Good

Sheffield Health and Social Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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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)
TAHXK	Fulwood House	Community Intensive Support Service	S4 7BW
TAHXK	Fulwood House	Community Learning Disability Team	S3 8NW

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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.

Summary of findings

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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 disability or autism as good because:

- Clients told us that they felt involved in their care and decisions made about their care and if they wanted a copy of their care plan they received one.
- Clients told us that staff were interested in their well-being and reported that they were happy with the services that they received from teams. Clients told us that staff were polite, respectful and caring.
- We observed staff interactions with clients and their carers. We saw that staff explained to clients the purpose of their visit.
- Incidents were reported by staff and were handled appropriately. After each incident staff and clients were debriefed and a review of the detailed risk assessment and management plan took place.
- The environments were accessible to clients who had difficulty with their mobility. Staff mostly saw clients in their own homes or other community venues.
- Staff understood the lone working policy and everyone understood their responsibility to stay safe.
- Staff completed assessments focussed on the involvement and intervention that the client required. They reflected the individual need of the client. Psychological therapies were available including cognitive behavioural therapy, dialectical behaviour therapy, and acceptance and commitment therapy.
- The teams had developed pathways to other services, for example to employment, housing and palliative care to enable them to access the most appropriate services. Where more specific knowledge was required, staff signposted clients to other organisations that were more appropriate to advise and support.
- Staff attended a number of meetings some monthly and some bi-monthly. These meetings allowed for the managers of the community teams to look at the service they were providing and the quality of the service. Professional meetings take place on a weekly basis at team level and a monthly basis at service level to allow for the development of various professions.
- Staff reported they did not feel bullied or pressured in their role and they felt confident about taking any concerns, complaints or safeguarding to their line manager in order to keep clients safe.

However:

- The recording of mental capacity assessments was inconsistent, and did not always follow the Mental Capacity Act Code of Practice. Staff understanding about the Mental Capacity Act was varied and the Act was not always discussed by staff making plans for clients care.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Incidents were reported by staff and were handled appropriately. After each incident staff and clients were debriefed and a review of the detailed risk assessment and management plan took place.
- There were good cleaning and infection control procedures in place. Cleaning regularly took place and all team offices were clean and tidy.
- The environments were accessible to clients who had difficulty with their mobility. Staff mostly saw clients in their own homes or other community venues.
- Staff diaries were managed to help cover for vacancies and sickness. Mandatory training was above the level expected by the trust.
- Staff understood the lone working policy and everyone understood their responsibility to stay safe.

Are services effective?

Good

We rated effective as good because:

- The teams completed assessments focussed on the involvement and intervention that the client required. They reflected the individual need of the client.
- The teams included clinical psychologists and psychological therapies were provided to clients which included cognitive behavioural therapy, dialectical behaviour therapy and acceptance and commitment therapy.
- Information needed to deliver care was stored securely. An electronic client record system was in place across the teams that we visited. Staff had the use of a tablet, this enabled them to access and complete records when they were away from the office.
- The teams had developed pathways to other services for example to employment, housing and palliative care to enable them to access the most appropriate services. Where more specific knowledge was required, teams signposted to other organisations that were more appropriate to advice and support.

However

- The recording of mental capacity assessments was inconsistent, and did not always follow the Mental Capacity Act

Summary of findings

Code of Practice. Staff understanding about the Mental Capacity Act was varied and the Act was not always discussed by staff making plans for clients care such as in referral and allocation or multidisciplinary meetings.

Are services caring?

Good

We rated caring as good because:

- Clients told us that staff were interested in their well-being and reported that they were happy with the services that they received from teams.
- We observed staff interactions with clients and their carers. We saw that staff explained to clients the purpose of their visit.
- Clients told us that staff were polite, respectful and caring.
- Staff respected clients' confidentiality.
- Clients told us that they felt involved in their care and decisions made about their care and if they wanted a copy of their care plan, they were given a copy.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Referral to initial assessment waiting times were below 18 weeks for both of the community based mental health services for learning disability or autism. The initial assessment to onset of treatment waiting times was also below 18 weeks.
- The community learning disability team had introduced a weekly multi disciplinary clinical allocation and review meeting. This meeting was attended by the specialist leads including but not exclusive to psychology, occupational therapy and the psychiatrist.
- Clients could be seen at a venue of their choice for any of their appointments.
- Information was available in formats clients could understand.
- The service was working to access hard to reach clients.
- Clients were asked about their experience of the service.

However:

- Staff did not use advance directives or emergency care planning tools, to support clients and their families during a crisis. Two carers we spoke with told us about difficulties they had in accessing support quickly in a crisis.

Summary of findings

Are services well-led?

