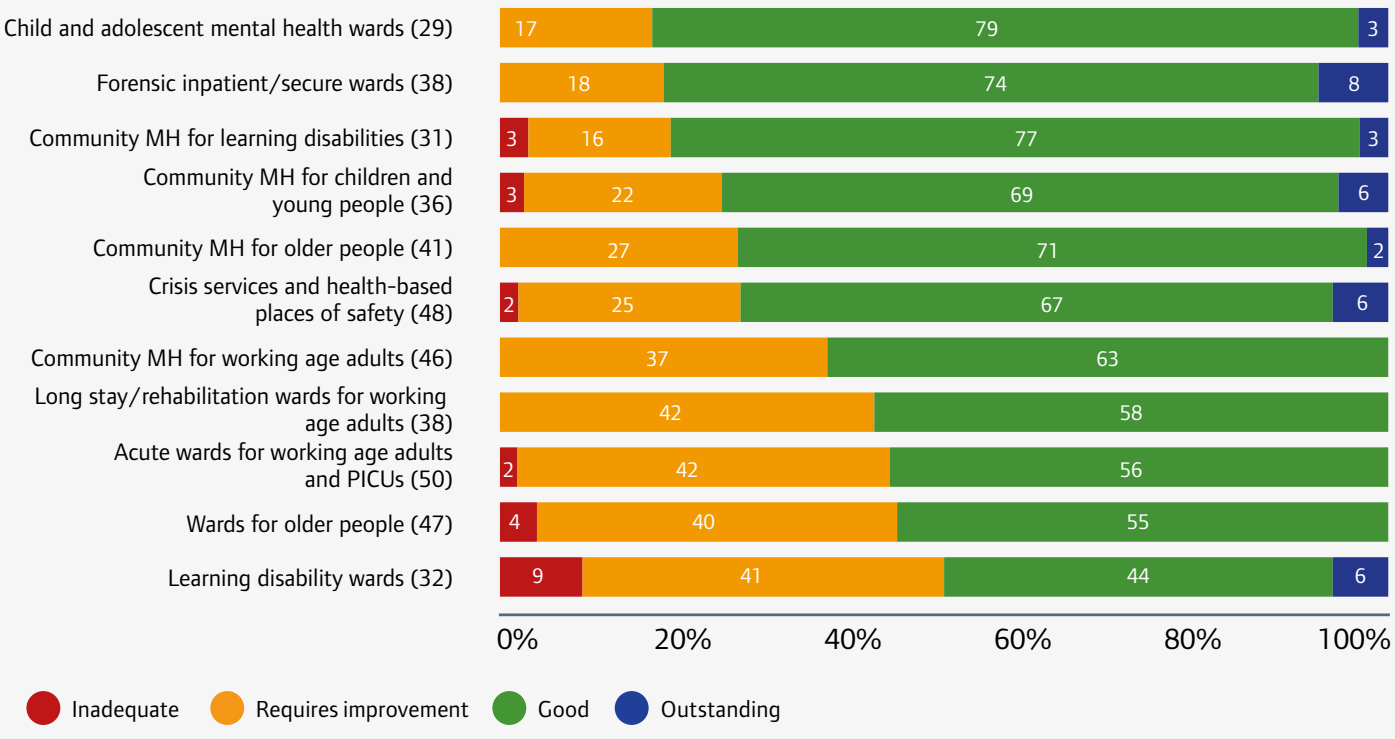
Lincolnshire Partnership NHS Foundation Trust

We visited the specialist community mental health services for children and young people at Lincolnshire Partnership NHS Foundation Trust in December 2015, and rated the service as outstanding for the key question 'are services effective?'.

We were impressed with the way in which staff had developed an outcomes-oriented model for the child and adolescent mental health service. The model, which had been recognised in NHS innovation awards, showed clear, positive outcomes for young people using the service. This was supported by feedback from social workers and school staff, who described good outcomes for young people who had used the service.

The service was also innovative in the way it created new interventions that were tailored to meet the needs of individual patients. Staff completed comprehensive assessments, which were kept up-to-date. There were also clear treatment plans in place that were recovery focused.

Figure 2.27 NHS mental health current effective ratings for core services, as at 31 July 2016



Source: CQC ratings data

concerned that we are still finding variation in the way that the MHA and Code of Practice are being applied. Further detail about our monitoring activities will be published in our MHA annual report in November 2016.

