

# 5 Boroughs Partnership NHS Foundation Trust

# Community mental health services for people with learning disabilities or autism

## Quality Report

**5 Boroughs Partnership NHS Foundation Trust**  
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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV	Willis House	St Helens and Knowsley Learning Disability Team	L35 2YZ
RTV	5 Boroughs Partnership NHS Foundation Trust	Halton Learning Disability Team	WA8 3LZ

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

### **We rated community mental health services for people with learning disabilities and autism as good because:**

Staffing levels were adequate to meet the needs of people who use the service. Staff had access to additional bespoke training in learning disabilities. We saw systems and processes for staff to ensure the safety of services.

Staff completed risk assessments and kept them up to date and relevant to the people who used the services.

Staff were able to identify abuse and safeguarding concerns and follow the correct procedures for their service. Staff knew how to report incidents or harm or risk of harm, and were aware of lessons learned from other areas of the trust when things had gone wrong

People who use the service were involved in their care planning. Staff understood the individual needs of the people using the service and knew how to support them and involve them in their care using a variety of communication aids to maximise their involvement.

Care pathways gave clear guidance on referral and assessment. We saw evidence that National Institute for Health and Care Excellence guidance and best practice was followed and shared within the teams.

Staff from a wide variety of disciplines worked in the teams and communication between them was effective.

People detained under a community treatment order were told their rights in a format that they understood.

People who use the services and their carers spoke positively about the care received and interactions they had with staff. People said that advocacy services were available should they want to access them.

The trust and the teams sought feedback from people and carers in a variety of ways.

There was a responsive triage/ duty system that allowed people to have contact with the service for advice and support when needed. People referred to the service were seen the same day if their need was urgent.

Team managers monitored waiting lists and there was a clear rationale for those waiting more than 10 weeks for care.

Facilities were accessible for people with physical disabilities. Easy read information was available on noticeboards in waiting areas.

People and carers we spoke to said they would feel able to make a complaint if they had one and felt that they would be listened to. We saw team meeting minutes that showed lessons were learned from complaints.

The core values of the trust were used as part of the appraisal process. There were good governance structures for reporting up to the trust and staff knew how to use the system.

The service level leadership and management structures were good. Teams felt that they were well led and supported and there were good monitoring systems for training, supervision and appraisals.

We saw clear commitment to improving services through research and audit. There was also open communication with commissioners to develop key performance indicators metrics focused on learning disabilities.

# Summary of findings

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

### Are services safe?

#### We rated safe as good because:

- Staffing levels and skill mix were planned and there were enough staff to meet the needs of the people who used the services.
- Staff completed risk assessments that were up to date and relevant to the people who used the services.
- There were systems and processes in place for staff to ensure their safety.
- Staff were able to identify abuse and safeguarding concerns and follow the correct procedures for their service.
- Staff knew how to report incidents of harm or risk of harm and were aware of lessons learned from other areas of the trust after things had gone wrong.

However we found that some areas of mandatory training did meet 75%, the trust provided an action plan for all mandatory training across the trust to show how it will increase compliance

Good



### Are services effective?

#### We rated effective as good because:

- People who used the service were involved in their care planning. A variety of communication aids were used to maximise people's involvement.
- Care pathways gave clear guidance on referral and assessment.
- We saw evidence that National Institute for Health and Care Excellence (NICE) guidance and best practice was followed and shared within the teams.
- Staff had access to additional training in learning disabilities.
- Staff from a wide variety of disciplines worked in the teams and communication between them was effective.
- People detained under a community treatment order were told their rights in a format that they understood.

However we found that decisions were made to a person lacking capacity but the process or decision making that had led to the conclusion was not evident.

Good



### Are services caring?

#### We rated caring as good because:

Good



# Summary of findings

- People who use the service and carers spoke positively about the care they received and interactions of all staff they have had contact with.
- Staff understood individual needs of the people who use the services and knew how to support them and involve them in their care.
- Advocacy services were widely available for people to access should they wish.
- The trust and the teams sought feedback from people and carers in a variety of ways.