Good

We rated well-led as good because:

- Staff told us their priority was to provide personalised care to clients in order for them to live in the community.
- Staff attended a number of meetings, some monthly and some bi-monthly. These meetings allowed for the managers of the community teams to look at the service they were providing and the quality of the service. Professional meetings took place bi-monthly and these allowed for the development of the various professions.
- Staff reported they did not feel bullied or pressured in their role and they felt confident about taking any concerns, complaints or safeguarding issues to their line manager in order to keep clients safe.
- Staff were committed to improving the service and reviewed, at regular intervals, how they might improve their service.

Summary of findings

Information about the service

The community learning disability team provides specialist health assessments, interventions and care for people with learning disabilities. It also has a role in developing capacity in trust services and supporting people with learning disabilities to access primary and secondary healthcare.

The community intensive support service is a multi-disciplinary team who provide a community service offering intensive support and rapid response for service users with complex needs who are presenting with severe risk.

The community learning disability teams were last inspected on 24 October 2014, they were not rated at this inspection, however actions were identified that the trust was required to take to ensure the service complied with minimum standards. The trust provided us with an updated action plan on 13 August 2016 outlining the actions taken to make the necessary improvements, these were:

1. The provider should ensure there is a long-term strategy to manage staff sickness and impact on workload and waiting lists. They now have a joint programme with the human resources department that ensures plans are in place to support staff experiencing difficulties with health and sickness issues. Procedures and team practices have been revised since the autumn of 2014 and effective systems for monitoring workload management issues are now in place. Caseload activity is monitored on a weekly basis through the clinical allocation and review meeting and activity meeting.
2. The provider should ensure basic and detailed risk assessments are easily accessible to staff to ensure risks are always known. They now have clear, established and consistent processes in place for clients on the community learning disability teams' caseload. The trust told us that a pilot was undertaken in February 2015 to support improvement in how the directorate gathers and records information regarding client risks as part of the assessment and referral process. Following the conclusion and evaluation of the pilot, standard protocols were developed and implemented to ensure information about client risk is clearly documented.
3. The provider should ensure mandatory training is up to date for all staff. The trust provided clinical risk update training (refresher) and eLearning for the Mental Capacity Act during May and June 2015. Refresher training in the use of the insight clinical records system is provided to staff on a regular basis. Arrangements to monitor and act upon rates of training compliance have been reviewed to ensure all staff are aware of their responsibilities individually and at the service level. This is reviewed as part of supervision and annual performance development review meetings.
4. The provider should ensure there is a long-term strategy for the management of new referrals. The trust has revised procedures and team practices and effective systems for referral and waiting list management are now in place. The revised arrangements define standard operating protocols for referral management supported by performance data and team governance arrangements.Monitoring reports provide oversight of waiting list updates, caseload updates and performance management statistics for the community learning disability teams. There is also a human resources pilot in place to support complex case management.
5. Due to the reconfiguration of the learning disability service and newly appointed interim managers in place, we found they did not have full oversight of issues we found in relation to this team. Clinical leads were managing their own waiting lists and management did not have full insight or oversight of this. The service line management arrangements have been reviewed by the head of service and clinical director and the appropriate leadership structures will be confirmed. It has been agreed that they will recruit band 'eight A' senior nursing staff for the community learning disability teams.

Summary of findings

Our inspection team

Our Inspection team was led by :

Chair: Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust

Head of Hospital Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jennifer Jones, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised of a Care Quality Commission inspector and a physiotherapist, a psychologist, a nurse and an expert by experience that was a user of services. One of the specialists was a learning disability and autism advisor with special interest in the Mental Capacity Act, Deprivation of Liberty safeguards and the issue of consent.

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from clients through questionnaires

During the inspection visit, the inspection team:

- visited both community offices
- spoke with eight clients who were using the service
- spoke with the manager
- spoke with 24 other staff members; including doctors, nurses and social workers (who were employed by the local authority)
- observed six home visits with staff
- attended and observed one clinical allocation and review meeting and two clinical sessions.

We also:

- collected feedback from 32 clients using comment cards
- looked at 24 treatment records of clients
- 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 received information from 32 comment cards and eight clients about the service.

Clients told us the community services were good and that staff listened to them when they were unhappy. They told us the staff were 'brilliant' and helped them to achieve their goals. Their carers told us that staff had helped them through their experience of services. However two carers raised concerns about access to support in a crisis or emergency situation.

Clients told us they felt involved in care planning and listened to what they wanted and helped them achieve that. They knew how to make a complaint and found staff to be courteous and friendly.

Summary of findings

Good practice

The introduction of the four week appointment system alongside the clinical assessment and review meeting each week had enabled the trust to clear their waiting lists and ensure staff were properly deployed.

The posture management assessment clinic had allowed staff to work long term with clients to enable them to have good outcomes with their posture.