Caring

Similarly to last year, our inspectors found that overall NHS mental health services were treating people with compassion, kindness, dignity and respect. To date we have rated 96% (416 out of 435) of NHS core services as good or outstanding for the key question 'are services caring?'.

Through our inspections, we have found some great examples where services had supported people with mental health problems to make decisions about their own needs and involved people in a person-centred way.

While a similar proportion of independent hospitals received an outstanding rating for this key question (eight services, 5%), 10 services have been rated as requires improvement or inadequate for caring. Areas for improvement include services having an increased focus on involving patients in making choices.

Responsive

Key factors underpinning good and outstanding responsive practice in mental health providers are:

- assessing people promptly and starting treatment quickly
- enabling people to leave hospital as soon as they are ready
- wards and care settings that are comfortable and adapted to people's individual needs
- responding promptly to concerns and complaints, and learning lessons from them.
- involving patients in designing and planning services
- identifying unmet needs and changing provision to meet this.

Feedback from our inspectors highlighted examples where people were involved in the design and development of the service, for example through service user groups and staff interviews, to identify and meet their preferences, aspirations and unmet needs. Trusts offering services to patients from areas where services were not available was another example of a good responsive service. In addition, trusts working with other organisations, such as

Innovative approaches to communication

Cheshire and Wirral Partnership NHS Foundation Trust

Cheshire and Wirral Partnership NHS Foundation Trust is one of three NHS trusts that we have rated outstanding for the key questions 'are services caring?' up to 31 July 2016. When we visited the trust in June 2015, we found that staff went the extra mile to make sure that patients' and their families were involved in their care, and that their needs and wishes were met.

Feedback from patients and carers was positive. Staff involved patients, families and carers in decisions about care, and developed care plans in collaboration with the patients. In particular, we were impressed with the care on the learning disability wards. On these wards we found some examples of outstanding interactions between staff and patients, with staff using innovative approaches to communicate effectively with patients.

The trust had also signed up to the 'Triangle of Care' initiative. This is a national programme developed to improve carer engagement in mental health acute inpatient and home treatment services. The trust had received recognition for its commitment to improve support for unpaid carers and their families, with a second gold star from the national Carers Trust.

"Significantly changed the culture"

Calderstones Partnership NHS Foundation Trust, Lancashire

Calderstones Partnership NHS Foundation Trust provides specialist and forensic learning disability services to more than six million people across the North of England, as well as Scotland and Northern Ireland.

We initially inspected the trust in July 2014 and found major concerns with the application of the Mental Health Act 1983, medicines management, staffing and how patients were being protected from harm. Following the inspection, the trust developed a comprehensive action plan and worked with external stakeholders to address the issues raised. We held monthly meetings with the trust and Monitor (now NHS Improvement) to oversee the implementation of this plan. When we returned to the trust in October 2015, we found significant improvements including a reduction in the number of episodes of restraint, seclusion and the use of rapid tranquillisation, and the eradication of the use of emergency response belts.

Dr Paul Lelliott, the Deputy Chief Inspector of Hospitals (lead for mental health), said, "Since our first comprehensive inspection in July 2014, the trust has implemented a new model of working called 'safe wards' that focuses on reducing restrictive practices and improving patient outcomes. The new model has significantly changed the culture in the trust, and enabled staff to work collaboratively with patients and reduce the need to use physical interventions to manage behaviour that staff find challenging. When we re-inspected the trust, managers, staff and patients all commented on the improvements made."

Patients supported through transition

Cambian Sherwood Lodge, Nottinghamshire

Cambian Sherwood Lodge is a specialist learning disability rehabilitation service for men with a learning disability and other complex needs. When we visited the service in November 2015, we found some excellent examples of the service responding to patient needs. We found that the hospital started planning for a patient's discharge as soon as they arrived. Staff put patients at the centre of their care and made sure that they were fully engaged with their rehabilitation and plans for leaving.

The team worked well with external agencies to make sure that patients left the service at the right time and were well supported through the transition from being in hospital to living elsewhere. Patients also had the opportunity to apply for paid therapeutic jobs. Jobs were advertised and patients were interviewed for them.