## Are services responsive to people's needs?

### We rated responsive as good because:

- There was a triage/ duty system in place which allowed people to have contact with the service for advice and support when needed. Urgent referrals were seen the same day.
- Waiting lists were monitored by the team managers and rationales were clearly evident for those waiting over 10 weeks.
- Facilities were available for all people who use the service with disabled access and toilets. Easy read information was available on notice boards in the waiting areas of the teams.
- People and carers we spoke to felt they would be able to make a complaint if they had one and felt they would be listened to. We saw team meeting minutes which showed that lessons were learned from complaints

Good



## Are services well-led?

### We rated well-led as good because:

- The core values of the trust were used as part of the appraisal process.
- We saw evidence of good governance structures being in place for reporting up to the trust and how this was communicated within the staff team.
- Service level leadership and management structures were good and teams felt they were well- led and supported
- There were good monitoring systems in place for training, supervision and appraisals in all teams.

Good



# Summary of findings

- We saw there was clear commitment to improving services through research and audit. There was open communication with commissioners to develop key performance indicators which were focused on learning disabilities.

# Summary of findings

## Information about the service

The 5 Boroughs Partnership NHS Foundation Trust provides community learning disability services across Halton, Warrington, St Helens and Knowsley boroughs. Learning disability services for the Wigan area are provided by Bridgewater Community Healthcare NHS Trust.

Halton community learning disability Team (CLDT) provides assessment, care and treatment for people who have a learning disability in the borough of Halton, which is funded by Halton Clinical Commissioning Group (CCG) and is based at the Bridges Learning Centre in Widnes. The building is not owned by the trust.

The Halton team works alongside Halton Borough Council at meadow community support centre in Widnes. The council employs the community learning disability nurses and social workers for the borough. The Bridgewater Community Healthcare NHS Trust, which employs a community matron, also works alongside the Halton team.

The St Helens and Knowsley CLDT provides assessment, care and treatment for people who have a learning disability in the Knowsley and St Helens boroughs. The team are based together at Willis House in Whiston. They are funded by St Helens CCG and Knowsley CCG.

St Helens and Knowsley team includes community learning disability nurses. They work with social workers employed by St Helens and Knowsley councils.

We did not inspect Warrington community learning disability team.

The primary function of all the community learning disability teams is to support patients with learning disabilities in all settings, providing specific and additional input as required to respond to their healthcare needs. The teams also provide health facilitation to support people with learning disabilities to improve their health, well-being and social inclusion, both directly through their interventions and indirectly through their support and relationships with other NHS and Service Providers.

## Our inspection team

Our inspection team was led by:

**Chair:** Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

**Head of Inspection:** Nicholas Smith, Care Quality Commission

**Team leaders:** Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?



# Summary of findings

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited two community learning disability sites and looked at the quality of the environment
- spoke with eight people who were using the service and seven carers
- spoke with the community team managers
- spoke with 15 other staff members, including doctors, nurses, occupational therapists, speech and language therapists, psychologists and physiotherapists
- interviewed the matron with responsibility for these services
- attended and observed two team meetings and four outpatient clinics
- attended and observed a patient self-advocacy group and four home visits.
- looked at 15 care records of people who use the service

looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

We spoke to eight people who used the services and seven carers. They told us that they were listened to by doctors and staff and that staff were very helpful, caring and respectful.

People felt that they were involved in their care and care planning and were given timely information about the services provided.

Carers felt they were able to pick up the phone to speak with staff should they need to and told us they would be listened to.

People who use services and carers gave positive praise about the services and staff in all community learning disability teams including the facilities and information available.

## Good practice

There was evidence of research taking place to help inform best practice and care pathways.

There were good levels of support with communication and communication aids to help assess people's understanding of their rights under the Mental Health Act and people's capacity to make decisions about their care.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The trust should improve compliance with mandatory training in the areas that fall below the trust target levels.
- The trust should ensure that assessments of people's capacity to make decisions about their care are recorded consistently.

# 5 Boroughs Partnership NHS Foundation Trust

## Community mental health services for people with learning disabilities or autism

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
St Helens and Knowsley Learning Disability Team	Willis House
Halton Learning Disability Team	5 Boroughs Partnership NHS Foundation Trust

#### Mental Health Act responsibilities

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

At St Helens and Knowsley we reviewed two care records for people who were subject to a community treatment order (CTO). We found that both people had had their rights under the Mental Health Act (MHA) explained to them. In one case, we saw evidence that a speech and language therapist had prepared an easy read document that explained the principles of the CTO. There was evidence to show that the person understood the information about the CTO and used a scale of 6 faces to express how her mental health was. There was no one subject to a CTO in the Halton team.