The speech and language team had won a Care Coordination Award for innovation from the Care Coordination Association for a project called “Improving service user care through effective learning and development” in October 2016. They worked with a private provider to ensure they could manage clients who had dysphasia in a way that treated the client with dignity and ensured they were safe.

The service had implemented new pathways including rapid response and dementia. Staff were encouraged to identify and develop pathways for staff to follow that would improve the service for clients.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the recording of mental capacity assessments is consistent, and in line with the Mental Capacity Act Code of Practice. Where a best interest discussion takes place when a client lacks capacity to make a specific decision, this should be recorded appropriately.

  The trust should ensure that regard to the Mental Capacity Act is embedded in day to day practice such as in discussion in professionals meetings. Staff should be able to evidence such discussion. Staff should have a consistent level of understanding of how the Act applies to their own role.

- The trust should ensure that clients have an advanced statement or emergency plan in place so carers know what to do in the case of an emergency or crisis to ensure clients have their needs met in a way that helps them and in a way they have chosen.

Sheffield Health and Social Care 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
Community Intensive Support Service	Fulwood House
Community Learning Disability Team	Fulwood House

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.

The Mental Health Act was part of the mandatory training for staff and 100% of staff who required this training had received it.

Staff told us that they did not regularly work with clients subject to the Mental Health Act by guardianship or community treatment orders. Advice was provided by the Mental Health Act office at the trust.

Community learning disability teams used the care programme approach when working with clients who had a mental health need that impacted on their physical, psychological, emotional and/or social needs. This was in line with the Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act was part of the mandatory training for staff and 100% of staff had completed this training. The

community learning disability teams also required level two training in the Mental Capacity Act and evidence from the trust showed that 100% completion had been achieved.

We observed staff with clients, and each time they considered a client's capacity and discussions took place to determine whether a best interest meeting was necessary.

However the recording of capacity was inconsistent between staff groups because staff did not always complete capacity assessments thoroughly, and recorded capacity in different areas of the computer system. For example six of seven records reviewed contained an incomplete two-stage capacity assessment which was not completed in line with the Mental Capacity Act Code of Practice.

Staff understanding of the Act was variable. We spoke with 21 staff employed by the trust and five of them had a limited understanding of the Act and how it was monitored. We observed multi-disciplinary meetings where staff discussed clients and their care needs but did not discuss the Act in reference to these clients. Because these clients had additional needs such as a learning disability, there was an indication that they may require support to make specific decisions but it was not clear that this was always fully considered.

Good

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

We visited two community teams one was based at Love Street and the other at Firshill Rise. The environments were accessible to clients who had difficulty with their mobility.

Staff from the community teams mostly saw clients in their own homes or other community venues. Consultations and meetings could take place at both locations but meetings were organised for the benefit of the client and took place at their preferred location. Interview rooms were not fitted with an alarm system, however staff told us they had access to mobile alarms.

The team at Firshill Rise had access to a clinic room, which was shared with a ward. It was equipped with weighing scales and an examination couch. Hand washing facilities were available along with instructions about appropriate hand washing techniques. Staff did not routinely complete physical health examinations. They encouraged clients to attend their own GPs for physical health checks and any monitoring tests that needed to be carried out to monitor the effects of medication prescribed for their mental health needs.

Both environments were clean and well maintained. Furniture and flooring was in a good state of repair. We saw that regular maintenance was carried out at both sites.

There were good cleaning and infection control procedures in place. Cleaning regularly took place and all teams' offices were clean and tidy. We saw cleaning being completed during our inspection and we saw colour coded equipment for specific use to prevent cross infection. There were also designated bins for different types of waste.

Safe staffing

We looked at the staffing establishment across both teams. Managers told us that staffing and skill mix for the teams was constantly under review. This was to ensure the most appropriate service could be provided. When a role became vacant it was assessed to see if there was a continued need for that role or if there was another way the service could be provided. An example of this was the psychiatry support. There was one consultant psychiatrist and three specialist nurse practitioners. This meant that the psychiatrist could concentrate on assessing all new referrals and then signposting clients to appropriate support. The specialist nurse practitioners had all received training to enhance their skills as mental health nurses.

Information supplied by the trust for the period 1 May 2016 to 31 July 2016 showed that for the community intensive support service there was 1 whole time equivalent vacancy for a qualified nurse. In the community learning disability team, there were 4 whole time equivalent vacancies for qualified staff and two whole time equivalent vacancies for clinical assistants.

The community intensive support service had a sickness level of 15%, which was above the trust average of 5%, whilst the sickness level for the community learning disability team was 2%. These figures were taken over the twelve-month period up to 31 July 2016. Managers of both services told us staff had been on long-term sick leave, this was around personal issues rather than work issues. We looked at staff sickness records and found that the trust was responsive to the needs of staff and had implemented reasonable adjustments that allowed staff to return to work whilst making sure they stayed well.

