Right support, right care, right culture

How CQC regulates providers supporting autistic people and people with a learning disability

October 2020

Contents

Registering the right support was published following consultation in 2017. From time to time we revise the guidance we issue. This guidance has been revised and retitled and continues to be statutory guidance in accordance with s.23 of the Health and Social Care Act 2008.

Our policy on regulating providers that support autistic people and people with a learning disability remains unchanged from *Registering the right support*, but, having sought feedback, we have aimed to clarify to providers how we implement the policy in this update.

Introduction

Right support:
- Model of care and setting maximises people's[i] choice, control and independence

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

Right culture:
- Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

Autistic people and people with a learning disability are as entitled to live an ordinary life as any other citizen. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.

We are the quality and safety regulator of health and social care services in England. Under section 3 of the Health and Social Care Act 2008 our objective is to protect and promote the health, safety and welfare of people who use health and social care services. We encourage providers to develop services for people that comply with national policy and current best practice:[ii]

- Service model
- Building the right support
- Building the right home
- Learning disabilities and behaviour that challenges: service design and delivery NG93

We expect all providers, existing and future, to understand our regulatory approach. They must be aware of how we embed human rights in this and the requirements this places on them.

[i] In this guidance, 'people' means autistic people and those with a learning disability. 'Services' means the provision of care and support to meet people's individual needs within the scope of regulated activities. These activities are delivered by providers that are registered with CQC typically, but not exclusively, in the settings described in our service type guidance.

[ii] The National Service Model, *Building the right support*, Building the right home and other key national policy and good practice guidance (see Background section for further information)

Our position on the size of residential services

People who use services have told us they want a stronger focus on outcomes for people. We have listened to this feedback and it has been the driving force behind the changes we have made to this guidance. Our main concern is the quality of life people are able to experience and the care they receive, and this will continue to be case.

This guidance has always been set alongside other standards in the system and we continue to maintain that link. This includes NICE guidance (CG142) on the definition of 'small' services for autistic people with mental health conditions and/or behaviour that challenges. This states that residential care "should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation)". Our review into restraint, prolonged seclusion and segregation for people with a mental health problem, learning disability or autistic people supports this and, for people currently in the hospital system, this is likely to require commissioners and providers to develop bespoke services.

For people with a learning disability and behaviour that may challenge, NICE guidance (NG93) recommends people should have the option to "live alone with appropriate support if they prefer this and it is suitable for them. If adults prefer not to live alone with support, or it is not suitable for them, offer them the option of living with a small number of other people in shared housing that has a small-scale domestic feel. Involve people in choosing how many people, and who, they live with."

While we continue to refer to NICE guidance in describing what 'small' means for how we apply our approach, we want to be clear that this is not the same as having an absolute upper limit for the size of services. CQC has never applied a six-bed limit in its registration or inspection assessments.

We have previously refused to register services that are smaller than six beds because they could not assure us that they could deliver person-centred care in line with current best practice. We have also registered services with more than six beds because they have been able to demonstrate how care will be high quality and person-centred.

We will continue to consider the size and design of residential settings as part our assessments, alongside other considerations.

We will only register, and favourably rate, services that allow people's dignity and privacy to be maintained and that facilitate person-centred care. This must be in line with current best practice guidance and not be developed as new campus or congregate settings.

In our experience of registering and inspecting these types of service, the larger a service is, the harder the provider will need to work to clearly demonstrate it delivers high-quality, person-centred care. This guidance sets out in detail what that person-centred care needs to look like. It is unlikely that services that are not similar to ordinary residential accommodation will be registered.

Purpose of this guidance

This guidance is statutory guidance in accordance with s.23 of the Health and Social Care Act 2008.

This guidance:

- applies to any service that currently, or intends to, provide regulated care to autistic people and people with a learning disability. This includes children and young adults, working age adults and older people
- describes our regulatory approach for these services, covering our registration, inspection, monitor and enforcement functions
- makes our expectations clear to future and existing providers.

We will use this guidance in our assessments and judgements to promote consistency. However, we will base each assessment and judgement on the evidence presented in that case.

We will always take appropriate regulatory action if:

- people's needs are not being met, or
- providers cannot demonstrate they can care for people in a way that is person-centred, and promotes choice, inclusion, control and independence.

We encourage providers to discuss their proposals or development ideas with us before submitting an application or making changes to services. This can help providers make an informed decision about whether plans are likely to comply with this guidance.

How can providers demonstrate they are meeting the requirements?

Key aspects of what we will look for

Providers of **new** services must demonstrate, and providers of **existing** services are expected to demonstrate, how they will meet:

- our characteristics of ratings for good in healthcare and adult social care
- the regulations (including fundamental standards)
- people's expectations, as set out in the service model
- the requirements in this guidance to demonstrate that:
  1. There is a clear need for the service and it has been agreed by commissioners
  2. The size, setting and design of the service meet people's expectations and align with current best practice
  3. People have access to the community
  4. The model of care, policies and procedures are in line with current best practice

People's expectations (service model)

Human rights and people's needs and preferences are at the heart of our registration decisions and inspection judgements. When developing and delivering care, providers must show us that they comply with regulations, apply national policy and nationally recognised, evidence-based guidance and must demonstrate that their services meet the needs of autistic people and people with a learning disability.

People expect providers to comply with Building the right support and the accompanying service model when designing or running a service.

This means that people expect the following:

- "I have a good and meaningful everyday life"
- "My care and support is person-centred, planned, proactive and coordinated"
- "I have choice and control over how my health and care needs are met"
- "My family, and paid support and care staff get the help they need to support me to live in the community"
- "I have a choice about where I live and who I live with"
- "I get good care and support from mainstream health services"
- "I can access specialist health and social care support in the community"
- "If I need it, I get support to stay out of trouble"

- "If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to."

[Source: Service model for commissioners of health and social care services Oct 2015]

We expect providers to show how their service meets the needs of people in line with current best practice. If they do not follow best practice in any way, they must provide compelling evidence that demonstrates how their alternative approach will deliver appropriate and person-centred care. We support genuine innovation where providers can demonstrate that their model aligns with the service model and positive outcomes can be achieved.

1. There is a clear need for the service and it has been agreed by commissioners

"I have a good and meaningful everyday life"

"My care and support is person-centred, planned, proactive and coordinated"

- ✓ The service has been requested by, or has been agreed with, local commissioning partnerships. We need written correspondence to prove this.
- ✓ It is supported by the Market Position Statement.
- ✓ It is underpinned by:
  - Joint Strategic Needs Statements and Joint Health & Wellbeing Strategies
  - Sustainable Transformation Partnership
  - Integrated Care Systems plans.
- ✓ Commissioners, people who use services and their advocates have been, and are, involved in the development of the service.
- ✓ The service is for local people to meet a local need and is not intended to admit people outside of the local area.
- ✓ **Services people pay for:** the provider should give evidence to identify there is a local need.
- ✓ **Hospitals only:** new or extra provision is to provide inpatient care for people in the local area. It is not intended to admit people outside of the local area.
- ✓ **Hospitals only, regional provision:** NHS England must have requested these hospital services, and written confirmation must be provided as evidence of this.

2. The size, setting and design of the service meet people's expectations and align with current best practice

"I have a choice about where I live and who I live with"

- ✓ People who use services, and their families and representatives, are involved in the design of the service. Providers should explain how they have taken account of their preferences.
- ✓ The service design conforms with current best practice, including:
  - NICE guidance NG93: Learning disabilities and behaviour that challenges: service design and delivery
  - NICE guideline NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
  - NICE Clinical Guideline CG142: Autism spectrum disorder in adults: diagnosis and management
  - Supplementary information for commissioners October 2015
  - Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014
- ✓ The service is in the local community or has good access to the local community and its amenities. It is not in secluded grounds or geographically isolated.
- ✓ The service uses co-production to develop services, by involving people in its design and planning.
- ✓ The size, scale (number of beds) and design of the premises:
  - do not compromise the quality of care, people's safety or their human rights
  - allow people's dignity and privacy to be maintained
  - facilitate person-centred care
  - are in line with current best practice guidance
  - are not developed as a new campus or congregate[iii] setting.
- ✓ Within the premises, the environment:
  - will not feel impersonal and intimidating
  - will not feel institutional
  - maintains people's dignity and privacy
  - meets people's sensory needs and preferences.
- ✓ The service operates so people:
  - can choose whether to use communal areas
  - have privacy for themselves and with visitors.
- ✓ In shared homes, people have a say in who shares their accommodation.