CTO paperwork was correctly completed, up to date and stored correctly. However, in one case we found that not all the paperwork required was stored in the case file. We spoke to the MHA administrator who told us that all the paperwork for the CTO and section 3 was all in place and they would ensure that it was placed in the case file; we saw later that this had been done.

From the information that we received from the trust we found that Halton team had 42% of the team trained in the MHA, St Helens had 73% and Knowsley had 44% trained in the MHA.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated awareness of the Mental Capacity Act. Staff took practicable steps to enable patients to make decisions about their care and treatment by using a variety of communication methods wherever possible.

Staff understood there was a process to follow should they have to make a decision about a person's capacity to consent and they had completed all the relevant training for their role.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

The community learning disability teams' buildings we visited were clean and well maintained. Both buildings varied in the office spaces that was available. The Halton team had one office shared by all the different types of staff and one consultants room with a waiting area. Staff could book offices in a building that they shared with other organisations for appointments. St Helens and Knowsley had offices for each different type of staff and a consultants room with a waiting area. The Halton were based in a building that was not owned by 5 Boroughs Partnership. The building was being sold and new premises were being sought.

The meeting and interview rooms in the community teams' buildings did not have alarms. Portable alarms were used by the St Helens and Knowsley team for clinics and assessments. The Halton team saw people who were a risk to others in their home environment, where they were assessed as being less distressed and therefore less of a risk in their own environment.

The teams assessed for ligature points areas of their buildings, including toilets, that were not supervised by staff. Ligature points are places to which someone intent on self-harm might tie a something to strangle themselves. Staff in the Halton team reviewed their consultant clinic list weekly to identify service users at risk of suicide or self-harm and prepared a plan to manage their visits. The St Helens and Knowsley teams discussed all risks at their weekly meeting. The measures that were put in place meant risks to people who accessed the services were lessened.

The Halton team had a clinic area where a blood pressure machine and weighing scales were stored for use during outpatient clinics. The St Helens and Knowsley teams had a clinic room that was well stocked with all relevant equipment required for conducting physical examinations and venepuncture.

A cleaning log showed that all medical equipment was cleaned and well maintained. We saw information displayed in the clinical area for managing sharps disposal,

clinical waste disposal, control of substances hazardous to health and an action booklet for safe use of chemicals. This ensured that staff knew about safety protocols relevant to the clinical area. Equipment such as sharps bins, personal and protective equipment and a first aid box were available.

### Safe staffing

All community learning disability services had their staffing establishment estimated through the use of the professional judgement model which is a tool that helps to assess how many staff are needed to run the service. These were seen to be completed for Halton CLDT in September 2014 and for St Helens and Knowsley in October 2014.

Halton CLDT reported no vacancies within their team and a 2.2% sickness rate for the period of July 2014 to June 2015. The reported establishment was:

- Team Leader - occupational therapist (OT) 1.0 whole time equivalent (WTE)
- OTs 1.5 WTE
- Therapy assistant OT/ physiotherapist 1.0 WTE
- Speech and language therapist (SALT) 2.7 WTE
- Therapy assistant SALT / OT 1.0 WTE
- Clinical psychologist 1.0 WTE
- Assistant psychologist 0.5 WTE
- Physiotherapist 1.0 WTE
- Medical secretary 0.40 WTE
- Team/clerical secretary 2.0 WTE
- Clerical secretary 1.0 WTE

St Helens CLDT reported no current vacancies within their team and a 6.0% sickness rate for the same period. The reported establishment levels were:

- Qualified nurse 4.4 WTE (for St Helens Only)
- Unqualified nurse 1.0 WTE (for St Helens Only)
- OT 1.7 WTE (0.7 WTE in Knowsley team)
- Therapy assistant OT/physiotherapist 0.7 WTE (for St Helens Only)
- Physiotherapist 2.0 WTE (0.50 WTE in Knowsley team)
- SALT 0.9 WTE – team leader (split equally with Knowsley team)
- SALT 2.2 WTE (1.0 WTE in Knowsley team)
- Therapy assistant OT/ SALT 0.8 WTE (split equally Knowsley team)