The service had continued to manage the referrals through staff sickness as they had implemented a four week planned diary appointment system, coupled with an expectation that a percentage of staff work would be face to face. The percentage was dependent on hours worked and speciality offered. We observed a clinical allocation and review meeting and managers were able to see staff diaries for the preceding four weeks and they booked in appointments for clients who they assessed as being the most critical. Staff carried a case load determined by hours worked and speciality offered. All of the staff we spoke with felt the system worked and they did not feel overloaded.

Both teams we visited said there was appropriate medical cover when the psychiatrist was working. They were accessible to clients, carers and staff and responded promptly to any calls or messages for help. However, staff told us that when the psychiatrist was not on duty they had to rely on doctors who did not always have experience in

Good

Are services safe?

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

learning disabilities. They felt this compromised what they considered an excellent service. The trust crisis team provided support out of hours; again, staff felt this disadvantaged their clients.

We had a discussion with the psychiatrist about their workload and they told us they were busy but it did not feel like they could not manage their workload. They told us that once they had done the initial assessment they could determine the best way forward for the client and this did not always include seeing them. The psychiatrist worked closely with, and supervised, the specialist nurse practitioners that worked as part of their team.

The trust set out mandatory training requirements for all staff. Information provided by the trust showed that as at 13 October 2016, the training compliance for community mental health services for people with learning disabilities or autism was 85% which exceeded the trust target of 75%.

Assessing and managing risk to patients and staff

Teams assessed risk to clients and staff promptly. We looked at 24 care records and each record contained a detailed risk assessment and management plan. Allocations were dealt with through the clinical allocation and review, referrals were triaged through guidance provided by the trust and relevant to the specialism required. An example of this was a referral to the speech and language therapy department for clients suffering from dysphagia; this is where a client is at a high risk of choking. A referral received for this service would be seen within 48 hours from receipt of the referral.

The community learning disability teams had not recorded any use of restraint with clients. However, in order to ensure the use of restraint with clients in any setting was reviewed and monitored, the team recorded any restraint used. This was done via an 'alternative to restraint' referral which were discussed weekly at the referral and allocations meeting.

The trust had not reported any safeguarding incidents to the Care Quality Commission regarding community mental health services for people with learning disabilities or autism between 1 March 2016 and 31 August 2016. They had raised three safeguarding concerns internally. Staff training in the safeguarding of vulnerable adults and children was mandatory and over 85% of staff had completed this training. We spoke with 24 staff and they described to us different types of abuse and what their response would be.

During our inspection, we did not see the use of advanced statements or emergency care plans. An advanced statement is where a client has identified how they want staff to deal with them when they are unwell. This means interventions would be carried out in line with the client's wishes. We spoke with two carers who told us that they had difficulty accessing emergency care in the time of a crisis.

The community teams had systems in place to be able to respond to changing situations. Both teams operated a duty system and it was the responsibility of the duty worker to respond to emergencies. Staff told us that if the duty worker was busy other members of the team would support them. This included completing urgent home visits. Any changes in a client's situation led to a new referral going to the clinical allocation and review meeting and were discussed in a multi disciplinary forum.

The trust had a lone working policy in place. Staff in the community teams had customised it to suit their needs. This meant they had a special sentence, they would use this sentence if they felt they were at risk. Staff could access each other's diaries and their planned visits were diarised. The business support manager told us what would happen if staff ever rang in and quoted the sentence, other staff knew what to do if they felt at risk or if a colleague rang in. If someone did not return when they were expected or call to say they would be late then the lone working procedure would be implemented. All community staff had a mobile phone and they were expected to carry these at all times. Where clear risks had been identified, visits were carried out in pairs.

Track record on safety

The trust has a responsibility to report incidents and accidents. The community mental health services for people with learning disabilities or autism reported no serious incidents between 1 April 2015 and 31 March 2016.

Reporting incidents and learning from when things go wrong

A web based form allowed staff to complete an incident or accident form. During the inspection, we spoke to 24 staff. They all had access to the web based form and could describe what incident they would report.

Good

Are services safe?

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We looked at incidents reported and found there were a range of incidents recorded. Some of the incidents reported were missed appointments, medication errors and possible safeguarding events.

Staff told us if there was an incident they would apologise and be open and transparent about what had happened and why. They referred to the duty of candour policy. On occasions where an incident was more serious this would be independently investigated. Clients were sent a letter of apology when necessary and an explanation of what happened. The team received feedback in their multidisciplinary meeting. No one could tell us how lessons learned for the rest of the trust were fed down to them.