In hospital, patients had access to a wide range of activities, seven days a week and could decide what they preferred to do each day. Patients could influence this through suggestion boxes, the morning planning meeting or by asking a member of the occupational therapy team. Staff made plans to meet patient preferences, and patients could access services in a way and at a time that suited them.

joint-working between police and mental health services, was regarded as a sign that the service was responsive to people's needs.

We found pockets of good practice in developing integrated care. For example, proactive and coordinated approaches to planning a patient's discharge from the point they were admitted. Our inspectors viewed this as essential for improving the experience of people receiving mental health care. Being responsive to the patient's preferences and needs, and planning discharge into good quality and suitable housing, can help to avoid a patient being readmitted to hospital.

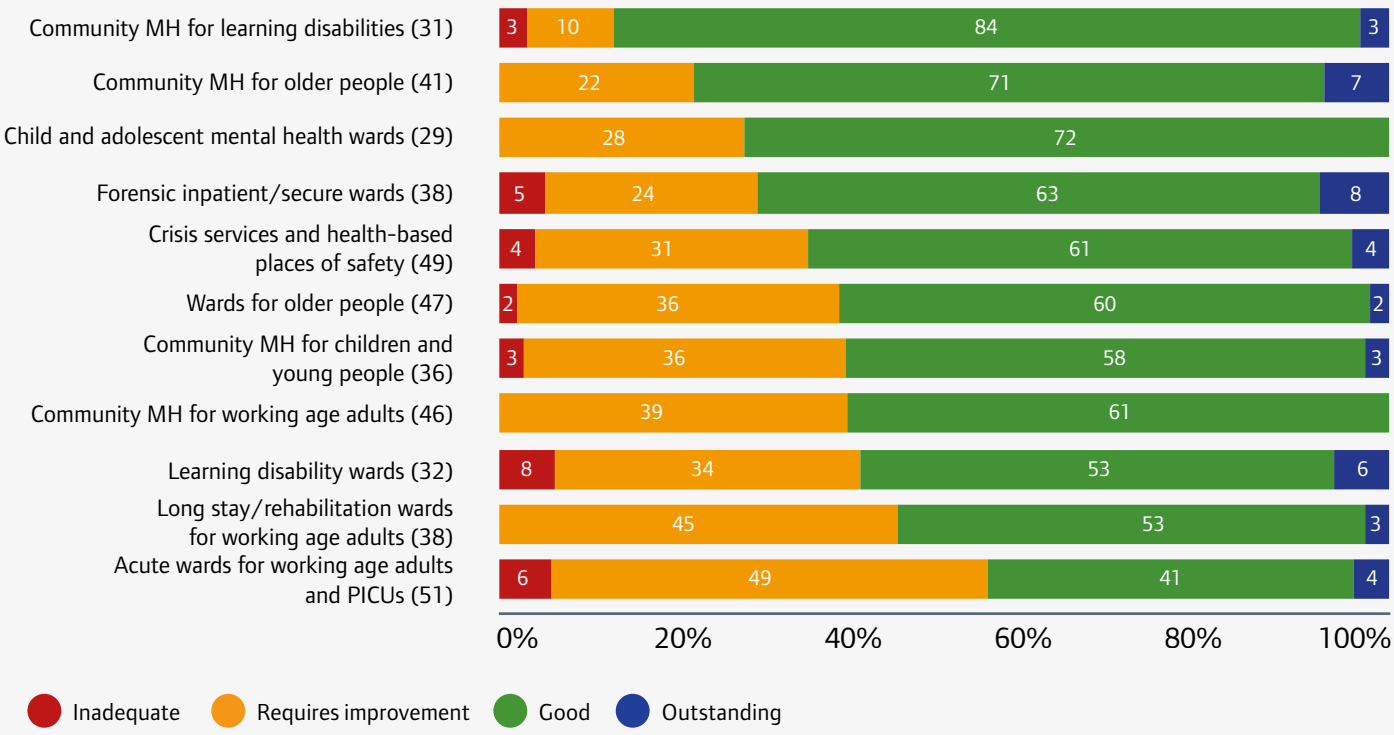
However, with 20 NHS trusts rated as requires improvement, and 33 independent hospitals rated requires improvement or inadequate, there is still more work to be done. Our inspectors found that some services did not consider accessibility beyond often limited wheelchair access, leaving people with visual or hearing impairments unable to fully access the care they needed. We also found:

- long waits from referral to assessment or referral to treatment in community mental health services – especially in child and adolescent mental health services
- long waits for specialist psychological therapies
- delays in making Mental Health Act assessments when people are taken to a health-based place of safety
- failing to plan discharge for people in rehabilitation and learning disability wards
- failing to respond to concerns and complaints.

