Birmingham Community Healthcare NHS Trust

RYW

Learning Disability Services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Learning Disability Services. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Learning Disability Services and these are brought together to inform our overall judgement of Learning Disability Services

Summary of findings

Ratings

Overall rating for Learning Disability Services	Good 
Are Learning Disability Services safe?	Good 
Are Learning Disability Services effective?	Good 
Are Learning Disability Services caring?	Good 
Are Learning Disability Services responsive?	Good 
Are Learning Disability Services well-led?	Good 

Summary of findings

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Summary of findings

Overall summary

Services were judged safe at the time of our inspection. There were arrangements in place to minimise risks to people receiving care and staff working in the services. Staffing levels were safe in the services we inspected.

Care and treatment were effective and focused on the needs of the people receiving care. We saw evidence of collaborative working and person-centred care.

People receiving care and their families felt well supported and involved in their care. Where they were able, patients were encouraged to make decisions relating to their treatment and care. Staff were dedicated, compassionate, kind and caring.

Learning disabilities services were responsive to people's needs. Services were accessible to people from all communities. We saw evidence that work had been undertaken to ensure that people who had been referred to the service were appropriately triaged and assessed by the multi-disciplinary team to ensure they were placed with the appropriate care pathway.

The service was well-led. The Board and senior managers had an oversight of the reported risks and measures had been put in place to manage them.

Summary of findings

Background to the service

Birmingham Community Healthcare Trust was registered on 30 March 2011 and provided learning disability services throughout the city of Birmingham. A variety of inpatient and community services are delivered to people who have complex health care needs and learning disabilities.

Learning disability services were delivered from 4 in patient locations and 6 community teams, during the inspection we spoke with patient's families and staff at 6 of these locations.

Care was delivered by specialist learning disability nurses, doctors, psychologists, community nurses, district nurses, health care assistants and allied health professionals.

The inspection team included two CQC inspectors, a learning disabilities specialist nurse and an expert by experience and their support worker. An expert by experience is a member of the public who has experience of using services or caring for people who use services, like the ones we were inspecting.

Throughout the visit we spoke with four patients, 14 representatives of people using the service and 24 members of staff. We observed patient care and we looked at 14 sets of patient records. As part of our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Our inspection team

Our inspection team was led by:

Chair: Dr Cheryl Crocker, Director of Quality and Patient Safety, Nottingham North and East Clinical Commissioning Group

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Dentist, Nurses, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Birmingham Community Healthcare NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

Summary of findings

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Birmingham Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 23 and 27 June 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 46 locations which included 13 community inpatient facilities and the dental hospital. The remaining locations included various community facilities. We carried out an unannounced visit on 27 June to one of the inpatient units.

What people who use the provider say

During our inspection we spoke with patients and their representatives. All of the people we spoke with were very positive about the care and treatment they received within Learning disability services. Patients and their families felt safe using the service and they felt they were treated with kindness and compassion.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The Trust should ensure that it has effective health and safety measures in place, including the storage of medical gases, management of clinical waste, removal of out of date stock and appropriate fire risk assessments.
- The Trust should ensure that staff are aware of and utilise the Deprivation of Liberty Safeguards are effectively in a person's best interests and in compliance with legal requirements.
- The Trust should consider the nature of the environment in residential learning disability settings and ensure whilst they meet infection control standards, they reflect a home environment.
- The trust should ensure that repairs and maintenance to equipment and facilities is carried out within acceptable timeframes across the learning disability services.

Action the provider COULD take to improve

- The Trust could ensure that there are clear managerial structures within learning disability services.

Birmingham Community Healthcare NHS Trust

Learning Disability Services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Learning Disability Services safe?

By safe, we mean that people are protected from abuse

Summary

We found that services were safe. We saw there were arrangements in place to minimise risks to people receiving care and to community based lone workers. Staffing levels were safe in the services we inspected although there was some concern about staffing levels and workloads in the community.

There was awareness amongst staff to identify and consider serious incidents, incidents, near misses and risks to people and what to do with that information. There were effective systems in place to learn from incidents and we saw that staff reviewed incidents so that shared learning could take place.

We observed a clean environment in all of the locations we inspected and staff followed infection prevention and control guidelines.

The trust used the NHS Safety Thermometer which gave information about safety in services. This information was displayed on a notice board at each of the locations we visited.

Detailed findings

Incidents, reporting and learning

There had been no reported 'never events' within learning disability services between 2012 and 2014. Never events are classified as such because they are so serious that they should never happen.

The service had achieved 100% harm free care in September 2013. This is a tool to measure how many patients had infections or sustained falls or pressure ulcers during their hospital stay. At the time of our visit 94% of patients received harm free care.

The trust had an up to date incident reporting policy and there was an effective incident reporting system within learning disability services. Staff were aware of the system and encouraged to use it. Staff were able to give examples of times when they had reported incidents and told us they received feedback on the outcome of incidents they had reported.