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

During our inspection we visited two community learning disability teams. We reviewed 24 care and treatment records. We found that assessments were recorded for all clients.

Community learning disability teams completed assessments focussed on the involvement and intervention that the client required. Different disciplines in the team completed assessments to reflect the need of the client. For example, low mobility, dysphagia (which presents a risk of choking) and challenging behaviours. Assessments reflected the individual need of the client. The care programme approach was used and each need identified had a plan. This plan was reviewed after each intervention.

Community learning disability teams had developed pathways to other services, for example to employment, housing and palliative care to enable them to access the most appropriate services for clients. The Community Intensive Support Service had developed a pathway of working with clients placed out of area in secure hospitals. The purpose of this was to ensure attendance at reviews and assessment to focus on them returning to their local area in a planned way whilst moniroting the clients' care and treatment. In addition to this, the community teams had taken responsibility for on-going care and treatment reviews. In line with the transforming care agenda, this review process is designed to work in a person centred way with clients in long stay hospitals to support timely discharge. At the time of inspection the team had worked with clients and their families to discharge 24 clients from long stay hospitals.

The service has also reviewed its pathway for clients with autism. The team met on a monthly basis with an allocated representative from each part of the multi disciplinary team. The purpose of this meeting was to ensure care was co-ordinated for the clients and that assessments were completed a timely manner meeting with national guidelines.

Information needed to deliver care was stored securely. An electronic client record system was in place across the teams that we visited. Access to the electronic client record system was secure. Staff required a user account with password access. All staff had access to the electronic client record system. Staff had the use of a tablet that was linked to their calendar in the office and the electronic records system. This enabled staff to access and complete records when they were away from the office.

We reviewed care records with staff present. We found there were inconsistencies in how different staff used the client record system to record and store information. This included where information was uploaded to on electronic client records. We found that all electronic client files differed because staff uploaded information into different places. This meant that there was a risk that staff could not find information they needed to support clients. However we did not see that this had caused any incidents.

Mental capacity assessments were either not recorded or saved in different places. To counter this the trust had developed an electronic mental capacity assessment form for staff to use. This was not being used in the community learning disability teams at the time of our visit as it was scheduled for use by the teams in March 2017.

Other teams had real time access to information recorded on the electronic records. This included crisis teams and inclient wards that may need information to deliver care outside of operating hours.

Best practice in treatment and care

Community mental health services for people with a learning disability or autism had participated in eight specific audits for the services. These included:

- Physical health monitoring in clients prescribed Clozapine
- Prescribing observatory for mental health
- Use of anti-psychotic medication in people with learning disabilities
- An audit of Alternatives to Restraint referral outcomes within Sheffield Health & Social Care Provider Services.
- Dysphagia – respite (dysphagia is a difficulty in swallowing)

There were a range of psychological therapies recommended by National Institute for Health and Care Excellence available. Community learning disability teams that we visited had clinical psychologists and psychological

Are services effective?

Good

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therapies were provided to clients. Psychological therapies available included cognitive behavioural therapy, dialectical behaviour therapy, and acceptance and commitment therapy.

The teams we visited provided some support with housing and benefits. Where more specific knowledge was required teams worked with and signposted to other organisations that were more appropriate to advise and support. The manager of the community learning disability team told us that in December 2016 they were hoping to employ two workers who would help clients to get in to employment, called 'building better opportunities workers'. This was in partnership with the local council.

Teams considered the physical health care needs of clients. Teams did not carry out physical health checks at their team bases. Teams arranged for clients to access clinics for monitoring of clozapine, lithium and/or high dose anti-psychotic therapy. Clients accessed services at GP surgeries in the community. A member of the nursing team took a lead role in liaising with GP practices to ensure that clients requiring additional support due to their enhanced level of need were able to access this such as annual health checks, health action plans and hospital passports. The team had also been involved in the 'big health event' in Sheffield to highlight health awareness with learning disabled adults and their carers.

Teams used a variety of clinician and client rated outcome measures to measure the effectiveness of care and treatment provided to clients. Allied health professionals used a Therapy Outcome Measures tool. This was a clinician rated outcome tool. Psychologists used client rated outcome measures which included the Clinician Outcomes in Routine Evaluation Learning Disability and Goal Attainment Scoring to measure the effectiveness of interventions. Teams also used the challenging behaviour interview in the assessment of severity of challenging behaviour and the health of the nation outcome scale (learning disabilities) to measure health and social functioning.

Skilled staff to deliver care

The staff working in the teams came from a variety of different professional backgrounds. Teams comprised of a consultant psychiatrist, psychologists, specialist nurse practitioners, community team managers, learning disability nurses, occupational therapists, physiotherapists, dieticians, speech and language therapists and administrative staff. Teams worked together to share experience and support.