[iii] Campuses are group homes clustered together on the same site and usually sharing 24-hour staff and some facilities. Congregate settings are separate from communities and without access to the options, choices, dignity and independence that most people take for granted in their lives.

3. People have access to the community

"I can access specialist health and social care support in the community"

"I have choice and control over how my health and care needs are met"

"My family and paid support and care staff get the help they need to support me to live in the community"

- ✓ Services are located so people can participate in their own local community. If people move to be close to their family, they can participate in the community their family belongs to.
- ✓ People are registered with local health services and have access to the full range of community health services.
- ✓ If a service provides in-house activities and services, people can still take part in the same services or activities in their chosen community.
- ✓ **Hospitals only:** there are effective systems to support people to increase their independence and transition to be part of the community.

4. The model of care, policies and procedures are in line with current best practice

"If I need it, I get support to stay out of trouble"

"I get good care and support from mainstream health services"

"If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality, and I don't stay there longer than I need to"

- ✓ Policies and the approach to care and treatment to support people's behavioural needs are not:
  - reactive or,
  - reliant on restrictive practices or seclusion.
- ✓ Providers understand the inherent risk associated with closed cultures. They have put measures in place to ensure these cannot develop.
- ✓ The care model focuses on people's strengths and promoting what they **can** do.
- ✓ There is an integrated approach to support with clear networks across health and social care.
- ✓ The service shows how the Positive Behaviour Support values base informs their practice.
  - ✓ **Supported Living only:** arrangements meet the REACH Standards and the REAL tenancy test.

- ✓ **Supported Living only:** arrangements align with our Housing with Care guidance.

Shared lives schemes

We expect schemes, shared lives workers and carers to ensure that people using services experience current best practice that maximises people's rights to take control of their own lives within and outside of the home safely.

This means:

- people can manage their own needs and affairs as much as possible
- people are able to engage with and have meaningful relationships in the wider community
- they can exercise their democratic rights as citizens in accordance with the principles and values of this guidance.

Specialist colleges

We expect:

- colleges to ensure that the care and accommodation provided to young adults enables them to have maximum choice and control over their lives
- staff to support them to do this in the least restrictive way possible
- the care they receive should help them to thrive in a learning environment among their peers, and to reach their full potential
- their care should not be compromised by a residential environment or institutional practices that do not accord with the principles and values of this guidance.

Appendix A: Case studies

These case studies illustrate *Right support, right care, right culture* in action throughout our regulatory functions. Many are based on actual applications and services, and our judgements made about them.

Contents

- Safeguarding notifications and information from public about NHS mental health trust – rated requires improvement

Inspection

- Inspection of an independent hospital – issued an urgent Notice of Decision
- Inspection of an NHS trust inpatient ward – rated outstanding
- Inspection of an NHS trust inpatient ward – rated requires improvement
- Inspection of an independent hospital – rated good

ADULT SOCIAL CARE

Registration: Care homes

New care home – application granted

The service
Two semi-detached properties, each for 2 people. A care home to support autistic people and people with a learning disability and associated complex needs. The houses were on a residential street with easy access to local amenities.

How we judged the application
We found that the service has been developed and designed in line with the values that underpin *Right support, right care, right culture*.

This proposal was:
- person centred
- commissioned by local commissioners
- developed specifically for people from the local area who wished to return there
- a model of care consistent with current best practice:
    - a focus on ensuring people's human rights were assured
    - a no restraint policy to protect people from potential harm
    - staff would use nationally recommended de-escalation techniques
    - a positive behaviour support lead in each service.

The provider could show they had:
- sought the views of the people using the service
- met neighbouring clinical commissioning groups and local authorities
- developed the service in line with the market position statement
- aligned the model of care with current best practice.

We granted registration.

Increase the size of a care home – application refused / appeal dismissed

The service
A small residential care home for 6 people. It supports autistic people and people with a learning disability and associated complex needs. In 2017 we rated the service as good.

The provider applied to increase the maximum number of places from 6 to 8. One of these would be in a self-contained building, converted from a double garage and workshop in the care home garden.

How we judged the application
We found the application did not fully reflect the principles and values of *Right support, right care, right culture.* The proposal:

- was not person-centred
- did not consider whole life service provision
- did not promote choice and control
- did not provide a model of care consistent with current best practice.

We refused the application to increase the size of the service:
- The bungalow:
    - was not suitable to meet the needs of a person with complex care needs
    - would not enable a person to live independently
- The provider had failed to:
    - consult with existing people and their representatives on the proposed changes
    - assess the impact those changes might have on the existing people who use the service.

The outcome at tribunal
The provider appealed against our decision and took the matter to the first-tier Care Standards tribunal. The tribunal concluded that:
- the provider had not:
    - given us adequate evidence they had carried out a consultation with people already using the service
    - considered the risk of a negative impact on existing people using the service arising from additional people (and staff) in their home
    - devised a plan to show how the risks associated with increasing the maximum number of places would be mitigated and managed
- the current good rating had little relevance to the application. This rating was based on the conditions when we inspected. They could not be used to justify significant changes that might alter those conditions
- there was an 'unacceptable risk' that the provider would fail to provide adequate care in future if registration was granted.

The appeal was dismissed.

Increase the size of a care home – application refused / appeal dismissed

The service
A residential care home for seven people in a geographically isolated location. It supports autistic people and people with a learning disability and associated complex needs. In 2018 we rated the service as good.

The provider applied to increase the maximum number of places from seven to 10. The service is on a site with two other CQC registered services, a children's home registered by Ofsted and a day centre. Up to 26 people were accommodated across these services.

How we judged the application
We found the application did not fully reflect the principles and values of *Right support, right care, right culture.* The proposal:
- did not promote choice, control and independence

- did not provide a model of care consistent with current best practice
- did not take into account all service specific national recognised guidance
- had the characteristics of a congregate setting as:
    - it was a geographically isolated location which presented clear barriers to person-centred care / dignity and respect for people
    - it did not provide good access to local amenities and services.

The provider had not:
- sought the views of the people using the service
- consulted with local commissioning partnerships.

We refused the application to increase its size because the provider had failed to:
- comply with CQC statutory guidance
- consult with people who lived at the service and their representatives on the proposed changes
- assess the impact those changes might have on people
- demonstrate that the service would provide person-centred care.

The outcome at tribunal
The provider appealed against our decision and took the matter to the first-tier tribunal. The tribunal concluded that:
- the provider had not:
    - given us adequate evidence they had carried out a consultation with people already using the service
    - considered the risk of a negative impact on existing people using the service arising from additional people (and staff) in their home
    - devised a plan to show how the risks associated with increasing the maximum number of places would be mitigated and managed
- there was an 'unacceptable risk' that the provider would fail to provide adequate care in future if registration was granted.

The appeal was dismissed.

Add a new location (care home) – application granted

The service
A care home for 16 people, comprising four bungalows in a quiet cul-de-sac. This is off a residential street in the centre of a busy town with good access to all amenities and transport links. The service had been rated as good in 2016 and 2018.

A new provider purchased the care home, so this was a transfer of business ownership. The new provider was registered for accommodation and personal care for two other care homes. There were 13 people living at the home.

How we judged the application
We found parts of the application did not align with current best practice, specifically in relation to the physical environment.

The environment had attributes of a campus, with:
- four group homes clustered together on one site

- shared staff
- staff available 24 hours a day.

Yet, we granted the application because the provider:
- planned to maintain the same positive model of care and staffing arrangements
- had consulted with people and their representatives and could demonstrate that they would:
  - continue to be supported to have control, independence and choice in their care and support
  - be involved in the ongoing recruitment of staff
  - be consulted and engaged in choosing who shared their accommodation
- had assessed the impact the changes might have on people
- demonstrated that the service would continue to provide person-centred care
- had engaged with local commissioners who were positive about the change in ownership
- had a history of providing a responsive service to people in their other care home locations.

Add a new location (care home) – application granted

The service
A new 8-bed residential care home location, offering a short break service for adults with a learning disability and/or autistic people.

How we judged the application
We found that the service has been developed and designed in line with the values that underpin *Right support, right care, right culture*.