# Are services safe?

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

- Psychologist 3.6 WTE (1.1 WTE in Knowsley team)
- Psychology assistant 1.0 WTE (for St Helens Only)
- Team/clerical secretary 5.8 WTE (split equally with Knowsley Team)

Knowsley CLDT reported no current vacancies within their team and a 1.9% sickness rate for the same period. The reported establishment levels were:

- Qualified nurses 6.0 WTE
- Unqualified nurse 1.0 WTE
- OT 0.6 WTE
- Therapy assistant 1.0 WTE

On the day of inspection we found there to be the required levels of staffing for all teams to ensure that the service was safe for the people who used the service. The apparent higher sickness levels within the St Helen's team were due to how the data was managed incorporating both ST Helen's and Knowsley staff within their budget.

St Helen and Knowsley staffing for the purpose of their budget and their electronic workforce management system the staffing for each team are reported to be as above. The information we received from the trust for sickness and absence, mandatory training, and appraisals are all reported based on the above staffing. However information provided by the trust for caseloads and waiting times are based upon the staff being split in their correct boroughs.

Halton CLDT had not used bank or agency staff in the previous 12 months. St Helens and Knowsley CLDT had recruited an agency worker to work within their team to cover maternity leave. The team manager said the staff member had worked closely with people with learning disabilities before in another service and they were aware that the person's skills and experience were suitable for the role. This ensured that people who used the service continued to have a service delivered by skilled and experienced staff.

Mandatory training compliance for the CLDTs for a twelve month period from June 2014 until June 2015 was:-

## Halton – All Mandatory Training

- Fire – 69 %
- Infection prevention – 91%
- Moving and handling ( non-patient) – 100%
- Safeguarding children Level 1 – 94%
- Basic Life support – 83%

- Information Governance - 88%
- Equality, Diversity and Human rights – 100%
- Conflict resolution training – 94%
- Health and Safety – 100%

## St Helens – Mandatory Training

- Fire – 76%
- Infection prevention – 91%
- Moving and Handling – 79%
- Safeguarding Level 1 – 97%
- Basic Life support – 77%
- Information Governance - 66%
- Equality, Diversity, and Human Rights - 100%
- Conflict resolution training – 90%
- Health and Safety – 100%

## Knowsley – Mandatory Training

- Fire – 67%
- Infection Prevention – 78%
- Moving and Handling – 89%
- Safeguarding Level 1 – 100%
- Basic Life support – 89%
- Information Governance - 44%
- Equality, Diversity, and Human Rights – 78%
- Conflict resolution training – 78%
- Health and Safety – 100%

Overall, staff in the teams had done 75% of their mandatory training. Exceptions to this were the Halton and Knowsley teams for fire training and the St Helens and Knowsley teams for information governance training. However, the trust provided an action plan for all mandatory training across the trust to show how it will increase compliance. Other mandatory training has been reported within the detail of the report.

## Assessing and managing risk to patients and staff

Risk screens (form 3a) were completed by staff on initial assessment and updated every six months for people subject to the care programme approach and every 12 months for all others. We were told that where a person's risks were identified as low only a risk screen would be completed, but where risks had been identified as higher a further risk assessment and management plan (form 3b) would be completed. We reviewed 10 care records of people who use the service and found that all contained risk screens, and risk management plans where required and that were current and up to date.

# Are services safe?

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

All staff across the CLDTs had received risk management training. The compliance rate for clinical risk assessment and management training was lower:

- Halton team 18%
- St Helens team 30%
- Knowsley team 33%.

On reviewing the case records one out of the 10 records had a personalised relapse prevention plan. However these were completed on an individual basis dependant on the needs of the person.

Staff groups were allocated referrals based on the person's need. Each staff group, for example, OTs, would review the referrals at their weekly meeting. The case load of each OT, any discharges, and the level of priority that the referral needed to take based on risk were reviewed by the team. This included those who were already awaiting allocation and assessment. This showed that waiting lists were monitored to review risk of people who use the services.

We saw from the information the trust provided for the 12 month period up to June 2015 that:

- Halton CLDT were 90% compliant with safeguarding children level 2 training and 100% compliant with safeguarding adults training.
- St Helens CLDT were 100% complaint with safeguarding children level 2 training and 96 % compliant with safeguarding adult training.
- Knowsley CLDT were 87.5 % complaint with safeguarding children level 2 training and 89% complaint with safeguarding adults training.