Well-led

The quality of leadership can have a direct effect on the quality of care offered by a provider. Good leadership – both at a provider and ward level – is key to providing good care. We can see this in the ratings for NHS trusts and independent hospitals,

Figure 2.28 NHS mental health current overall ratings for each core service, as at 31 July 2016



Source: CQC ratings data

with 78% of trusts and 93% of independent hospitals having the same overall rating as their well-led rating. Our ratings reflect both the quality of local leadership of clinical services and the quality of leadership and governance at board level. However, as noted in the introduction, many mental health trusts are large and geographically dispersed, making good governance particularly challenging. This is highlighted through our inspections of larger trusts, where we have found examples of poor practice in one or two wards when the rest of the trust is performing well.

Trusts that we have rated as good or outstanding for well-led, or have shown improvement following an initial less good inspection, often have senior leadership teams that have engaged actively with the frontline staff. Our inspectors stress the importance of senior leaders making themselves more available. An example of good practice given was one trust holding a "big breakfast" informal meeting with staff and the chief executive. Other improvements relating to the well-led key question included improved staff recruitment processes, such as taking better account of the fit and proper person requirement, and actions to improve staff morale.

The two trusts that we rated as outstanding overall in September 2016 were characterised by the quality and style of leadership. Both trusts had an open culture in which the senior leadership team valued their frontline staff. Nevertheless, our ratings for the

Waiting list actively managed

Berkshire Healthcare NHS Foundation Trust

We visited Berkshire Healthcare's community CAMHS in December 2015 and found that the waiting list for the service was actively managed. This included face-to-face as well as telephone contact with young people and their families. Patients on all of the referral pathways were seen within an acceptable time with prioritisation according to urgency, risk or need. A substantial proportion of people on the autistic spectrum disorder diagnostic pathway, where waits were longest, were seen within 12 weeks based on need.

Focus along care pathways

2gether NHS Foundation Trust, Gloucestershire

2gether was highlighted as an example of a mental health trust working well in close partnership with other agencies. It has a social inclusion team that works closely with NHS providers, voluntary sector organisations, clinical commissioning groups, local authorities (social services and education). 2gether was viewed as innovative, notably for working with schools and in other local organisations to raise awareness of mental health and the profile of mental health services. It was seen as an example of good, joined-up thinking – not just seeing a patient, but also seeing the person in their entirety. Inspectors highlighted its focus along care pathways and across a range of providers to ensure there were no out of area placements for adults. This ensured bed availability and transitions between services were monitored and managed well. Inspectors thought that this had a huge impact on bed availability, as support systems keep people healthier in the community.

key question 'are services well-led?' show that there is more work needed, with just over half (24 out of 47 trusts, 51%) of NHS trusts and 122 out of 161 (75%) independent mental health hospitals rated as good or outstanding.

Ratings by core service

The picture of quality at a core service level is variable, with some NHS community services achieving higher ratings than their NHS inpatient counterparts and vice versa. Of all core services, NHS community services for people with a learning disability or autism performed best. Out of 31 services, we rated 26 (84%) as good and one (3%) as outstanding. In these services, we found that staff were skilled and appropriately trained, patients were involved in planning their care, and there were systems in place to deal with urgent referrals. In contrast, we rated 17 out of 32 (53%) NHS inpatient services for people with a learning disability or autism as good and two (6%) as outstanding (figure 2.28).

Of the NHS community-based mental health services, those for children and adolescents performed least well; we rated 21 out of 36 (58%) as good and one outstanding, compared with 21 out of 29 (72%) child and adolescent mental health wards rated good. Our ratings show that community services for children and young people performed worse across the effective, responsive and well-led key questions.

In particular, inspectors found an increase in referrals to community CAMHS and long waiting times. This supports other evidence that has shown that the longest waiting times between referral and the start of treatment were nearly 10 months.