We saw evidence that incidents had been reported and that lessons had been learnt as a result of investigations

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Are Learning Disability Services safe?

involving service users, staff and outside agencies. We saw that learning from incidents was shared within the Trust via emails, divisional meetings, risk meetings, team meetings, supervision and through the staff newsletter.

The trust used the NHS Safety Thermometer which gave information about safety in services. This information was displayed on a notice board at each of the locations we visited. Staff were able to explain the purpose of this information and how it helped them to monitor the safety of the people using the services.

In addition, the trust used a system for auditing and reporting on common risk areas across the service, called Essential Care Indicators (ECIs). These were a set of measurements for assessing the quality of care plans and assessment tools used to manage fundamentals of care. The trust's Quality Account published information about targets and achieved compliance. At the locations we visited managers were able to tell us about these ECIs and show us the results for their units, along with action plans for improvement where results were below the expected measure.

Cleanliness, infection control and hygiene

There was a policy in place for the prevention and control of infection. Services we visited were clean and we saw evidence that cleaning took place according to schedules. We saw that equipment had stickers indicating the last date and time they had been cleaned. Personal Protective Equipment (PPE) in the form of gloves and aprons were readily available and we saw staff wearing these when appropriate. Hand washing facilities were available and we observed staff washing their hands in between episodes of care. However, paper towels and waste paper bins were not available in some bedrooms at one of the locations.

In one of the locations we inspected, we saw that some items such as nutritional supplements were being stored in boxes directly on the floor. We raised our concern with the manager of the location who took immediate action to remedy the situation. We saw that the trust carried out regular infection control audits and that the results of these were made available to staff and to patients and their families.

There was an effective system in place for the management of waste. The trust had a waste handling policy. Staff we spoke with were aware of the policy and procedure. All sharps bins we saw (containers used for the disposal of needles and other sharp objects) were labelled and dated correctly. Clinical waste, including sharps, was disposed of appropriately under a contract with an external provider; however we did note that at two locations clinical waste bins were not covered or secured.

Maintenance of environment and equipment

Equipment was available in sufficient quantities to ensure the safety of patients and meet their assessed needs. However, staff told us that storage of equipment was a challenge. We saw in two locations we visited that an unoccupied bedroom was being used for the storage of equipment. In the event that this bedroom would be occupied, there would be a negative impact on the layout of the environment and consequently on patients. Equipment and consumables would potentially clutter up corridors and communal areas.

The in-patient locations we inspected had access to specialist pressure relieving equipment and mattresses. These were being used appropriately according to patients' assessed needs. Resuscitation equipment was being checked on a daily basis. However within two locations, we found blood glucose monitoring strips to be out of date.

All staff we spoke with told us that there was a process for reporting faulty or damaged equipment. In most locations we found the equipment was maintained and checked regularly to ensure it continued to be safe to use. We saw that equipment was also clearly labelled to indicate when it was next due for a service. However, there was concern regarding the timeliness of response from the estates division regarding premises repairs and faulty equipment. We saw evidence that some issues had been logged more than nine months previously and had not been addressed appropriately. Staff in residential and respite learning disability services told us that in some cases the delays were due to the uncertainty around commissioning arrangements for the future of some of the services.

Medicines

There were effective systems in place for the handling, administration, storage and disposal of medicines. Controlled drugs (CDs), which are medications that are governed by specific legislation, were managed according to legal requirements and emergency medicines were in date and fit for use.

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Are Learning Disability Services safe?

We reviewed Medication Administration Record (MAR) charts and saw that appropriate prescribing and recording of the administration of medication was taking place.

Medication fridge temperatures were monitored and recorded on a daily basis and corrective action taken if the temperature deviated from the expected range. However, we noted that room temperatures where medication requiring storage below 25 degrees were not recorded, we could therefore not be assured that medication was always being stored at an appropriate temperature at all times.

Pharmacy teams completed a monthly audit of medicines, errors were recorded and lessons were learnt. Patients' medication records were accurate and up to date. However, we found that in one location staff were not provided with the latest version of the British National Formulary.

At one location we found that the storage of oxygen cylinders was inappropriate and external signage was not in place. We raised this with the manager who agreed to take immediate action.

Safeguarding

There was a trust wide policy and procedure for safeguarding adults and children, 95% of staff had received training in safeguarding. Staff understood their role in safeguarding patients and were able to explain how they would raise concerns. We saw evidence that safeguarding concerns had been raised correctly following procedure. We saw that the trust carried out audits of safeguarding and that they worked with other agencies to ensure that patients were protected from abuse.

Records

Staff had access to information governance training as part of their mandatory training. The trust's mandatory training policy stated this training was refreshed annually.

All of the records we looked at were in a paper format. Within all of the areas we inspected we saw that records were stored securely in order to ensure they could not be accessed by people who did not have the authority to access them.