We spoke to 15 staff across the CLDTs and found they were able to identify abuse and what a safeguarding concern was. They were also able to describe the safeguarding procedures for their services. Although the individual services did not hold safeguarding strategy meetings all said that they attended meetings held by social services and followed up on actions that came from this. We saw during our inspection a safeguarding concern was raised and this was dealt with immediately by the staff through a referral to the appropriate social services team and also to the trust.

Each team had local procedures in place for lone working. We saw a signing in and out sheet which was completed by staff and contact details with next of kin and car details. Staff told us that if they were returning after hours and the office was closed there was a buddy system in place to use which would agree how and when they would contact the buddy and who to contact in an emergency. Each team also adopted a code word should a staff member contact the office to raise concerns about their safety. This showed there were effective safeguards in place to ensure staff safety when lone working.

There were no medicines stored or dispensed from either site.

## Track record on safety

On review of the information that we received from the trust and speaking with the team managers and staff, we found there had been no serious untoward incidents within the last 12 months.

## Reporting incidents and learning from when things go wrong

Staff were able to explain that incidents were reported through their incident reporting system. Staff also said that they would inform their line manager of any incidents. Staff told us that they were open with people when things went wrong and were able to explain duty of candour.

We spoke to staff and they told us they received feedback regarding incidents that had happened in the trust through team meetings. We reviewed team meeting minutes and found lessons learned from the trust core brief were discussed. We saw evidence of this for the last three months.

Team managers gave us an example of an incident they had received feedback on that happened in the trust which had resulted in a ligature audit being carried out on the disabled access bathrooms. We saw the ligature risk assessment for these in each area.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

On review of 10 of the care records across the CLDT we visited, eight had care plans or statements of care which provided a detailed description of the interventions, adaptations or care to be given. We spoke with three people who use the services and five carers. One carer stated that the person they cared for did not have a care plan. All the others said that they had care plans or health action plans which were kept at their home.

On reviewing the care plans and statements of care we found them to be individualised and that these had been done with the person taking into account their likes, dislikes and wishes. All staff we spoke to said they used a variety of methods to include people in their care plans. For example using visual / pictorial care plans to explain what is needed, tablets and applications (apps) were used to help with discussion around the care plan.

We saw there had been pathways of care developed for people who received care or were referred to the learning disability services at the trust. These were:

- Eligibility and access into 5 Boroughs Partnership learning disability pathway
- Challenging behaviour pathway
- Mental health and learning disability pathway
- Learning disability and autistic spectrum pathway
- Dysphagia for adults with a learning disability learning disability pathway
- Dementia diagnostic pathway

The care pathways all had easy read flow charts which outlined the stages of the pathway with roles and responsibilities for the individual services and staff.

### Best practice in treatment and care

The CLDTs had psychologists as part of their teams. They ran groups such as the angry feelings group and managing my emotions group as well as providing 1:1 cognitive behavioural therapy, eligibility assessments and behavioural management plans.

We also observed a 'looking after myself programme' which was centred on a journey of wellbeing map which was a pictorial road with a number of streets squares and

avenues on it such as smokers square or self-esteem high street. This was a course that ran for 8 weeks and looked at health promotion, helpful hints and tips, smoking cessation, and sign posting for all who attended.

We were told that there was a NICE guidance meeting which was held by the trust. A member of staff from each CLDT had been allocated to attend and bring back any relevant updates on guidance relevant to the service. On reviewing the team meeting minutes for the CLDTs we found that NICE guidance was a standard agenda item and was discussed.

During a speech and language therapist meeting at Halton team, the new standards for learning disability services were discussed as well as new local guidance on malnutrition. NICE guidance was a standard agenda for discussion at St Helens and Knowsley team meetings.

### Skilled staff to deliver care

There was a wide multi-disciplinary team across all CLDTs included speech and language therapist, occupational therapist, physiotherapists, psychologists and consultants. St Helens and Knowsley teams had community LD nurses integrated into the teams, however in the Halton team they had a community matron and community nurses who, although part of the learning disability pathways, were not employed by the trust but were part of other organisations.