The proposal was:
- person-centred
- commissioned by local commissioners
- developed specifically for local people who needed a period of respite
- a model of care that was consistent with current best practice.

The provider had evidence that they had:
- sought the views of the people using the service
- aligned the model of care with current best practice.

We granted registration.

New supported living service – application refused

The service
The application was to provide personal care to 21 people in a bedsit apartment block. The service was geographically isolated, with limited access to local amenities and services. There were no public transport links and it was a 30-minute walk to the nearest train station.

What we found
People did not have choice in who provided their care and support. This is one of the fundamentals of the REAL Tenancy test, a nationally recognised best practice tool. We found that:

- although people would have individual contracts for accommodation and personal care, they:
    - could not choose their own care provider
    - would have to find alternative accommodation if they wanted to change providers
    - did not have unrestricted access to their own homes
    - needed the provider's permission to personalise their rooms
- the proposed service model was more like a residential care home than a supported living service:
    - it had one communal lounge, a large dining room and one large industrial kitchen which people living in the self-contained bedsits could not use
    - people could not cook independently if they wanted
- it had not been developed in partnership with local commissioners
- the provider said they would take referrals from anywhere in the country.

How we judged the application
We refused the application because the provider would not be delivering the regulated activity they had applied for.

We were concerned:

- that the provider had not consulted with local commissioners
- about the ability of the provider to provide truly person-centred care in a setting which did not align with current best practice guidance
- that the service was geographically separate with poor access to transport and the wider community which meant people would not have choice and control over how they accessed their local community
- they proposed to accept referrals nationwide. This would be difficult for:
    - people to retain links with family, friends and familiar places
    - commissioners to oversee the quality and continued suitability of the service.

We passed our concerns about this proposal to the local authority through the local Transforming Care Partnership.

Change service from residential care to supported living – application granted

The service

A large five bedroomed house used as a care home on a residential street in a small rural village. There are currently two people living in the house.

The provider applied to register for the activity of 'personal care' to be provided to people in these premises. It plans to run a supported living service from this address. They had remodelled the premises to enable independent living.

What we found

The service had been developed in line with the underpinning values of *Right support, right care, right culture* because:

- people had accessible copies of the tenancy. In one case, a relative appointed by the Court of Protection to be a person's deputy would sign the tenancy
- the organisations providing the personal care and the housing were linked but managed separately and covered under separate agreements with the people living at the house
- it involved people:
  - the provider had known and worked with the current people, and people who planned to move in, for a long time
  - they had redesigned the service in consultation with people and their families. This included creating a small multi faith room so that people at the service had an appropriate space to participate in their chosen faith
  - had clearly explored people's cultural support needs and ensured that staff were fully aware of how to support people in a culturally sensitive way. This included supporting people to maintain their faith practices.
- it promoted choice:
  - people told us that they were aware that they could choose who provided their care, but they were very happy with their existing provider
  - one person needed overnight support and chose a different provider for this. One bedroom would be a sleepover and guest room
  - people living at the service were involved in choosing who they lived with. They had chosen all the décor during the remodelling of the environment.
  - the building was redesigned so each room had an en-suite bathroom
  - the kitchen was remodelled to make it more accessible with cabinets and cooking facilities at an appropriate height to ensure they were, each person had their own cupboard space for food and they were supported to cook meals when they chose to.

How we judged this application

We granted registration.

Monitor: Care homes

Change statement of purpose (care home) to provide services to people with a learning disability – rated the 'effective' key question as requires improvement and notified commissioners

The service
A care home registered to provide care for 46 people. At registration the provider advised that it would deliver care to older people, people with dementia and people with physical disabilities. The provider was last inspected 18 months ago and were rated good for all key questions.

The provider submitted a revised statement of purpose. This showed that they intended to provide services for people with a learning disability.

This change to service user band does not require a registration application as they are not conditions of registration. But the provider must submit a revised statement of purpose to notify us of this change.

What we found
The provider told us that commissioners had asked them to ringfence four places for people with a learning disability. They were already providing care to two people with a learning disability and planned to admit two more. They were unable to tell us how they met the needs of people in line with statutory guidance. This prompted us to inspect the service.

Our inspection
We found that their existing service model was designed to meet the needs of older people with dementia. It was not suitable for working age adults with a learning disability:

- care and support did not always reflect current evidence-based guidance, standards and best practice to meet the needs of people with a learning disability
- staff had not been trained to meet the needs of people with a learning disability and had limited knowledge about this
- people were not supported to follow their interests and take part in activities in their local community
- people could not access education and work opportunities
- training and development plans were not designed around people's learning, care and support needs.

Outcome of inspection

- We rated the service as requires improvement for the 'effective' key question.
- We notified the commissioners that the service did not meet the requirements of the service model.

Change statement of purpose (care home) to reflect no plans to deliver care to people with a learning disability – change requested

The service
A care home registered to provide care for 15 people. While planning the inspection we noted that the statement of purpose showed the service delivered care to people with dementia, people with a learning disability and autistic people.

What we found
We reviewed a range of information available to us, including previous reports, application information and the provider's website. We contacted the provider to clarify whether they did provide services for people with a learning disability. The provider told us that they did not provide, and had no plans to deliver, care to people with a learning disability.

Outcome
We asked the provider to update their statement of purpose to show the correct service user bands. The provider had to submit a revised statement of purpose to notify us of any changes to the services provided, including the service types and service user bands. They had to do this within 28 days of making any changes.

Monitor: Community services

Increase the size of a supported living service – enforcement action

The service
A supported living service had doubled in size in the last 12 months. This came to light through relationship management meetings with local authority commissioners.

The service was last inspected two years ago and rated good. Since then, there had been two changes of registered manager.

The provider had taken on a service, rated as requires improvement, from a neighbouring local authority.

What we found
We carried out a targeted inspection of the key questions 'caring' and 'well-led'. We found the service was not developed to fully reflect the principles and values of *Right support, right care, right culture*. This was because:

- the registered manager was new in post and lacked experience of service development at this scale
- the provider failed to seek the views of the existing people using the service
- the provider did not assess the impact of absorbing an underperforming service on the quality of care of the existing network
- plans to manage providing care over two local authorities were limited and no systems had been set up to do so
- the service was no longer promoting independence, choice and control to all people

- the model of care was inconsistent. Best practice was adopted in some premises but most were not providing good care.

Outcome of inspection
We rated the service as requires improvement. We also took enforcement action requiring the provider to set up an action plan to improve:

- management capacity to oversee the increased size and geographical spread of the service
- the quality of care through staff training, supervision and recruitment.

Adding a supported living service to a domiciliary care agency – rated good

The service
A small domiciliary care agency (DCA) delivering personal care to older people with dementia and sensory impairment. At last inspection we rated them as outstanding.

The agency submitted an annual provider information return (PIR), completing both the DCA and supported living service (SLS) sections. They had never made an entry stating they were providing a SLS before.

Adding a new service type and service user band led us to carry out an inspection. We wanted to ensure that the provider was able to meet the needs of this new group of people.

What we found
Commissioners had asked the provider to set up a bespoke team to take over the SLS. The commissioner expressed their confidence in the provider who had experience of developing specialist services.

The SLS was for older adults with a learning disability. One tenant was experiencing the onset of dementia. Discussions had taken place at an early stage with the people already using the service. The provider had involved people in the recruitment and training of the new staff team.

The provider had developed the new service with reference to NICE guidelines, including the quality standard resource Learning disability: care and support of people growing older (QS187).

Outcome of the inspection
We rated the service as good.

The principles and values of *Right support, right care, right culture* were evident in the planning and development of the new service. We were also assured that the new service would not impact on the quality of care already delivered by the DCA. We were confident that the provider was able to sustain good quality care in both services.

Complaint about choice of personal care provider in a supported living service – submitted a proposal for cancellation of registration

The service
The provider delivered personal care to seven people in a shared house. The house was in a residential street with easy access to local amenities. People living at the service had separate tenancy and care agreements.

We received a complaint from the representative of a person living at the service. They had asked to change the company who provided their personal care and had been told that they would have to find alternative accommodation.

Our action
We contacted the complainant and the local authority commissioners.