During our inspection we looked at the care records of 14 patients across learning disability services. Most of the records were well organised and information was easy to access. Records contained a detailed assessment of the needs of patients before they arrived in the service. This assessment included information provided by relatives and other services about health and social care.

Lone and remote working

Lone working policies were in place for staff working in the community and managers told us that staff followed them. There was also a requirement for risk assessments to be undertaken for all lone working staff. Staff working in the community were not issued with individual mobile phones or with personal alarms. One manager told us that each community team had a mobile phone that could be used by any member of the team if required. Managers told us they relied on staff to use their personal mobile phones to communicate with office bases or to return to their base to liaise with other members of the multidisciplinary team (MDT).

Staff told us they used their own mobile phones to maintain contact with other members of the team and they would text each other to ensure their whereabouts were known.

Lone working staff received conflict resolution training in the prevention and management of violence. This was mandatory for all lone working staff and was refreshed annulally. The trust's lone working policy stated that lone worker devices may be issued to staff where a risk assessment indicated a requirement.

Managers told us that in order to minimise risks associated with lone working, initial patient assessment would always be undertaken at a base and by two members of staff. Visits that were deemed as high risk were identified in patient records. If a visit was deemed to be high risk staff would go in pairs rather than go alone.

Adaptation of safety systems for care in different settings

The provision of care for people with learning disabilities took place in different settings. Some patients were receiving care in their own homes, some accessed respite care or day services, whilst others were receiving long term care in care homes.

Teams operated local risk assessments to reflect the type of services and where they were being delivered. We saw that systems were in place to monitor and respond to risk. We

Good

Are Learning Disability Services safe?

saw that staffing levels and skill mix supported safe practice in the areas we inspected and that risk assessments had been conducted to ensure staff and patient safety.

We saw that where people were unable to mobilise, ceiling track hoists had been installed to ensure they were fully supported in their environment.

Assessing and responding to patient risk

In addition to the trust wide corporate risk register, there was also a local risk register for learning disability services. The risks identified on these registers represented those risks that managers and staff had discussed with us during our visit. Staff told us that they knew how to escalate risk and that they received feedback.

The trust used a recognised early warning tool known as the Modified Early Warning System (MEWS) to record patients' physiological observations within in patient areas. This enabled staff to recognise when patients were deteriorating. We saw that MEWS scores were completed before patient's accessed services and again on arrival. They were also recorded in patients' records when they had been unwell or when staff had concerns about their health. We looked at completed MEWS charts and saw that staff had taken appropriate action and repeat observations were taken in the necessary timeframes.

People who used the service had individual risk assessments in place, such as for the risk of developing pressure ulcers or the risk of falls. The risk assessments seen had been regularly reviewed and updated.

Staffing levels and caseload

Planned and actual staffing levels were clearly identified and displayed within each of the locations we inspected. At the time of our visit, residential services had been consistently staffed above the trusts' minimum staffing levels. This was because staff had been re-deployed following the closure of other services. We saw evidence of this from staffing rotas and staff confirmed that this was the case. Relatives told us "There are enough staff and I recognise them". In one service we saw that a person's health care needs were so great that they had two staff to support them twenty four hours a day.

A senior manager from learning disability community services told us that there were issues with nursing caseloads but that these were reviewed regularly and that recruitment for community nurses was in progress. However staffing numbers in one community nursing team had reduced from six to four and there were no plans to recruit to the vacancies despite an increasing workload.

Deprivation of Liberty safeguards

We saw that staff received training in relation to the Mental Capacity Act (MCA) and that this was refreshed every three years, but could not establish the level of training received in relation to the Deprivation of Liberty Safeguards (DoLS). Staff understanding of the MCA and DoLS was variable.

Throughout our inspection we met patients who, under the recent Supreme Court Ruling, were possibly being deprived of their liberty (inappropriately restricted of their freedom). For example we met patients who had been assessed as lacking capacity to make decisions about where they lived and the care and treatment they received, who required continuous supervision and control and were not free to leave the premises. When we looked at the care records for these people we found that assessments had not been made in relation to DoLS, and that applications had not been made to authorise DoLS within residential or respite learning disability services. We spoke with senior managers about this and they responded immediately with an action plan to review all patients and make any applications required, and update all patient records in relation to this.

Managing anticipated risks

In addition to the overarching trust risk register, learning disability services maintained its own risk register. All managers we spoke with were able to clearly articulate the risks for their area of responsibility. In addition, senior managers were aware of the anticipated risks within Learning disability services. The trust's business continuity plan dated 2010 was being updated at the time of our visit to reflect the changes that were taking place with the provision of learning disability services.