Staff across all CLDTs had received training specific to their role. A learning disability training alliance had been developed to provide in house training for practitioners such as Makaton for beginners, autism awareness for practitioners and carers, eating and drinking skills and social stories. We found some staff had attended conferences relating to autism and received training in positive behaviour support.

From the information we received from the trust all staff currently in post had received corporate and local induction.

The supervision matrix included clinical supervision, line management supervision and personal development reviews in all areas. We saw that staff had received line management supervision in line with trust policy and clinical supervision in line with their professional requirements. Staff we spoke with said they were



# Are services effective?

Good 

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

supervised and the team leaders felt that supervision only didn't happen due to sickness or clinical emergencies. It was clear through discussions with all staff that supervision was prioritised.

There were reported to be 16 non-medical staff in Halton CLDT three of whom had not had an appraisal. Of the 29 non-medical staff in St Helens CLDT, 13 had not had appraisals and nine non-medical staff in Knowsley CLDT one have not had an appraisal as of June 2105.

Two medical staff had been reported to have been revalidated and a further two were due to be revalidated.

## Multi-disciplinary and inter-agency team work

Staff we spoke to reported learning disability nurses not being part of their team at Halton CLDT as a "problem", specifically around them having different policies, and some concerns they would not complete epilepsy plans and behavioural plans. This had previously caused difficulties. We were told that this has been escalated and there was on-going discussion with senior managers and the clinical commissioning groups to resolve this. However we were told that there were no reported incidences of where care had been affected by this.

A weekly allocation meeting occurred within each team. This looked at any referrals that had been received and allocated for assessment, waiting lists within each discipline, inter disciplinary referrals within the team, external referrals that were needed, the previous week's actions and any discharges. This ensured there was a good handover of information between the teams.

## Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Halton CLDT had no people who use the services subject to a community treatment order (CTO) but had 4 people subject to Ministry of Justice conditional discharge with restrictions. The responsible clinician told us that they reported to the Ministry of Justice every three months and the person's social supervisor oversaw care plans and risk assessments.

At St Helens and Knowsley we reviewed two care records for people who were subject to a CTO. We found that both people had had their rights under the Mental Health Act (MHA) explained to them. In one case, we saw evidence that a speech and language therapist had prepared an easy read document which explained the principles of the CTO.

There was evidence to show that the person understood the information about the CTO and used a scale of 6 faces to express how her mental health was. There was no one subject to a CTO in the Halton team.

From the information that we received from the trust we found that compliance figures for MHA training were :

- Halton team had 42%
- St Helens team had 73%
- Knowsley team had 44%

This is mandatory training and is below the trust's standard of compliance.

CTO paperwork was correctly completed and was up to date and stored correctly. However in one case we found that all the paper work required was not stored in the case file. We spoke to the MHA administrator who told us that all the paper work for the CTO and section 3 was in place and would ensure that this was placed in the case file, we saw later that this had been done

## Good practice in applying the Mental Capacity Act

That Halton team had 92% of the team trained in the Mental Capacity Act (MCA), St Helens 100% and Knowsley 67%. Only Knowsley team fell below the trust standard of compliance.

We reviewed 10 care records across the CLDTs and found five assessments of people's capacity or best interest decisions being made. We found that in two of the five assessments they made reference to the person not having capacity but this did not show the process or decision making that had led to the conclusion. However in the three other assessments, they were completed in full and showed clear decision making around a person's capacity and both the person and the person's carers had been engaged fully in this process.

We found other capacity assessments in Halton CLDT that had been completed which appeared to have been written in retrospect. These were assessment based around consent to physical health care interventions such as venepuncture. However these were not completed by Halton CLDT but by the community matron who is employed by another organisation and works jointly with Halton CLDT.

Staff we spoke with understood that there was a policy in place and confirmed that they had received training in the MCA. Staff spoke of using communication aids to help



# Are services effective?

Good 

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

determine capacity such as talking mats and electronic tablets. Staff knew that they should always assume the capacity of a person unless there was evidence to suggest otherwise.

# Are services caring?

Good 

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

## Our findings

### **Kindness, dignity, respect and support**

We spoke to eight people who use the services and seven carers. All spoke highly of the CLDTs stating “I can’t say enough good things about them”, “the doctor I see listens to me”. All thought the teams were helpful, respectful, and caring.