We completed a comprehensive inspection at the service. We found that people living at the service were not supported to live an independent life. For example:

- people could not choose who provided their personal care
- staff cooked and shopped for all meals and people could not choose their own meals or mealtimes
- people's medication was locked in a medicine cupboard in the kitchen and only staff had access to this
- staff had their office in a spare room in the house and people had not given permission for this
- people were not allowed to personalise their own rooms.

We were concerned the provider was not aware of how to meet the needs of autistic people and people with a learning disability. Staff were not trained to support them, nor were they recruited safely.

The premises were owned by the provider and were not fit for purpose.

They were not meeting the requirements of a supported living service in line with *Right support, right care, right culture*.

The outcome
The service was rated as inadequate.

We were concerned the provider would not improve because:

- there was a lack of leadership insight
- the provider had insufficient resources to improve the premises and the model of care
- the provider's action plan was unrealistic.

Despite the opportunity to improve and local authority support, after three months there was no material change to outcomes for people.

We submitted a proposal for cancellation of registration.

Inspection of a large care home – rated good

The service
A residential care home that includes nursing care. Up to 22 people can live in one adapted building and an adjoining bungalow. When we inspected, 11 people were living at the house and two in the bungalow.

What we found
The home is bigger than most domestic style properties. Yet the size did not have a negative impact on people. We believed that this was because the home was under occupied and people living there did not have complex support needs. We expressed concern that any increase in the number of people living at the home may impact on the provider's ability to continue to provide personalised care.

The environment
Externally:
- the building design fitted into the local residential area
- there was nothing outside to show it was a care home (no signs, intercom, cameras, industrial bins)
- staff were discouraged from wearing anything that suggested they were care staff when outside.

Internally:
The home was very spacious and made best use of larger communal areas.

We noticed some things that needed improvement:
- some features suggested it was a care home:
  - signs referring to service users and staff information
  - a staff notice board was in the entrance hallway

The provider addressed these in consultation with people after our first day of inspection.
- one person was living temporarily in an area that was no longer fit for purpose. It needed maintenance work.

The provider promptly responded to our concerns.

Running the service
People received personalised support and staff knew people very well. They had positive behaviour support plans in place, although these were not always person-centred.

People had three different care plans each:
- not all information was up-to-date or clear
- some information was person-centred but this wasn't consistent
- not all areas were included that were appropriate for some people, for example, end of life care

- they needed more detail to include guidance from other healthcare professionals.

How we judged the service
The outcomes for people did not fully reflect the principles and values of *Right support, right care, right culture*:
- people's care plans were too large and not completed to make sure they were all person-centred
- one person's living space was no longer fit for purpose
- some areas of the home still had hospital-like features.

Yet we rated the service overall as good because:
- care provided was person-centred, despite care plan shortfalls. We gave recommendations for improvement
- the service was larger than most domestic homes, yet it promoted choice, independence and inclusion
- the provider addressed identified shortfalls
- two people at the service were from out of the local area due to the risks associated with remaining in their own home area. However, the provider ensured that both people maintained regular contact with their family members who were important to them
- we were confident the leadership would improve the accommodation to make it feel more like people's home
- the provider had worked with commissioners and had made the decision to vary their registration to reduce the number of people living at the service.

Inspection of a care home – rated inadequate

The service
A residential care home comprising two, five-bedroom properties on a quiet residential street. Located in a large town with access to local amenities.

What we found

<u>The environment</u>
Externally:
- the building design fitted into the local residential area
- there was nothing outside to show it was a care home.

Internally:
- the home was designed to enable people to socialise in communal spaces, but also have time alone, or see visitors in private
- the kitchen was accessible to all people living at the home
- people had been supported to personalise their own rooms.

Running the service
People's human rights were not upheld.

Staff did not follow or act in accordance with the Mental Capacity Act (MCA):

- people's consent was not always sought
- they used unlawful restraint, seclusion and segregation practices
- the registered manager failed to notify CQC that authorisations of deprivations were in place as required by our regulations.

People's needs were not always re-assessed or reviewed when their needs changed:

- staff did not always have or display the skills and knowledge to meet people's needs
- people were not supported to maintain a balanced diet
- systems for monitoring and learning from accidents and incidents were inadequate:
    - they were inconsistently and inappropriately recorded
    - there were no monitoring or analysis tools in place to manage, monitor or learn from them
- policies and procedures for safeguarding adults and children were not up-to-date or robust.

How we judged the service

The provider had failed to meet the fundamental standards. Outcomes for people did not reflect the principles and values of *Right support, right care, right culture*:

- people were not protected from avoidable harm
- people were not encouraged or supported to become independent, or have choice and control over their support
- people did not receive planned and coordinated person-centred support that was appropriate and inclusive for them
- people's legal rights were not protected.

We rated the service as inadequate.

Inspection of a care home – rated outstanding

The service

A residential care home registered to deliver care and accommodation to 10 people. Situated in a residential street in a small rural village.

What we found

The environment

Externally

- although larger than most domestic properties, the building was a similar size to other properties on the street
- there was a large sensory garden, which people in the house could access.

Internally

- the kitchen was accessible to everyone
- people had personalised their own rooms.

Running the service

The provider had developed the service in line with the key principles of choice, independence and inclusion. The service was exceptionally person-centred, demonstrated in how staff:

- knew every person they cared for in-depth, what was important to them and the best way to provide care to them
- worked in a way that put the needs of people first
- protected people from social isolation
- were extremely responsive to people's needs, for example each person had an accessible health action plan which was reviewed regularly
- supported people to have maximum choice and control of their lives
- ensured that all medicines were prescribed in line with the provider's STOMP (*STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines*) pledge and psychotropic medicines policy.

The service had:

- innovative and creative methods to support people to communicate and to provide steps for them to follow to increase self-confidence and promote independence
- clear evidence of how they encouraged people's independence and reduced social isolation.

How we judged the service
The outcomes for people reflected the principles and values of *Right support, right care, right culture*:

- people received personalised support and were enabled and supported by staff to be independent
- the service had a positive staff culture that was person-centred and inclusive
- people's legal rights were protected
- the service had a strong emphasis on continuous improvement and research was carried out into current best practice.

We rated the service as outstanding.

Inspection of a care home – rated requires improvement

The service
A residential care home registered to deliver Accommodation and personal care to two autistic people who have learning disabilities. Situated in a residential street in a large town with good access to local amenities.

What we found

The environment
Externally:

- the building design fitted into the local residential area
- there was nothing outside to show it was a care home.

Internally:

- the communal areas of the home were spacious and personalised to the people who lived there – we saw photos of people's family and friends displayed
- the home had ample space for people, and staff respected when people wanted to have time alone.

Running the service
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests:
- people were encouraged to maintain their independence
- relatives felt their loved ones were treated with kindness
- staff understood safeguarding and how to keep people safe
- information was provided to people in different formats relevant to their communication preferences
- people were supported to maintain relationships.

However:
There was no registered manager in post; the deputy manager was overseeing the day-to-day running of the home.

People were not always sufficiently protected from the risk of harm:
- care plans did not always give enough information to support people safely
- there were serious discrepancies in recording medical information in people's hospital passports which, if followed, could result in harm
- there was no written plan for staff to follow to identify what the risks may be to people and how they could manage them in the event of an emergency evacuation of the premises
- there was a clear rationale for when restrictive interventions were used, which was reviewed and recorded in the person's records. However, training provided did not accord with current practice by a certified trainer and did not sufficiently take into account people's needs on the autistic spectrum when applied.

Medicines were not always dispensed in line with best practice guidance:
- staff were secondary dispensing medicines for people who were leaving the service for a short time. The medicines were not labelled with administration instructions, and this could lead to errors in administration
- checks were not fully effective and failed to ensure prescribed medicines had not expired.

How we judged the service
We identified breaches in relation to failure to meet a condition of registration and good governance at this inspection. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed, and restrictive practices did not fully take account of person-centred needs.

We rated the service overall as requires improvement.

Inspection: Community services

Inspection of a supported living service – rated good

The service
A small supported living service in a village, providing personal care to four people with a learning disability in their own homes.