Our findings support those of *The Five Year Forward View for Mental Health*, published in February 2016. This highlighted children and young people as a priority group. It called for a substantial reduction in the waiting times, and stated that by 2020/21 at least 70,000 more children and young people should have access to high-quality mental health care when they need it. It also recommended that CQC and Ofsted should consider assessing how the health, education and social care systems are working together to improve children and young people's mental health outcomes, as part of the joint targeted area inspection programme.

Our inspections have identified examples of good practice that show how referrals and waiting lists could be managed to ensure that patients are seen in a timely way, and in turn improve their outcomes.

Nevertheless, our findings in CAMHS reflect a wider concern that, despite calls for better integration, some community services are becoming less integrated. Inspectors reported that joined-up working between NHS trusts and local authorities was becoming more strained because of financial restrictions with, for example, social workers being 'pulled back' and joint working groups being disbanded. In particular, inspectors noted that better integration was essential to improve transition planning from child to adult services.

Other inspectors highlighted 'pockets of good practice' of integrated care, for example proactive approaches to discharge planning from mental health hospitals and raising awareness of mental health services.

Learning disabilities

Following the publication of *Transforming care: A national response to Winterbourne View* in December 2012, CQC has been an important part of the Transforming Care Delivery Board. We are committed to ending the institutionalisation and isolation of people with a learning disability, through integrating care into the community. As part of this, we are tightening the regulation and inspection of providers of learning disability services, and are strengthening providers' corporate accountability.

In February 2016, we published our revised policy on registering new services and changes to services. Our policy outlines the requirements that providers seeking to register with us will need to develop their services in line with *Building the right support*. This is a national plan to develop community services and

close inpatient facilities for people with a learning disability or autism who display behaviour that challenges, including those with a mental health condition. CQC will not support the development of institutional facilities for people with a learning disability, whether these are designated as a hospital or a care home. We will not consider applications from providers that seek to register an inappropriate assessment and treatment unit or hospital, care home or location for independent living.

Changes can and should be made to improve the quality of care and outcomes for patients. The clearest example we have to date are the improvements made at Calderstones Partnership NHS Foundation Trust. We have described above the transformation of the culture of Calderstones led by the managers following our initial inspection in 2014. As part of the transforming care programme, Calderstones has now been taken over by Mersey Care NHS Foundation Trust. The improvements made put the hospital, its staff and patients in a far better position to adopt the new model of care.

As part of our commitment to the Transforming Care Delivery Board, we have further developed our methods for inspection of services for people with a learning disability. We have worked with partners to clearly mark out enforcement routes for failing providers, and we are already looking at how our inspections of GP practices and acute hospitals can give greater prominence to the quality of care that people with a learning disability receive, including for their physical health.

We are pleased to see that, while the number of learning disability beds available has fallen steadily over the last few years, bed occupancy rates have remained stable or also slightly fallen, suggesting that a transition to community settings is taking place. We will be continuing our work to support this transition in 2016/17.

Developing independent life skills

Example of a good application

Provider A applied to increase the number of places at a care home service from six to 12 places. The existing six places are currently provided in two single independent flats and a small group home – all have their own front door, accessed by the main entrance. The proposed additional places are six individual flats that are accessed through the main entrance or their own front doors, which are at the side or rear of the building.

The new flats are modern and individually designed, with an open plan kitchen/lounge and separate bedroom with full en-suite facilities. They have access to a communal lounge, for the sole use of the new flats, where people can meet and socialise together. There is also an independent staff room at the rear of the flats for support staff.

The additional places will be offered as a supported living service. Each tenant will have independent care packages, and staff will be recruited according to the needs of each person. Service objectives include supporting people to develop their independent life skills before moving on to homes of their own. The supported living service will have a dedicated staff team. It is not proposed that staff will work across the care home and supported living service.

The current care home, which is located in a village on the outskirts of a town, is rated good. The service is on a main bus route, and people are well supported to build and maintain relationships and access community services in the village and beyond.

The provider has supplied evidence that they have consulted local commissioners. They have confirmed that there is a local need and they will be willing to seek placements. The provider has also consulted people who currently use the service, some of whom have shown an interest in transferring to the supported living service.

Care Quality Commission

How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter > @CareQualityComm

Read the summary and download this report in other formats at > www.cqc.org.uk/stateofcare
Scan this code on your phone to visit the site now.

Please contact us if you would like this report in another language or format.

CQC-347-410-102016

ISBN 978-1-4741-3755-3