We observed staff speaking about people who use the services in a respectful and kind manner when in discussion with other professionals and also during home visits and clinics.

We saw evidence through our discussions with staff and reviewing the care records that staff understood the needs of the people who use their services and worked alongside them in their care.

### **The involvement of people in the care that they receive**

We reviewed the care records of 10 people who use the service. In six of the records there was evidence people had

participated in the development of their care plan. However the people and carers that we spoke with all said that they had had varying degrees of input into care plans or their health action plan, whether this was making corrections to the plan or being fully involved in the development of the care plan.

Information about advocacy services was displayed in the waiting areas of the services. People who use the services told us they had access to advocacy should they want it, and one person told us that they were a peer advocate.

One person who used the service told us they were part of a recruitment interview panel for the trust.

We were told by carers and people that use the service that they received a survey from the trust once a year and there were also opportunities at St Helens and Knowsley to participate in a ‘you said, we did’ session with the team leader. Some carers explained that they often gave feedback to the staff who visited. We saw that information the trust received from the friends and family test was communicated to the teams.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

From the information received from the trust and from discussion with team leaders we found there were no key performance indicators that require the teams to report referral to assessment times. There were on-going discussions with the CCGs for the boroughs about how these will be measured and will form part of the KPIs in the future.

We were told each service had inter-discipline waiting lists which were monitored by each discipline and also through discussion at team meetings. We also saw evidence that team managers reviewed all people on the waiting list over 10 weeks and a reason was provided for each. One of the reasons for people remaining on the waiting list for 10 weeks was that a person could be referred to another discipline: for example remained an open case to an OT but could be put on a physiotherapy waiting list.

The average waiting time from referral to first appointment for Halton CLDT was 40 days, Knowsley CLDT was 38 days and St Helens CLDT was 29 days. This was a snap shot which looked at people who were seen for the first time in the month of June 2015 and then calculating how many days from referral to seen date.

The teams had a duty or triage person who was able to take calls promptly from people who use the service, carers or other professionals. This included taking new referrals and responding in an adequate time frame. When urgent referrals were taken, people could be seen on the same day if needed.

From information received from the trust was a snap shot of cases open to the CLDTs in June 2015, Halton CLDT had 232 cases open which averaged at around 14 cases per staff member. St Helen and Knowsley due to the way in which the staffing establishment data has been reported the information on caseloads had to be combined to average out the case load.

St Helens had 236 cases open to them where Knowsley had 417 cases open which combined was a case load of 653, and an average case load per staff member of 17. However when we spoke to the staff in the CLDTs we found that the caseloads would vary dependant on experience and grade

of the staff member, the hours they worked, and the complexity of the person's needs they were working with, therefore consideration had been given to each staff members case load capacity.

### The facilities promote recovery, comfort, dignity and confidentiality

There was relevant information on all noticeboards across both sites. This included information on available carers' support and forums, how to make a complaint and information around physical health support and groups. Information was also available on the different disciplines and services offered by each team.

St Helens and Knowsley CLDT had a full range of rooms available for their use, this included treatment and clinical areas that were stocked well with all equipment required to examine people. We also observed that some of the rooms were used for groups such as the LAMP group, social skills group and managing your emotions.

Halton CLDT did not have as many facilities available to them, however as they did not have community nurses based within their team this facility was not required. Treatment rooms and clinical rooms were provided where the community nurses were based. Physical health equipment was available for the doctor to use doing their outpatient clinics.

Staff we spoke with said that they would always try to go out to see people in their own homes rather than them coming into the building as for some people that could be distressing.

### Meeting the needs of all people who use the service

We saw that both sites were accessible to people using wheelchairs. Halton site had a ramp to the main entrance, with a buzzer at the bottom of the ramp for people could request assistance if they needed. At St Helens and Knowsley site there was flat direct access into the main entrance.

There were noticeboards at entrances and waiting areas with leaflets and information in easy read and pictorial format. We did not see any information in other languages but we were told that there was easy access to translation services should this be needed.

# Are services responsive to people's needs?

Good 

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

## Listening to and learning from concerns and complaints

Halton and Knowsley CLDT had received no complaints in the last 12 months. St Helens CLDT had received two complaints and had one complaint upheld. None of these complaints had been referred to the parliamentary ombudsman as people were satisfied with the response from the trust.