What we found
During the site visit we found:

- the provider, registered manager and long-standing team of support staff created an exceptionally caring service in real partnership with the people using it
- that people told us that they were very happy with the care they received
- people were supported with personal relationships, staff were confident about having conversations with people about their sexuality needs.
- the service promoted good health and wellbeing outcomes for people, including supporting people to have an annual health check with their local GP
- the care and support from staff had made significant improvements to people's quality of life
- staff were very respectful and aware they were supporting people living in their own home
- new practices were adopted in accordance with current best practice to further develop people's quality of life through greater independence and activities.

Outcome of inspection
We rated this service as good overall but awarded a rating of outstanding for caring.

Things that made this service exceptional:

- a strong caring culture led by the provider, that truly put people first
- the service was led by the people using it. Staff were available in the background if people needed support, but this was guided by people and at their request
- staff had supported people to develop, but the real sense of people living together in their own house, owning and leading the service was evident in the way people supported each other
- people helped each other to express their thoughts, knowing and respecting each other's individual communication styles
- staff had a comprehensive understanding of, and supported, people's cultural and diverse needs
- people told us about the fantastic health and wellbeing goals they had achieved. They had planned and owned ways to achieve these and sought support when they wanted it
- there was a strong focus on continuously developing people's ownership of meaningful activities, independence and quality of life. This was an essential part of monitoring the service quality.

Inspection of a specialist supported living service – rated outstanding

The service

A supported living service that specialises in supporting adults with a range of complex needs and behaviours associated with Prader-Willi Syndrome (PWS) and learning disabilities. PWS is a genetic condition that means people with the condition will have an insatiable desire for food, which can make the person eat excessively resulting in obesity and other health conditions. This service supports three people in a house.

What we found

The environment

Externally:

- it was a four-bedroom semi-detached house in a residential area
- there were no outward signs to differentiate it from other houses in the street
- local shops and amenities were a 10-minute walk from the house. This meant there were shops in the community, but food shops were not close by.

Internally:

- the home was designed to enable people to socialise in communal spaces, but also have time alone, or see visitors in private
- the kitchen was accessible to everyone, but all food cupboards were locked and people understood the reasons for this
- people had been supported to personalise their own rooms and communal areas
- the fourth bedroom provided sleep-in facilities for one carer.

Running the service

People's human rights were upheld. Staff acted in accordance with the MCA:

- people's consent was sought for most aspects of daily life
- people's finances were overseen by the Court of Protection and restrictions to food were managed in their best interests
- support systems and one-to-one staffing levels meant they could quickly respond to crisis situations and least restrictive practices were used to avoid the need to use restraint
- the registered manager notified CQC that authorisations were in place as required by law.

People's care was delivered in a person-centred way:

- people received a structured lifestyle based on their choice and preferences, which helped them to cope more easily with PWS
- staff displayed the skills and knowledge of PWS to meet people's needs and promote their independence and interests
- people were supported to manage their weight and food choices. They had seen huge benefits to their health and wellbeing. They were educated about food choices, activity levels and how to control food cravings in social settings and when alone

- the tenants were well-matched socially so were compatible and formed good personal relationships with each other
- the staff and manager have been trained in PWS. The provider ensured they solely worked at the scheme to keep relationships and care consistent
- accidents and incidents were consistently and appropriately recorded, particularly around issues of access to food, and people told us they understood the reasons why food was restricted.

How we judged the service
We rated this service as outstanding for the caring, responsive and well-led key questions. The staff and management team were creative, committed and determined to supporting people to live independent lives and challenge the barriers people faced living with PWS. People were supported to lead meaningful lives that helped them to focus on their interests, employment and relationships and less on their condition.

Inspection of a supported living service – rated inadequate

The service
A large suburban detached house was converted into two semi-detached properties. Each provided support for five people to live in the community.

People had spent a significant part of their lives in long stay hospitals and have complex needs. In December 2016 the service had been rated as good overall.

What we found

The environment
Externally:
- the homes were adapted housing located in a local residential area
- tall fencing and locked gates were not in keeping with other properties on the street
- the concentration of staff cars around the property drew complaints from local residents.

Internally:
- there were four autistic people living in the homes but no evidence of autism-friendly layout and décor (such as appropriate lighting or quiet spaces)
- rooms had some personalisation, but all bedroom furniture was standardised
- bedroom doors were ‘stable’ type, used to seclude people in their rooms when behaviours challenged the service
- adaptations appeared to restrict access rather than promote independence:
    - locks were on the kitchens; people were not allowed to enter without permission
    - bathrooms had locks at the top of the doors which could only be opened by staff.

Running the service
People’s human rights were not upheld:

- staff did not follow or act in accordance with the MCA and code of practice. The provider had not applied for relevant authority to restrict people's liberty
- the registered manager failed to notify CQC when people's liberty had been restricted and authorised as required by law
- we found unlawful restraint, seclusion and segregation practices being used.

Model of care:
- people were not treated as individuals and care was not provided in a person-centred way – for example, everybody ate the same meal at set times
- people were isolated from the community and had limited contact with family and friends, with rigid visiting hours
- staff did not always have, or display, the skills and knowledge to meet people's needs
- staff appeared focused on keeping people at home. They felt they were protecting them from the local community as local residents had complained
- some staff were using physical restraint despite having no formal training
- some staff were dismissive of people's requests to engage with them
- there was some evidence of a closed culture in operation
- records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service
- there was no real implementation of tenancy agreements; people did not hold their own keys and were not allowed out without permission
- the provider is the managing agent for the landlord to collect people's rent and receives a fee for this work. So, there is no clear separation between landlord and care provider.

How we judged the service
We judged the service as inadequate overall.

The service did not meet the principles of *Right support, right care, right culture* because:
- the personal care provided was institutional, denying people choice and control within their homes
- the congregate setting, the fencing and parking drew negative attention to the service from the local community, rather than helping people to integrate and become more independent
- the service was not safe or effective because not all staff were trained in the use of restraint or de-escalation, and the methods employed were likely to cause harm rather than de-escalate situations
- people did not have choice in who provided their care.

Inspection of a supported living service network – rated outstanding

The service
A large supported living service. 150 people lived in supported living accommodation across the community, but not everyone was receiving a regulated activity of

personal care. People receiving supported living services rented accommodation separately from the care that was provided by the service.

What we found

The environment
Externally:

- people lived in homes that were predominantly small shared houses and bungalows. Most properties were general housing in the community
- one property was adapted apartments housed in one block with working aged adult tenants
- another setting was a cluster of bungalows, similar in type to retirement bungalows for older people, and generally older people lived in those homes
- the apartment block and bungalows were located in the community in congregate settings with no outward signs they were specialist housing.

Internally:

- homes were designed to enable people to live as independently as possible. Adaptations promoted independence and reduced risk to safety
- all rooms we visited were accessible to people living in the different housing types
- decor and layout were autism and dementia friendly and updated to improve wellbeing and support for people with complex needs.

Running the service
People's human rights were upheld and staff acted in accordance with the MCA:

- people's consent was always sought; staff used innovative ways to communicate so people's needs and wishes could be expressed
- where people did not have capacity to make certain decisions, appropriate assessments were carried out, involving advocates if needed
- they always adopted least restrictive practices and clear plans were in place to use positive approaches as much as possible
- relevant authorisations had been granted by the Court of Protection where people's liberties were deprived.

Model of care:

- there was a longstanding established staff team who had built up knowledge, experience, continuity and trust with people
- they used a range of assisted technology to support people to promote independence and inclusion
- the ethos was one of independence and enablement
- some of the people using the service had complex needs. The frequency of the care and support was responsive to people's individual requirements
- staff were trained and skilled to support people with complex needs and take measures to quickly mitigate or minimise people's distress
- they adopted least restrictive practices to administer medicine to avoid medication rounds and medicines administration record charts in people's own homes. People were enabled to f-administer
- accidents and incidents were consistently and appropriately recorded. Monitoring tools were used to analyse incidents to learn lessons and improve practice

- easy read and accessible information was available throughout the service to reflect individual communication needs.

How we judged the service
The service was given an overall rating of outstanding:
- the level of support and model of care was unique to each setting, driven by the needs and aspirations of people living in their own homes
- choice, independence and inclusion was achieved through individual person-centred plans delivered by caring staff and driven by leadership instilling a progressive well-led culture founded on current best practice
- congregate settings were mitigated by the model of care, ensuring people were an integrated part of the local community.