Major incident awareness and training

We saw the trust had a lock down policy for dealing with major incidents. There were plans in place to respond to and manage unexpected emergency situations. We saw that there were risk assessments in place, for example in relation to fire. Staff had received fire safety training and were able to explain what they would do in an emergency. Plans had been discussed with other teams and staff in these teams were able to tell us their role in supporting services in an emergency. Staff told us that fire drills took place every six months in residential settings and we saw

Good

Are Learning Disability Services safe?

evidence of this in records. One of the patients also told us about the fire drills and explained that "every door closes automatically and staff come and find you". The staff we spoke with were aware of escalation procedures if a risk was identified. However, we did not identify and personal emergency evacuation plans for patients with limited mobility.

Good

Are Learning Disability Services effective?

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

Summary

Overall services for people with learning disabilities were effective, evidence based and focused on achieving positive outcomes for patients. We saw evidence of good collaborative working to support and coordinate care throughout the services we visited.

Staff were mostly up to date with mandatory training and developmental training was also available. There were effective clinical supervision arrangements in place across the service, together with regular team meetings being held throughout the service.

Detailed findings

Evidence based care and treatment

Staff told us that they followed National Institute for Health and Care Excellence (NICE) guidance where applicable and that whenever there were changes in practice the Trust respond immediately with an offer of update training, usually in-house. Records showed where staff had included an assessment of the risks presented by the patient's condition, a recognised risk assessment tool had been used. For example the risk of developing pressure damage was assessed using the Waterlow scale, a nationally recognised tool.

Records for in-patient learning disability services included evidence based care and treatment plans. These records included information on clinical needs, mental health, physical health, nutrition, hydration and social needs. In most instances the information in the records had been regularly reviewed and updated. Records and our observations showed that care in these services was personalised, holistic and enabled patients to maximise their health and well-being. Some of the patients who had limited communication had pictorial displays in their rooms entitled "My Good Life" giving staff a clear picture of their wishes. Representatives of the people using the service told us that they had been involved in the preparation of these displays alongside key staff.

We found that although Mental Capacity Assessments (MCAs) had been undertaken when required, there were inconsistencies in the recording of the assessments. Some records had been completed in line with the requirements of the Mental Capacity Act 2005. We saw records of decisions about the care of patients that had been made and documented in accordance with best interests decision making guidance, for example a decision about medical screening had been taken in accordance with the law. However, we also saw Mental Capacity Act documentation which was incorrectly completed. For example, the assessments we looked at concentrated on day to day activities and focused on the persons general care needs. Stage one of the capacity assessment focused on the person's diagnosis as a reason for them not having mental capacity instead of documenting the conversation that should have occurred to establish how the patient was or was not able to understand, retain, weigh or communicate the question.

Pain relief

We saw that pain relief was appropriately prescribed and administered. Staff told us that if patients were unable to communicate their pain verbally they would look for signs of pain through patient's behaviour or their expressions. This was detailed in patients individual care plans. We did not observe any patients to be in pain or to be distressed throughout our inspection.

Nutrition and hydration

Patients' risk of malnutrition was assessed each week using the Malnutrition Universal Screening Tool (MUST). We saw that appropriate action had taken place when patients were identified as being at risk of malnutrition. We saw when patients had been prescribed nutritional supplements they were receiving these in line with their prescription.

Some patients were unable to eat or drink due to difficulties with swallowing and received their nutrition and hydration via a Percutaneous Endoscopic Gastrostomy (PEG) tube. We observed that patients were receiving the amount of fluids and nutrition that had been prescribed for their individual needs. Staff had been trained in caring for patients with a PEG tube in situ and they knew what to do if the PEG tube became dislodged.

Good

Are Learning Disability Services effective?

We saw that menus were prepared to meet the nutritional needs and preferences of patients. We also saw evidence that religious needs were catered for, for example, we saw how one location planned for and prepared halal food for patients. Information about people's dietary needs and preferences was recorded in their care records and also displayed in kitchen areas where appropriate to support staff in providing appropriate nutrition. Care records included appropriate recording of patient weights, dietary intake and hydration.

We observed patients being supported to eat and drink and we observed staff eating with patients. Patients told us they got enough to eat and drink. We saw that some patients had been out for lunch during our inspection. Snacks and drinks were available between meals if patients felt hungry or thirsty.

Patient outcomes

The care and treatment provided achieved positive outcomes for people who used the service. Patients and their representatives expressed they were happy with the services provided.

Community learning disabilities staff also told us about a patient journey project that had been undertaken between June 2013 and March 2014. The aim of the project was to explore the experience patients had when they access learning disability services. The working group were then looking at what they did well and areas where improvements could be made. The outcome of the project was to ensure that referrals were appropriately screened and that patients accessed the most appropriate care pathway. We were also told that there were plans to undertake a mapping exercise they were undertaking to measure the effectiveness of multi-disciplinary care pathways.

In addition, the trust used a system for auditing and reporting on common risk areas across the service, called Essential Care Indicators (ECIs). These were a set of measurements for assessing the quality of care plans and assessment tools used to manage fundamentals of care. The trust's Quality Account published information about targets and achieved compliance. At the locations we visited managers were able to tell us about these ECIs and show us the results for their units, along with action plans for improvement where results were below the expected rate.