Staff told us that they felt supported by their teams and could ask their colleagues including the consultant psychiatrist for advice and support when needed.

The trust had an induction process, which included training courses and a local onsite induction to the teams. Induction training met with the Care Certificate standards for care. Staff had access to their own training record on the electronic training system that the trust used

Staff performance was measured through the appraisal process. The appraisal rate for non-medical staff for community mental health services for people with learning disability or autism was 88% at the time of inspection. This was higher than the average score for the trust at 86%. Community intensive support services achieved 100% of staff having completed appraisals. The trust's compliance rate for appraisal of medical staff was 95%. As of 31 July 2016, no data was provided for the appraisal rates for medical staff within community based mental health services for people with learning disabilities and autism.

Managers told us that specialist training was acquired where there was a need. Managers told us that poor staff performance was managed through the trust's policies.

Multi-disciplinary and inter-agency team work

Regular and effective multidisciplinary meetings took place. These involved all members of the multidisciplinary teams. Teams met at least once a week and all staff ensured that they attended team meetings. During our visit, we observed a multidisciplinary meeting.

We attended sessions with clients, their carers and health professionals where their progress and plans for the future were discussed.

The community learning disability team was situated in the same office as the local authority learning disability team. There were close working links and staff from the local authority told us that because of their proximity to the health team there was a lot of low level inter agency working. This meant that staff would discuss issues and situations between themselves to determine the best course of action. This was done in such a way that maintained the confidentiality of the clients.

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.

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

As part of our inspection, we reviewed adherence to the Mental Health Act and the Mental Health Act Code of Practice. The trust set Mental Health Act training as a mandatory training requirement for all staff. Information provided by the trust showed that staff had completed the Mental Health Act training.

Information provided by the trust showed that there were no clients subject to community treatment orders receiving treatments from the teams that we visited during our inspection. Staff told us that they did not regularly work with clients subject to the Mental Health Act by guardianship or community treatment orders. Staff confirmed they could speak to their managers, colleagues and consultant psychiatrists for advice around the Act. Staff also told us they could contact the Mental Health Act office at the trust for advice.

Community learning disability teams used the care programme approach when working with clients who had a mental health need that impacted on their physical, psychological, emotional and/or social needs. The Mental Health Act Code of Practice states that the care programme approach should be used to plan, deliver and co-ordinate clients' care for those who have complex mental health needs. We reviewed 24 care and treatment records and we found evidence that there was appropriate use of the care programme approach used by teams.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act is a piece of legislation that maximises an individual's potential to make informed decisions wherever possible and provides processes and guidance to follow where someone is unable to make decisions. As part of our inspection, we looked at the application of the Mental Capacity Act.

Training in the Mental Capacity Act level one was a mandatory requirement for all staff. We reviewed information relating to staff training records and found that overall, 100% of staff across the teams that we visited had completed training in level one Mental Capacity Act and Deprivation of Liberty Safeguards. The community learning disability team also required level two training in the Mental Capacity Act and information provided by the trust showed that all necessary staff had completed the training. During our inspection, we observed staff completing home visits to clients. At each visit there was consideration of a client's capacity and we observed a discussion with staff about the need for a best interest meeting.

We reviewed seven care records where we specifically looked at the details recorded in relation to the assessment of the clients' capacity. We saw that staff were completing capacity assessments for specific decisions. However we found that these assessments were not always completed fully following a two-stage assessment of capacity. Of the seven records we reviewed, six had not been thoroughly completed, by ensuring best interests discussions were undertaken when a client was deemed to lack capacity for a specific decision.

We saw that the recording of capacity and completion of assessments was inconsistent between different members of staff. For example the physiotherapy team told us that they recorded capacity to consent to treatment in care notes and did not use a specific capacity assessment form. We spoke with nurses who told us that social care staff completed capacity assessments.

Staff knowledge about the application of the Act in relation to the clients they worked with was varied. During our inspection we spoke with 21 staff employed by the trust and three social care staff employed by the local authority. Of the 21 trust staff we spoke with, five staff had limited understanding of the Act, for example they were not able to explain the principles of the Act or describe an 'unwise decision' or how the Act was monitored within the trust.