Inspection of a shared lives service – rated outstanding

The service
A shared lives service, which provides long-term placements, short breaks, respite care, day care and emergency care for adults with a range of needs, within carers' own homes. At this inspection there were 297 people using the service and in receipt of a regulated activity.

Running the service
We found that:
People's care and support was completely person centred:
- people's care and support was positive and consistent, and improved their quality of life
- staff and carers were able to keep people safe at times when their lives were in crisis
- there was a proactive approach to support people to take positive risks, ensuring they had maximum choice and control of their lives
- people were encouraged to learn new skills to enhance their independence and were treated with the utmost dignity and respect
- people's needs were met through robust assessments and support planning. There were outstanding examples of when the service had worked with other healthcare professionals to achieve positive outcomes for people and to improve their quality of life.
- people unanimously told us carers and staff were exceptionally compassionate and kind
- carers and staff knew people exceptionally well and supported them to maintain relationships with people that mattered to them
- medicines were managed safely and people were supported to be as independent as possible with their medicines.

The provider had:
- policies and systems that ensured people were supported to have maximum choice and control of their lives and were supported in the least restrictive way possible
- there was a robust recruitment processes for staff and carers

- there was a comprehensive and inclusive matching service which had exceptionally positive outcomes for people.
- staff and carers with excellent knowledge and skills matched to the people they cared for
- ensured training was relevant and accessible to meet people's needs.

How we judged the service

The service was given an overall rating of outstanding:

- there was a very open and transparent culture and people were empowered to voice their opinions. Without exception, people told us the service was well-managed
- the service planned and promoted holistic, person-centred, high-quality care resulting in excellent outcomes for people
- the values and culture embedded in the service ensured people were at the heart of the care and support they received
- we received overwhelming feedback of the positive impact this had on people and how they had changed people's lives. We saw excellent examples of how the care and support people received enriched their lives through meaningful activities
- independence and inclusion was achieved through individual person-centred plans delivered by caring staff and driven by leadership instilling a progressive well-led culture founded on current best practice.

HOSPITALS

Register: Hospitals

New care home on hospital grounds – application refused

The service
A seven-bed unit for adults located in a residential area of a small town. This unit formed part of the local NHS trust.

The service was currently registered as a hospital.

How we judged the application
We found that the service had not been developed and designed in line with the values that underpin *Right support, right care, right culture*.

This was because the proposal:
- was not developed so that the service was in line with the local authorities Market Position Statement
- did not align the model of care with current best practice
- was not supported by local neighbouring clinical commissioning groups and local authorities
- was not developed specifically for people from the local area who wished to return there. They intended to care for people from other, geographically-distant, authorities

We refused registration.

Monitor: Hospitals

Safeguarding notifications and information from public about NHS mental health trust – rated requires improvement

The service
An NHS mental health trust providing specialist services to people with a learning disability and autistic people who may be detained under the Mental Health Act. At their last inspection two years ago, a core service inspection of the learning disability and autism wards received a good rating.

What we found
Monitoring information showed a high, and increasing, number of safeguarding incidents and injuries.

A parent contacted us. They told us that staff were not supporting their son (X) in line with his care plan. The care plan set out that he should receive support to do

activities he enjoyed, such as cooking. X had an increased number of incidents reported on record.

The trust told us that they had stopped offering cooking for X. This decision followed an incident when X had thrown objects in the kitchen.

The incident occurred when the trust did not have staff to support the cooking activity for seven days in a row. In response to the incident, the trust had also removed all personal effects from X's room. This change in the planned care did not meet X's needs or align with current best practice. The manager confirmed that the change in X's care plan had taken place without any review.

We inspected the service. We were concerned that changes had been made to care plans without a proper review. Also, the trust had made changes to X's personal environment to manage behaviours that challenge. We considered this to be a disproportionate response to the situation.

Our inspection
We found that their existing service model had changed, and quality had declined since the last inspection:

- care and support did not always reflect current evidence-based guidance, standards and current best practice. This specifically related to meeting the needs of autistic people
- there had been above average staff turnover since the last inspection, and not all staff working with people had received adequate training
- people were not consistently supported to pursue their interests or undertake activities they wanted to, and changes to their physical environment, typically removing personal effects, was not warranted
- not all care plans were person centered and management of people's behaviour was not in line with current best practice.

Outcome of inspection
We rated the service as requires improvement for the effective and responsive key questions, with a breach of regulation. It was rated as requires improvement overall.

We notified the provider that the service did not meet the relevant requirements of the national service model.

We required the provider to:

- create an action plan setting out how they would address the shortfalls
- give evidence that they had done so.

Inspection of an independent hospital – issued an urgent Notice of Decision

The service
An independent hospital providing support and treatment for up to 14 men with a learning disability and complex needs. Some people were detained under the Mental Health Act. The provider is registered to provide the regulated activity of assessment and medical treatment for persons detained under the Mental Health Act 1983

What we found
When we inspected there were eight people receiving care and treatment at the hospital. The service had previously been rated as requires improvement and had been placed in special measures. This was a follow-up inspection.

Running the service
- Patient risks were assessed regularly, and medicines managed safely.
- Staff had the skills to develop and implement good positive behaviour support plans.
- People received a range of treatments in line with national guidance about current best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- People were treated with compassion and kindness.
- People's families and carers were involved in care decisions.

However:
- There were not enough staff on duty to safely provide the required levels of patient observations.
- They were not following the provider's protocol for close observation.
- Staff did not plan sufficiently for patient discharge.
- The registered manager did not have enough oversight of all the safety concerns and risks. They had not acted to correct all the concerns raised at previous inspections or from enforcement action.

How we judged the service
We judged the service as inadequate overall. We kept the service in special measures.

The service did not meet the principles of *Right support, right care, right culture* because:
- the service did not provide safe care
- people did not always have discharge plans, so they were kept in hospital longer than necessary
- many people in the service were not from the local community so were isolated from their families
- care plans, risk assessments and observation charts did not always align.

The provider had not:

- made sure staff had access to working personal emergency alarms
- ensured staff were completing observations in line with care plans and NICE guidance for close observation
- maintained the closed circuit television system adequately
- ensured blind spots on the ward were sufficiently mitigated
- addressed all actions from the previous inspection.

We kept the provider in special measures and issued an urgent Notice of Decision under S31 of the Health and Social care act and placed restrictions on admissions to the service.

Inspection of an NHS trust inpatient ward – rated outstanding

The service
A 15-bed inpatient ward for autistic people, who have extremely complex needs and display behaviours that challenge. The service also provides diversion for individuals who have been inappropriately placed within secure services. The provider is registered to provide the regulated activity of assessment and medical treatment for persons detained under the Mental Health Act 1983.

What we found
The ward had been specifically designed to allow for highly individual environmental adaptations to reduce anxiety and positively impact on behaviour that challenges.

Running the service
The clinical model was based on a time limited model and incorporated:

- detailed pre-and post-admission assessment
- evaluation and treatment of needs
- specification of community provision
- detailed discharge planning.

There was a focus on supporting people to return to their home community.

How we judged the service
We judged the service as outstanding. The service met the principles of *Right Support, right care, right culture.* This was because:

- The model of care provided:
  - a truly holistic approach to assessing, planning and delivering care and treatment to patients
  - a multi-disciplinary approach at all stages of treatment
  - excellent arrangements to assess, monitor and review physical health needs
  - a broad range of individualised therapeutic activities which took account of patient preferences, likes and dislikes.

- Patients and carers:
  - were active partners in the planning and delivery of care

    - were supported to develop and maintaining relationships with people important to them
    - used collaborative risk-assessment tools to manage their own risks
    - spoke very highly of staff and the quality of care received.

- Staff:
    - were passionate about their work and spoke with pride about the wards they worked on
    - used a dynamic approach to data, including when reformulating treatment plans
    - demonstrated a proactive approach to anticipating and managing risks
    - showed an advanced understanding of patient needs.

- Leadership:
    - had excellent performance management systems in place at service, ward and staff level
    - ensured that there were sufficient staff working on the wards, providing safe and effective care to patients
    - enabled staff to access a range of specialist training, directly linked to the needs of patients
    - actively encouraged staff to review practice and identify ways to improve service delivery and patient outcomes.