Performance information

Performance information was included throughout the services we inspected and available more widely through the trust's Quality Account for 2013-2014. This included information about patient safety, safeguarding, infection prevention and control, staffing and patient experience. This information was also available to the public via the Trust's website.

Competent staff

Patients were cared for by suitably qualified, skilled and experienced staff. The trust's recruitment process included appropriate checks before staff were employed and a comprehensive induction programme. All staff we spoke with confirmed they had received a period of induction on starting employment at the Trust. Managers completed a checklist to ensure that staff were suitably trained to begin work. We also saw that bank staff were required to maintain current qualifications in order to be eligible for bank shifts. We saw evidence that 85% of staff had received mandatory training which met the Trust target for staff training.

The trust had mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff. We saw evidence that appraisal completion rates for learning disability services were 89%. Staff told us that they received annual appraisals and supervision every four to six weeks according to the Trust's policy and we saw evidence of this in records. Clinical supervision was offered to staff and one manager told us how the team participated in regular informal team clinical supervision. Staff confirmed this.

Representatives of patients using the service told us they felt the staff were knowledgeable in providing care for people with learning disabilities.

Use of equipment and facilities

Equipment and facilities were generally fit for purpose. Premises used by learning disability services were generally well designed. In some locations we saw that some equipment had been adapted to meet the needs of the patients living there. For example in two of the locations the dining table was higher than normal to accommodate wheelchairs. We saw specially adapted baths and shower facilities and bathrooms were spacious enough to accommodate wheelchairs. However in two services we

Good

Are Learning Disability Services effective?

noticed the chairs in the dining room were very heavy and had no arms on them to enable patients to easily stand. On the day of our inspection we saw that staff had taken action to ensure the patient was comfortable.

We raised concerns that the décor was too clinical for those settings which were also peoples' homes. We discussed this with managers who indicated that they had been advised to remove carpets and paint walls a neutral colour to ensure premises met infection control procedures. One patient we spoke with told us that they felt unsafe as the carpet had been replaced with wooden flooring. A representative of a person using the service told us they were concerned about the wooden floors because their relative had seizures and would often fall to their knees if they were having a seizure. They felt the floor was a hard surface and might lead to injury.

We noticed a lack of dedicated storage space was a challenge in two of the locations we visited.

Multi-disciplinary working and working with others

A multi-disciplinary team (MDT) approach was evident across learning disability services. One of the managers told us that a MDT met twice monthly to review the needs of inpatients in learning disability services. This team included staff from speech and language therapy, physiotherapy, occupational therapy, psychiatry and pharmacy teams. We saw evidence that specialist nurses visited patients at their home and one relative told us about how a diabetic nurse visited to assist with the management of the condition. Another relative told us that district nurses came out to review the patient's pressure areas. Staff told us how tissue viability nurses also visited to support care and treatment. These visits were documented in patient's care records.

Managers told us that advice from other teams was always available by telephone. We saw examples where the Trust had worked with other providers to ensure effective care and treatment. For example one manager had worked with a local hospice to ensure that a patient could remain at their home whilst receiving palliative care. The hospice had supported staff with training and advice.

Staff told us about Consultation and Referral Meetings (CARM) which took place weekly to review referrals. Staff in residential services told us that they were able to make referrals to this team and that they could also make referrals to all Trust services by telephone.

Co-ordinated integrated care pathways

We saw examples of excellent holistic integrated care pathways. These clearly detailed anticipated care needs that had been drawn up by the multidisciplinary team and were patient and family focused. We saw that patients were supported by members of the multi-disciplinary team who worked together to ensure care was integrated.

Good

Are Learning Disability Services caring?

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

Summary

Everyone spoke positively about learning disability services throughout our inspection. Patients and their families felt well supported and involved in their care and treatment. Throughout our inspection we saw that patients were encouraged to make decisions and care was person-centred.

We saw that staff conveyed compassion, kindness and respect at all times. They demonstrated a good understanding of the policies and procedures relating to their practice and were respectful of the cultural diversity of the communities they worked in. All of the staff we spoke with were passionate about their work and were proud of what they did.

Detailed findings

Compassionate care

We found the care and treatment of patients and support for their families, within all services we inspected to be compassionate. We observed that each person's culture, beliefs and values had been taken into account in the assessment, planning and delivery of care. Staff ensured that confidentiality was maintained and we found that patients, their families and staff had developed trusting relationships that were focused on ensuring the patient was at the centre of all decisions made.

We spoke with three patients and 14 representatives of people using learning disability services. People who used services and their representatives told us that, without exception, staff were caring and compassionate.

The staff we spoke with were passionate about their job and expressed how privileged they were to be able to support people with learning disabilities.