Of the people and carers we spoke to only one person felt that they did not know how to complain, but said that they felt that they would be able to if they needed to. All other people who use the services and carers said they would feel confident in complaining should they need to, but "I don't have a reason to complain but I think they would listen if I did".

Staff we spoke with felt there were a low number of complaints. These were mainly informal complaints and related to interpersonal difficulties which were dealt with quickly and appropriately. Team managers were able to give us examples of how these issues were resolved and file notes were made to show outcomes from these discussions.

Staff said they felt that people who use the service and their carers were able to complain and two staff we spoke to stated they would encourage people to complain when they were unhappy about an aspect of their care or treatment. Staff also stated that they received feedback on complaints through team meetings. We reviewed the team meeting agenda and found that complaints were an agenda item for discussion.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

We saw the visions and the values of the trust were displayed in each of the teams and the trust values were also displayed as a splash screen on computers. We were told by team managers that the core values were linked in to staff appraisals

We found that St Helens and Knowsley team held a meeting on the 14 July 2015 which looked at the team objectives for the year and how these fed down from the trust objectives and in to staff appraisals.

Staff we spoke to said they were aware of the leadership and management structures in the immediate service. They were able to tell us the names of the senior managers up to operational manager level but were not aware of the last time they had visited the team.

### Good governance

We reviewed a set of local management business meeting minutes and the quality and risk management meeting minutes specifically for learning disabilities, which demonstrated how risks, quality and governance issues were monitored and actions taken.

We saw audits were regularly completed with action plans or recommended outcomes for consideration across all CLDTs. Some of these audits were trust wide audits that were repeated quarterly such as the hand hygiene audit, others were specific to the learning disability team such as the audit of the LD eligibility pathway.

Locally we saw in each CLDT that staff received mandatory training. However the electronic system that is used for E-learning does not always register when a staff member has completed a course which means data could be inaccurate. We saw team managers had systems in place to monitor staff's compliance and could tell us which staff this affected.

We reviewed compliance data for supervision and appraisals which showed that these were prioritised and undertaken regularly. Team managers felt that supervision was prioritised and staff we spoke to all said that line management and clinical supervision happened regularly.

We saw evidence in staff meetings that staff were informed of incidents from around the trust, complaints and lessons learned were also shared within the teams. We saw that information regarding patient safety alerts were discussed.

The CLDTs did not have any key performance indicators targets to meet, as these did not meet the needs of the service as they were very health driven and not learning disability focused. We were told that senior managers and the clinical leads for the service were in discussion with the CCGs to agree meaningful targets for CLDTs to achieve. We were informed these would be in place before the end of the year.

Team managers felt they had sufficient authority to complete their role and also enough administrative support to effectively deliver care.

### Leadership, morale and staff engagement

Staff we spoke with stated that they felt leadership and management locally was very good and supportive. Comments included, 'the team is well-led' and 'good supportive managers who are understanding of your role'. Staff felt they would be able to raise concerns and some gave examples of concerns they had raised with their managers. All felt that they were listened to and actions were taken.

Staff said they felt they worked within a good team that was 'a very supportive team', and 'a happy and supportive team', that it was 'a nice place to work' and 'the team is well organised'.

Staff told us they were aware of policies around whistleblowing and bullying and harassment and although they could not tell us what the policy said they knew that they could access the policy or take their concerns to their manager or the operational manager should they need to. All staff across the CLDTs had received training in bullying and harassment.

Staff were unable to tell us of a specific incident where they had to speak to carers or people who use the service to offer apologies or an explanation when something had gone wrong. However staff we spoke to were able to describe what duty of candour was and that it was about 'being honest when things go wrong' and 'being open'. We saw evidence that that duty of candour was discussed in team meetings.

# Are services well-led?

Good 

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

## **Commitment to quality improvement and innovation**

Pathways of care had been developed for people who received care or were referred to the learning disability services at the trust. We were told that these care pathways had been developed from the National Institute for Health and Care Excellence guidance and other best practice guidance.

To support the further development of the pathways and take into consideration national guidance, the service had undertaken several research and audit projects. These included the learning disability eligibility pathway audit, the deployment of the multi-disciplinary initial assessment tool across learning disability services and an eye movement desensitisation and reprocessing treatment for post-traumatic stress disorder and intellectual disability case study.