During the inspection we observed a multi disciplinary team meeting where several clients were discussed. The application of the Mental Capacity Act and clients' capacity was not discussed during this meeting. We also observed a referral and allocation meeting where the Act was not discussed by staff planning client care and support needs. The clients being discussed all had additional needs such as a learning disability and therefore may lack capacity to make specific decisions. It was not clear that staff gave full consideration to the Mental Capacity Act in relation to each client within discussions of their care plans.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

The feedback that we received from clients and their carers about the way staff treated clients was positive. During our inspection, we spoke with eight clients and 12 carers. Clients told us that staff were polite, respectful and caring. One client told us that they thought the community learning disability team that worked with them was "fantastic". Clients told us that staff were interested in their well-being and reported that they were happy with the services that they received from teams. Clients told us that they had good relationships with staff and they told staff about any concerns or issues that they had. Clients said that staff supported them to make things in their lives better. One carer told us over the last 2 years 'I and my family have had good support from psychology and my social worker. It couldn't have been better'. Other carers told us that the service was good and they worked to help clients achieve their goals.

Staff delivered compassionate care and understood clients' needs and feelings. We observed staff interactions with clients and their carers. We saw that staff explained to clients the purpose of their visit. On an initial visit, staff explained the service to clients and their carers.

Communication with clients was clear and individualised. Staff used open questions and simple language that clients understood. Staff gave clients time to respond and provided appropriate levels of verbal prompting to support clients. We observed that staff had a warm approach and a good rapport with clients. It was clear that staff knew individual clients well. During our observations we saw that staff considered clients' feelings and regularly asked if they were okay. At the end of visits, staff summarised their visit to clients and asked them and their carers if they had any questions. Staff involved carers in discussions and showed empathy and understanding of their concerns and views.

Staff respected clients' confidentiality. They ensured that meetings were held in a private room or at a location away from their home address, this ensured discussions could not be overheard by others.

The involvement of people in the care that they receive

Clients told us that they felt involved in their care and decisions made about their care. Clients that wanted a copy of their care plan told us that they had received one. Records that we reviewed showed that client views were taken into account when planning care. One client told us 'I am getting lots of support and people are listening to me and my mum about what is best for me'. We found that care plans contained interventions aimed at maximising clients' independence, health and well-being. For example, care plans were in place regarding safe eating and drinking following speech and language assessments of dysphagia. Dysphagia is the difficulty or discomfort in swallowing when eating and drinking. These outlined safe food and drink options. We saw that care plans were written in basic language, which clients could understand.

Both personal and professional carers told us that staff involved them; they were invited and included in attending visits and appointments. Teams invited carers to attend multidisciplinary meetings to discuss client care and treatment. Carers told us that teams were flexible and would change meetings to a suitable time and day so they could attend outside of their caring and personal commitments. Carers told us that staff provided them with information that they needed and all carers told us that they received copies of care plans. Staff spoke to carers regularly about how they were coping, and gave practical advice for client care and signposted to other organisations.

Clients had the opportunity to give feedback on the care that they received. Most clients and their carers told us that they received stakeholder surveys in an accessible, easy to read format. Clients could feedback about the care that they received by completing these surveys. Carers told us that they supported clients to complete feedback and send this back. Carers told us that they would speak to staff or the team manager to raise a concern or give a compliment.

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

Referral to initial assessment waiting times were below 18 weeks for both services in community based mental health services for learning disability or autism. The initial assessment to onset of treatment waiting times was also below 18 weeks. The intensive support service had a time of 46 days from referral to assessment and 48 days from assessment to treatment. The community learning disability team had a time of 50 days from referral to assessment and 25 days from assessment to treatment.

The community learning disability team had introduced a weekly multidisciplinary allocation meeting. This meeting was attended by the specialist leads including but not exclusive to psychology, occupational therapy and psychiatrist. At this meeting, the leads had access to diaries of staff and could book in appointments for the next four weeks. This allowed work to be allocated whilst not overloading the staff. Referrals were looked at holistically and appointments allocated on the assessed need. Clients were either booked an appointment or signposted to other resources including but not exclusive to; bereavement groups, health and sexual relationship support, older carers support, postural management and employment issues. The team also provided support to other providers and held a clinic in one large establishment every quarter. The result had been fewer re-admissions to inpatient wards because staff were getting the help and support they required at the same time as the clients. The service also provided advice and support to other providers, about alternative methods of restraint that could be used with clients. They also assessed the equipment used and the safety of the support planned and worked with providers to ensure clients were receiving care that was appropriate.

The community intensive support service was also working with service provider staff to support the implementation of positive behaviour support in care settings. The principle of this work is that it is an approach to reduce challenging behaviour in clients by supporting them and the staff working with them to change this behaviour by providing new strategies to deal with triggers. A reduction in these behaviours is positive for the client as it reduces their stress levels, increases quality of life and reduces admissions to long term care settings or secure hospitals.

The facilities promote recovery, comfort, dignity and confidentiality

Staff in the community learning disability team told us that there was adequate space to complete assessment and diagnosis. However, staff in the community intensive support service had limited space they could use for interviews and work with clients. The majority of their work was carried out in the community at clients' own homes. If a client could not or did not want to come to the office or use their own accommodation for a visit then alternative spaces would be found in the community, this could be a doctor's surgery or a day unit facility.