Dignity and respect

Throughout our inspection we saw patients and their families being treated with compassion, dignity and respect. We observed staff interactions with patients and their families to be positive, respectful and person-centred.

Staff took time to talk to patients and explain what they were going to do before they did it. We observed numerous examples of staff approaching patients with kindness and respect. Staff had positive relationships with patients and relatives. Our expert by experience told us that the staff they observed treated everyone with the respect and dignity which they deserved.

Patient understanding and involvement

Staff told us that they offered choices to patients, and used picture cards, facial expressions and eye contact to understand the choices of people who have difficulty communicating verbally. During our visit we saw that staff used these communication methods.

We spoke with families of people who use services and they told us that they were always consulted. We saw evidence that carers' meetings were held monthly and minutes were available from this meeting for people to read. The patients we spoke with told us they were able to make choices about various aspects of their daily life, for example what time they wanted to go to bed.

Emotional support

Staff developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Relatives told us that they could visit at a time that was convenient to them and that staff were extremely supportive.

We saw that where appropriate patients had "When I Die" documents in their records. Staff told us and we saw evidence that patients and families had been involved in the preparation of these plans. One relative told us that they had asked for guidance regarding end of life care and had been supported in a pragmatic and compassionate way.

Promotion of self-care

Care plans gave guidance for staff in supporting people to remain as independent as possible for as long as possible. Families were encouraged to be involved in care wherever possible. Within respite services we saw that patients were encouraged and enabled to be as independent as possible.

During our observations we saw that staff supported patients to maintain their independence. For example they did this by providing equipment within easy reach which supported patient's mobility or enabled them to drink unaided.

Good

Are Learning Disability Services responsive to people's needs?

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

Summary

We found that learning disability services were responsive to people's needs and that people from all communities could access services. Effective, collaborative multi-disciplinary team working ensured patients and their families were provided with care that met their needs, at the right time and without avoidable delay. Overall we found effective systems were in place to ensure people with a Learning disability, their families and those close to them received the support they needed.

Detailed findings

Service planning and delivery to meet the needs of different people

The learning disability service provided services across Birmingham, in which 23,800 (2.3 per cent of the 1.1 million population) had a learning disability.

Learning disability services within the trust had experienced a period of change. Some services had recently been decommissioned and the future of others was still undecided at the time of our visit. These commissioning decisions impacted on planning for the future within these services. The trust had a published vision for learning disability services. We saw that this vision was displayed in buildings where services were delivered. The strategy for learning disability services was less clear due to uncertainty about commissioning arrangements. Staff told us that they found it difficult to plan for the future because there was doubt about whether services would be re-commissioned. They told us that there was lots of change but "no clear trajectory". We spoke to several staff that were actively looking for alternative employment due to the uncertainty. They expressed concern about the impact of this on patients.

Care for people with learning disabilities took place in a number of different settings such as residential, respite, day services and people's own homes. There was an integrated approach to the delivery of care in all of the areas we inspected. We observed that all staff were committed to ensuring patients and their families received person-centred care.

Easy read written information was available for patients and their families and we saw that some staff had undertaken training in dementia awareness to enable them to better understand and provide care for patients who had also developed dementia.

Where people used residential, respite or day services they were involved in deciding what activities they chose to do. Activities were planned to meet the needs of different people. On the day of our visit to one service two patients were going out and we saw that there were plans to take other patients out the following day. We saw that patients in respite settings were supported to continue to access their day care services as well as activities within the home.

Female patients were offered care from a female staff member where their religion or preference required it, and adaptations had been made to premises to cater for the individual needs of patients, for instance windows had been frosted in one room to allow for extra privacy for one patient.

In respite care planning, consideration had been given to the mix of patients admitted at any one time to ensure effective care could be delivered.

There was a lot of uncertainty about the future of learning disability services and we saw that some services had already been decommissioned. The representatives we spoke with expressed that they were anxious about the future and the possibility of further closures.

Access to care as close to home as possible

We found the trust was committed to ensuring inpatient services were delivered as close to home as possible. Staff worked hard to ensure unnecessary hospital admissions were avoided. The parents of one patient with very complex health care needs told us that staff took every precaution to avoid their relative having to go into hospital.

In addition to providing residential, respite care and day care, community health services were provided across Birmingham by multi-disciplinary teams to enable people with additional complex healthcare needs to continue to live in their own home or with their family. These services

Good

Are Learning Disability Services responsive to people's needs?

included health facilitation (where patients with learning disabilities were supported by staff to access care for their health), speech and language therapy, dietetics, podiatry, psychiatry and general community nursing,

At the time of our inspection community services were being delivered from six locations, which meant that patients receiving care in the community could access clinics that were located nearest to them.