Inspection of an NHS trust inpatient ward – rated requires improvement

The service
A 12-bed assessment and treatment unit for adults with learning disabilities. This inpatient unit supports people who need to be in a hospital because of their mental health, behaviour and levels of risk posed to themselves or others. There were three units next door to each other, all admitting male and female patients. The provider is registered to provide the regulated activity of assessment and medical treatment for persons detained under the Mental Health Act 1983.

What we found
In 2016 we found the provider to be in breach of several regulations. They failed to:
- comply with mixed-sex accommodation guidelines
- undertake capacity assessments in line with requirements
- provide staff supervision in line with trust policy.

We later found the trust had not addressed the concerns about complying with requirements on mixed sex accommodation guidelines.

Since the last inspection, the service planned male and female only weeks to comply with mixed-sex accommodation guidelines. Patients at the one unit may be voluntary/informal, detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards (DoLS). The short stay units do not admit patients under the Mental Health Act.

Running the service

- The model of care:
  - people were supported by staff who had completed restrictive practice training. This taught them to use positive behaviour support plans and de-escalation techniques to reduce restraints and seclusions
  - there were good inter-agency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges
  - community treatment reviews were person-centred, compassionate and discharge-focused
  - the discharge coordinator liaised with professionals and families to ensure discharges were planned and patients were discharged in the most appropriate way.

  However:
  - there were unnecessary restrictions. Patients could not make, or have access to, snacks when they wanted them. The patient booklet stated that snacks were at set times only.

- Patients and carers:
  - received treatment founded in kindness and compassion
  - were actively involved in planning their care
  - were supported to understand why they were in hospital and how to move on
  - had access to information in an accessible format, which was displayed across the services in several different languages
  - had access to physical healthcare services.

  However:
  - the dignity and privacy of patients was compromised. The trust could not comply with mixed-sex accommodation guidance when they admitted males and females into short breaks units at the same time. On some occasions, patients were placed on enhanced observations to keep them safe, which they would not have needed had they been in single sex accommodation.

- Staff:
  - were focused on providing high-quality care
  - interacted with patients in a kind, caring and respectful manner
  - involved patients in planning their care and completed holistic and person-centred care and positive behaviour support plans
  - completed physical health checks and monitored people's physical health for the duration of their stay
  - applied the Mental Capacity Act appropriately. In the short breaks units, staff completed mental capacity assessments and DoLS applications; these were of good quality, decision-specific and correctly submitted.

  However:
  - they had not routinely recorded whether they had given copies of care plans to patients or to their carers where appropriate
  - they did not always comply with the Mental Health Act code of practice when secluding patients and did not complete seclusion paperwork appropriately.

- Leadership**:**
  - managers and staff said they felt isolated from the trust and from each other with little sense of a shared identity

- managers spent more time in some units than others
- there was no clear oversight of data and information-gathering processes
- there was no system in place to ensure that learning from incidents, complaints and concerns was effectively communicated to non-registered staff
- the trust could not provide data relating to staffing the unit prior to the inspection.

How we judged the service
We rated the service requires improvement and required the trust to take the following actions. The trust had to ensure that:

- staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Code of Practice
- all wards comply with guidance on the elimination of mixed-sex accommodation
- effective governance systems are in place to monitor the service.

Inspection of an independent hospital – rated good

The service
An independent hospital for up to 60 patients across four wards. The provider is registered to provide the regulated activity of assessment and medical treatment for persons detained under the Mental Health Act 1983:

- ward one: mixed acute admission ward for up to 20 patients. It provides assessment, diagnosis and treatment for people with mental health needs and secondary diagnosis of addictions
- ward two: low-secure forensic ward for up to 16 male patients with autistic spectrum disorders
- ward three: rehabilitation ward for up to 10 male patients with autistic spectrum disorders
- ward four: for up to 14 male patients with a diagnosis of autism or mild learning disability who also present with mental health needs. This opened in January 2018.

At our inspection in 2018 the service achieved an overall rating of requires improvement. It was rated as requires improvement for safe and well-led and rated good in effective, caring and responsive key questions.

What we found
When we inspected in 2019, we found that the quality of care at the hospital had improved. The provider had taken action to address previous breaches and best practice recommendations. There were additional safeguards in place to protect patients from de facto seclusion and excessive restriction when they were nursed on one-to-one observations.

There had been improvements in how the Mental Health Act was managed. Robust systems were in place to monitor patients' leave.

Governance systems to monitor the safety, quality and effectiveness of the service had improved. Overall, the hospital collected, analysed, managed and used information well to support all its activities.

Running the service

- The model of care:
  - there was a holistic approach to assessing, planning and delivering care and treatment to patients
  - interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE)
  - the provider had an ongoing initiative to reduce restrictive practice across the hospital. There was no long-term segregation of any patients since the ward had opened in January 2018. Seclusion was used appropriately and followed current best practice guidance
  - there was an active focus on trying to reduce restrictive interventions and blanket rules. This included reviewing CCTV footage from restraint incidents and de-brief discussions for both staff and patients. There were plans to reconfigure the ward so that a sensory room and a de-escalation were available.

- Patients:
  - were actively involved in the development and review of their care so that they could be supported in the way they wanted
  - had access to a wide range of evidence-based psychological therapies as recommended by NICE, including group and individual support
  - received treatment and care that was respectful, discreet, responsive, kind and compassionate
  - had access to education and work opportunities when appropriate
  - were provided with a comprehensive programme of activities, which met their individual needs and preferences
  - were supported to:
    - maintain contact with their families, carers and others that were important to them
    - to live healthier lives, including access to a gym and other activities
  - had easy access to information about independent mental health advocacy
  - were enabled to take Section 17 leave (permission for patients to leave hospital) when this had been granted.

- Staff:
  - showed a good level of understanding for each patient and their individual needs, including their personal, cultural, social and religious needs
  - spoke about patients with warmth and respect
  - informed and involved families and carers appropriately and provided them with support when needed
  - used a positive behaviour approach when supporting patients in accordance with each patient's positive behaviour support (PBS) plan
  - used recognised risk assessment tools which were completed on admission and after any incident
  - applied blanket restrictions on patients' freedom only when justified
  - used restraint only after de-escalation had failed. Every patient had an individualised care plan which specified how staff could support the patient when they became distressed to de-escalate the situation
  - were open and transparent and gave patients and families a full explanation if and when things went wrong

- used recognised rating scales, such as Health of the Nation Outcome Scales (HONOS), Model of Human Occupation Screening tool (MOHOST). Staff measured patients' progress and the effectiveness of their treatment at each ward round and against individual recovery goals
- worked together and with other health and social care professionals to deliver effective care and treatment
- planned for patients' discharge, including good liaison with care managers/coordinators, commissioners and community mental health teams.

- Leadership:
  - the senior leadership team had successfully communicated the provider's vision and values to the frontline staff. This was through the staff induction programme, away days and ward team meetings
  - senior managers were visible, approachable and responsive to the service's needs
  - staff believed leaders were committed to improving standards of care and treatment for all patients and families
  - there was an open culture within the staff team and they were confident in raising any concerns about disrespectful or discriminatory behaviour without fear of the consequences
  - there was a clear governance framework at ward level, which local leaders oversaw and fed into the provider's overarching governance structure and assurance framework
  - the service monitored the effectiveness of care and treatment and used the findings to improve them.

How we judged the service
We rated the service as good.

Appendix B: Background and further reading

Policy context

Since the BBC Panorama programme in 2011, which exposed the abuse of people at Winterbourne View hospital, there has been increased scrutiny of how the health and social care needs of people with a learning disability are being met. The first response to this was the Department of Health report, *Transforming care: A national response to Winterbourne View Hospital.*[1] This was accompanied by the Winterbourne View Concordat that many organisations, including CQC, signed up to.[2] Through this, signatories committed to taking action to transform the provision of health and social care for autistic people and people with a learning disability who display behaviour that challenges, including those who have a mental health condition. This was particularly in reference to those who are cared for in specialist hospitals.

In 2014, the report *Time for Change* was published by the Transforming Care Commissioning and Steering Group. It recommended an expansion of community capacity and strengthened commissioning in order to reduce reliance on inappropriate inpatient care discharge.[3]

In its 2015 consultation No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions, the Department of Health acknowledged that "…some people are being admitted to hospitals or placed in residential settings which can be a long way from their family or from their home and which is often not their choice. This can make problems with behaviour worse, delay recovery, complicate discharge and it reduces contact with family and friends."[4]

In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA) published *Building the right support*.[5] This is a national plan to develop community services and close inpatient facilities for people with a learning disability or autistic people who display behaviour that challenges, including those with a mental health condition. They also published an accompanying service model for commissioners of health and care services.[6] This describes what good care and support should look like. The principles for commissioning good services, including quality of life, keeping people safe, and choice and control, are consistent with both the fundamental standards set out in regulations and CQC's ratings framework.

In December 2016, NHS England, ADASS and the LGA published a housing guidance document, *Building the right home*.[7] This is guidance for NHS and local authority commissioners on how to expand the housing options available for autistic people and people with a learning disability who display behaviour that challenges, including those with a mental health condition.

The principles and ambitions of *Building the right support* are included within the NHS Long Term Plan 2019[8] which sets out commitments to reducing the number of people with a learning disability, autistic people or both in inpatient settings; to increasing the availability of specialist community support; and to improving the quality of inpatient care.

We support this work as a partner organisation of both the original Winterbourne View Concordat and the Transforming Care Delivery Board. It provides a clear picture of what good quality care models should look like. As NHS England and local commissioners develop community services and support to reduce reliance on inpatient provision, we will support this by making sure that applications from providers to register or change their registration are in line with this plan and the model, because they are aimed at delivering good quality care. We will also consider the extent to which applicants for registration and variations to their registration for services for autistic people and people with a learning disability have considered, and can demonstrate that they have applied, this model when determining whether to grant applications.

We have committed to taking a firmer approach to the registration and variations of registration for providers who support autistic people and people with a learning disability in *A fresh start for registration* and our report *The state of health and adult social care in England 2014/15*.[9,10] In October 2016, we published *The state of health and adult social care in England 2015/16*[11] in which we identified concerns that providers were continuing to apply to register residential services that were not consistent with the new service model for people with a learning disability.

The Department of Health's 2012 report *Transforming care* states that:

> "…the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings. Best practice is for children, young people and adults to live in small local community-based settings."[12]

As *Building the right support* says:

> "Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.
>
> …Just like the rest of the population, people with a learning disability or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes."

We recognise that it is a challenging time to operate in health and social care, but we have a clear and informed understanding of what good practice looks like. We will not compromise on ensuring the best care for autistic people and people with a learning disability. We will make registration decisions and inspection judgements aimed at ensuring that models of care for people are developed and designed and provided in line with *Building the right support* and other current best practice

guidance. We will support and encourage models of care that comply with national and best practice guidance, including those referenced in this guidance. In particular:

- We recognise that providers need to make decisions about how to invest their capital to expand their services, and that the likelihood of securing CQC registration is a key factor for providers.
- We do not routinely support the establishment of larger-scale services. Best practice guidance tells us that small-scale support best enables choice, community inclusion and independence. Where a provider wishes to establish a service that does not have a small-scale domestic feel, the onus is on them to demonstrate that they meet the fundamental standards and other relevant regulations. They must provide evidence that they can provide appropriate, person-centred care, which is inclusive, meets people's human rights and promotes choice and independence.
- We recognise the difficulties of discharging people from assessment and treatment units. This is because the current lack of suitable accommodation for autistic people, people with a learning disability, people with behaviour that challenges, or people with mental health conditions, can mean that new facilities, which do not comply with *Building the right support,* may still attract placements from commissioners. However, commissioners have signed up to implement the service model at a national level, and we believe that commissioners would prefer to commission services from developments in their own areas that comply with *Building the right support*, as opposed to commissioning services outside their areas that do not do so.

Since the publication of *Registering the Right Support* in 2017, the policy landscape has continued to evolve. We continue to review our guidance to take into account changes, with the aim of reducing inpatient care and supporting community-based options:

- The exposure of the violation of people's human rights at Whorlton Hall, where patients suffered horrific physical and psychological abuse has shone a light on closed cultures and the use of restrictive practices that must be eradicated. It reinforced how everyone involved in the care of people with a learning disability or autistic people has a part to play in identifying where abuse and human rights breaches may be taking place.
- In October 2019 we wrote to providers[13] to highlight the steps we have taken to strengthen the way we assess these types of services. We asked that providers consider what steps they can take to better protect the human rights of people in their service. We produced supporting information to help our frontline staff to assess services where there may be a risk of abuse and abusive cultures.
- The independent review by Professor Glynis Murphy[14] made a clear recommendation that CQC should not register or allow the expansion of services that are very isolated, in unsuitable buildings, with out-of-date models of care.
- The forthcoming CQC review of the use of restraint, seclusion and segregation exposes a system of care that lets down some people who, because of their circumstances, are among the most vulnerable in our society. The two-part review[15] finds many examples of undignified and inhumane care. It highlights

once more how a lack of appropriate community resources can lead to people needing to be admitted to hospital but can also prevent them from leaving.

- The Transforming Care agenda set a target of a 35%-50% reduction in inpatient care for people with a learning disability and autistic people by 2018/19. This has not been met, although the expectation remains for a 35% reduction to be achieved at the earliest opportunity. This has been complemented by new targets as set out in the NHS long term plan to reduce inpatient provision to half of 2015 levels by 2023-24.

- In February 2020 the Equality and Human Rights Commission sent a pre-action letter[16] to the Secretary of State for Health and Social Care for failing to meet the original target and lack of confidence in the new target being met, and as such, a failure to protect people's human rights.

- The annual LeDeR report[17] continues to highlight continuing health inequality for people with a learning disability and autistic people. The 2019 report showed that people from Black, Asian, and minority ethnic groups died disproportionately at younger ages than White British people. People with profound and multiple learning disabilities also disproportionately died at younger ages. The report also found that people with a learning disability died from an avoidable medical cause of death twice as frequently as people in the general population.

References

[1] Department of Health, *Transforming care: A national response to Winterbourne View Hospital*, 2012. https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

[2] Department of Health, *DH Winterbourne View Review: Concordat: Programme of Action,* 2012. https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

[3] Transforming Care and Commissioning Steering Group, *Winterbourne View – Time for Change: Transforming the commissioning of services for people with learning disabilities and/or autism*, 2014. https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

[4] Department of Health No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions, 2015

[5] NHS England/LGA/ADASS, *Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*. 2015. https://www.england.nhs.uk/learning-disabilities/care/

[6] NHS England/LGA/ADASS*, Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services,* October 2015. https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[7] NHS England/LGA/ADASS, *Building the right home: Guidance for commissioners of health and care services for children, young people and adults with learning disabilities and/or autism who display behaviour that challenges*, 2016. https://www.england.nhs.uk/learningdisabilities/wp-content/uploads/sites/34/2015/11/building-right-home-guidance-housing.pdf

[8] NHS England, The NHS Long Term Plan, 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[9] Care Quality Commission, *A fresh start for registration: Improving how we register providers of all health and adult social care services*, 2015. http://www.cqc.org.uk/sites/default/files/20150810_freshstartregistration_2015_final.pdf

[10] Care Quality Commission, *The state of health care and adult social care in England 2014/15.* October 2015. www.cqc.org.uk/content/state-care-201415

[11] Care Quality Commission, *The state of health care and adult social care in England 2015/16.* October 2016. http://www.cqc.org.uk/content/state-of-care

[12] Department of Health, *Transforming care: A national response to Winterbourne View Hospital,* 2012, paragraph 3.7. https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

[13] CQC, Letter to providers: Supporting improved care for people with a learning disability and/or autism or mental health problem, 10 October 2019. https://medium.com/@CareQualityComm/letter-supporting-improved-care-for-people-with-a-learning-disability-and-or-autism-or-mental-ee38c09933c1

[14] Professor Glynis Murphy, *CQC inspections and regulation of Whorlton Hall 2015-2019: an independent review*, 2020. https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

[15] CQC, *Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and / or autism*, 2019 https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people

[16] Equality and Human Rights Commission, 'Health Secretary faces legal challenge for failing patients with learning disabilities and autism', 2020. https://www.equalityhumanrights.com/en/our-work/news/health-secretary-faces-legal-challenge-failing-patients-learning-disabilities-and

[17] Learning Disabilities Mortality Review programme, *Annual Report 2019*, 2020. http://www.bristol.ac.uk/media-library/sites/sps/leder/LeDeR_2019_annual_report_FINAL2.pdf