Access to the right care at the right time

Respite services for patients with a learning disability were generally accessible and responsive to needs of patients and their families. Staff told us that most stays were pre-planned a year in advance but that where an urgent need had been identified they would try to rearrange services to accommodate the need. We spoke to relatives who relied on respite services. One relative told us that they were very pleased with the availability of respite services, but were concerned regarding the uncertainly of the service, which while commissioned until March 2016 it was unclear what service would remain after that point.

A senior manager told us that since the recent closure of some in-patient services, access to inpatient beds had become difficult. They told us that this had impacted especially on urgent admissions. A relative we spoke with told us it was difficult to get an urgent bed and they were concerned as to how they would cope if the remaining beds closed. This risk had been escalated and was listed on the risk register for the Trust's learning disability services team. Another senior manager told us that staff were keeping a log of steps taken to identify placements for adults with learning disabilities in an acute episode in order to inform future plans and effectiveness.

Referrals to community learning disability services were received through a single point of access (SPA).

Staff told us that a panel met every Tuesday to triage referrals and assign patients to an appropriate care pathway. This meant that patients had a maximum wait of six days before their referral was reviewed and a care or treatment pathway agreed. Where a quicker response was required, administration staff would approach a senior member of the group who would review the referral at the earliest opportunity. We were told that hospital referrals were always classed as urgent.

Staff told us that there were no waiting lists for speech and language therapy or for dietetics for patients with a learning disability. They told us that referrals to health facilitation for support whilst patients were receiving acute care waited a maximum of two days and in some cases were seen on the same day. Waiting times for referrals to psychology, physiotherapy and occupational therapy were all approximately 12 weeks which was less than the 18 week target. We saw evidence from the trust that in September 2013, 100% of patients referred were seen within the 18 week target with 95% being seen for the year to date at the time of the inspection.

Flexible community services

Community services were flexible around the needs of people using the service. Staff told us they prioritised people according to their need and there were arrangements in place to ensure urgent needs were appropriately supported.

Staff told us there was some flexibility around urgent needs relating to respite care, but this had become more difficult as beds had been decommissioned.

Meeting the needs of individuals

As part of the care planning process, patients and their families had opportunities to discuss preferences, choices, preferred name, religious beliefs and cultural needs. The services had arrangements in place to meet diverse needs. We saw that where appropriate, family members had received support to meet the healthcare needs of their relatives.

Moving between services

Patients and their families had been involved throughout their care pathways and their wishes had been considered. A transition pack had been developed to support young people as they moved from children's to adult services. Patients had a document explaining their preferences and wishes should they be transferred to an acute hospital. A qualified nurse would always accompany the transfer of patients requiring acute care and a health care assistant could stay with the patient at the acute hospital should this be required.

Respite services had details of patient's own GP practices on their records. They also had a duty GP available on call 24 hours in case a patient should deteriorate. Where it was necessary to contact the on call GP, they had responded. Where patients had been transported to hospital staff from the service accompanied them until their relatives arrived to support them.

Good

Are Learning Disability Services responsive to people's needs?

Discharge arrangements were made by the multi-disciplinary team in conjunction with patients, their families, community health services and the local authority social services departments.

Complaints handling (for this service) and learning from feedback

The trust had received one formal complaint relating to learning disability services in the 12 months prior to our inspection. There was a policy and procedure in place for people to complain about learning disability services. Information about how to complain was on display for patients and families. Families using respite services were provided with information about the complaints, comments and compliments' procedure with their booking confirmation letter. Staff and relatives told us that this happened. Patients we spoke with told us they knew how to raise a complaint.

Staff told us that they knew what to do if someone complained and how they would assist people to make complaints if they needed to. Some families told us that they did not know how to make a complaint but they had information if they needed it from the service. One relative told us that they were provided with an information sheet about making complaints. They all said that they would be comfortable to approach managers and staff with their concerns. We spoke with two family members who said that they had mentioned minor concerns to staff and that they had been acted on immediately. We saw evidence of this on a safety noticeboard within one service. This was on the "You said – We did" section.

We saw that information about advocacy services was on display where people used services, and evidence in patient records that advocacy services had been involved where appropriate to support patients.

Good

Are Learning Disability Services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

The service was well led at a local level with effective decision making and strategic planning. There were risk management systems in place across the service and staff had a clear oversight of risks and quality throughout the service. The service engaged well with people requiring the support of learning disability services and their families. Staff felt well supported at a local level, but due to the decommissioning of services felt uncertain about the future of the services they worked in. We found that there was some confusion amongst staff about senior and middle management structures within the learning disability services. The Board and senior managers had an oversight of the reported risks associated with learning disability services and there were measures in place to manage these risks at a local level.

Detailed findings

Vision and strategy for this service

Learning disability services within the trust had experienced a period of change. Some services had recently been decommissioned and the future of others was still undecided at the time of our visit. These commissioning decisions impacted on planning for the future within these services. The trust had a published vision for learning disability services. We saw that this vision was displayed in buildings where services were delivered. The strategy for learning disability services was less clear due to uncertainty about commissioning arrangements. Staff told us that they found it difficult to plan for the future because there was doubt about whether services would be re-commissioned. They told us that there was lots of change but "no clear trajectory". We spoke to several staff who were actively looking for alternative employment due to the uncertainty. They expressed concern about the impact of this on patients.

We raised this issue with senior managers who told us how staff had been engaged in three away days 18 months previously. These days had been an opportunity to consult on service development. However, the subsequent change in commissioning arrangements and the uncertainty regarding future intentions had created a challenge for the Trust around keeping staff, patients and families informed.

Guidance, risk management and quality measurement

Staff were clear about their responsibilities to monitor patient safety and risk. They were clear about procedures to report incidents and all demonstrated caring attitudes demonstrating that patients were at the centre of the work they carried out. This included incident reporting, maintaining a risk register and undertaking audits.

There were governance arrangements across learning disability services and staff demonstrated a good awareness of governance. We saw the Trust cascaded a weekly governance newsletter for staff working in learning disability services.

The Chief Executive was well known and visible across all services. Staff told us that she was approachable and communicated regularly with them via the intranet. They told us that there was an option to contact her via email through the intranet. One staff member told us that they had done so and she had responded. Another staff member told us she had an open door policy.

We found that there was some confusion amongst staff about senior and middle management structures within the learning disability services. Although organisational structure charts were displayed in a number of the locations we visited, staff were not always clear about responsibilities or accountabilities. Some staff told us that the leadership structure was confusing and muddled. A number of interim posts at senior and middle management levels had led to further uncertainty about structures.

Leadership of this service

Learning disability services were well led at a local level. Managers told us that they held regular team meetings; both weekly and monthly, minutes confirmed this. Staff

also told us about handover meetings between shifts. We saw documents which were used to share information between staff when they were coming on and going off duty.

Some staff told us that they were well informed about what was happening within the Trust whilst others felt isolated and unsure. There was a weekly newsletter regarding transformational change, and whilst staff welcomed this it often contained the same information.

Culture within this service

The majority of staff told us that they felt able to raise concerns with their line managers and that they were listened to. They told us there was a culture of openness, honesty and transparency within local teams. Staff and local service managers demonstrated total commitment to their services and we saw that teams worked well together to provide good care and positive outcomes for patients. However some staff told us they felt that senior managers were not listening to their concerns about low morale amongst staff due to uncertainty about the future, recent redundancies and redeployed staff.

Public and staff engagement

We saw that people who use services and their relatives were encouraged to give feedback on their experiences. Residential and respite services held regular carers' meetings and we saw minutes of these meetings. A large number of families participated in these groups. The families of respite and community services patients had organised a petition which led the commissioners to extend some services for an additional 12 months.

The learning disabilities service patient engagement network held meetings for patients and their families six times per year. Staff told us that these meetings were attended by staff from the wider learning disabilities teams as well as commissioners of services and representatives of local charities. The team had recently introduced the use of iPads to survey the experience of patients. They had visited patients at home or in their day centre following discharge from community services. Patients were supported by their carer to answer questions which were mapped against the trust's values, the friends and family test and customer service excellence models. Patients had also been able to suggest questions for inclusion. We saw evidence that the results were shared with all learning disability teams and wider within the Trust. Feedback from the survey in 2013 had shown that people did not know who to talk to if they were unhappy about services. So the team developed an accessible leaflet called "Listening to You" which informed people who to talk to if they wanted to raise a concern. This leaflet was shared with staff in all teams and community staff were encouraged to take leaflets out with them to pass on to patients. A questionnaire in 2014 showed that a greater number of people had an understanding of who to contact to raise concerns as a result.

Patient engagement network staff also told us how they shared people's stories with colleagues in other teams where appropriate. They recorded information on the "Good Stuff Slate" which contained quotes from families. They told us that it enabled staff to feel part of a wider team and get feedback on their contribution to the patient's story.

Innovation, improvement and sustainability

Community learning disabilities staff told us about a patient journey project that had been undertaken between June 2013 and March 2014. The aim of the project was to explore the experience patients had when they accessed learning disability services. The working group were then reviewing existing services to identify improvements. The outcome of the project was to ensure that referrals were appropriately screened and that patients accessed the most appropriate care pathway. We were told that there were plans to undertake a mapping exercise they were undertaking to measure the effectiveness of multi-disciplinary care pathways.

There was a project called Profound and Multiple Learning disability pathways (PMLD). This developed through conversations at the team's away days. The group had undertaken work to identify the population of people who present with PMLD in Birmingham and mapped the patient's journey through learning disability services. The group had made significant progress in developing a PMLD checklist from which people with PMLD could be identified, a PMLD database was held and updated. The group had also agreed that people with PMLD would receive a lifelong service and had developed a baseline assessment tool to be used when a patient entered the service and a service model which included care co-ordination and regular reviews. At the time of our visit this pathway was at the point of implementation.