We found all interview rooms had adequate sound proofing to protect clients' confidentiality.

Accessible information was available for clients. Clients were provided with easy read format information for their care plans, information leaflets, customer stakeholder surveys and information about complaints procedures. Information was provided to carers in a pictorial format to show them how to manage equipment. Leaflets were available to inform staff and carers of any updates to equipment. The leaflet showed people what had changed and if equipment was faulty who to contact to get it replaced or repaired. It also included the contact details for the community learning disability team and the equipment and adaptations team at the local council.

Meeting the needs of all people who use the service

All locations that we visited could be accessed by clients who had issues with their mobility and all had disabled toilet facilities. Both community teams were based on the first floor of the building they occupied. At the location for the community intensive support team, clients could access the environment by use of a lift. The community learning disability team had access to office space on the ground floor so that clients could be seen on site if necessary.

Teams had access to interpreter and sign language services. Teams accessed this through the trust and the trust made arrangements for an interpreter or signer to assist.

The trust was developing a transition team to ensure clients supported by the children's mental health team

Are services responsive to people's needs?

Good

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

were able to access support from the adult team in a seamless way. One member of staff organised the information to be shared with adult services and they were discussed in multi disciplinary meetings.

The community team had a worker dedicated to working with the black and minority ethnic community. They helped to access communities with a different cultural and ethnic experience. The service had also reviewed their eligibility pathway to ensure they offered an equitable service to clients who used English as a second language, and were reviewing how they recorded and assessed ethnicity.

We saw evidence that clients had been referred to a service that specialised in sexual and/or gender issues when they had expressed issues around their sexuality, sexual orientation or gender identity. The nursing team also held a sexual education and relationship group, to support clients with sexuality and relationship understanding. In addition to this the team also provided group support in response to clients needing advice and information about healthy living, sex and relationships, breast awareness and bereavement.

The community team had used the 'five good communication standards' produced by the Royal College of Speech and Language Therapists to develop a tool for practice. This included a training package and a communication assessment rating tool to inform services on how to practically improve communication with clients to improve quality of life and care.

However, staff did not always use advance directives or emergency care planning tools, to support clients and their families during a crisis. Two carers we spoke with told us about difficulties they had in accessing support quickly in a crisis.

Listening to and learning from concerns and complaints

Community mental health services for people with learning disabilities or autism had no complaints between 1 September 2015 to 25 August 2016. The community learning disability team had received eight compliments in the same period.

We spoke with clients and their carers who used the service. Most clients and their carers said that they did not know the complaints process however, if they needed to complain they would speak to their worker or contact the team and ask how they could do this. Information was displayed by teams about how to make a complaint.

Staff had good knowledge about how to deal with complaints appropriately. Staff told us that they saw complaints as a way of improving the service and reflecting on how things were done to learn lessons for the future. Feedback from complaints was discussed in team meetings.

Feedback from clients was requested by teams through surveys. Teams sent out surveys to clients to ask them to provide feedback on the service. Carers told us that they supported clients to complete surveys and return them back to the teams.

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

The trust worked to a vision of providing high quality health and social care services; this was underlined by their stated purpose 'to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community'.

The values of the trust were:

- Respect
- Compassion
- Partnership
- Accountability
- Fairness
- Ambition

Staff awareness of the vision and values of the organisation was limited although all the staff told us their priority was to provide personalised care to the clients in order for them to live in the community.

Staff were respectful and treated clients with respect and compassion. Staff worked with external organisations and community organisations to ensure holistic assessments for the clients so that when they transferred to their home address or supported living environments the information did not just concentrate on their mental health needs.

Staff were positive about local managers and the senior managers from the learning disability directorate. The Chief Executive of the trust had worked a shift with physiotherapy staff. Staff were not aware of other members of the senior board and several staff told us the wrong name for the chair of the board. However, the trust informed us that the chair of the board had changed in July 2016 and drop in sessions were planned for staff to meet the chair. These had not taken place at the time of our inspection.

The trust provided counselling support for staff if they needed to access this and covered a variety of different options from couples counselling to post traumatic stress counselling. They also offered group work to look at how to manage stress at work. The trust had registered as a mindful employer.

Good governance

We saw that staff attended a number of meetings some monthly and some bi-monthly. These meetings allowed for the managers of the community teams to look at the service they were providing and the quality of the service. Professional meetings took place bi-monthly and these allowed for the development of the various professions.

The management of both teams had ensured staff were completing their mandatory training and receiving their supervision. Mandatory training was above the level required for the trust.

Learning from complaints and incidents was good at service level. The multidisciplinary team discussed incidents and looked at lessons learned. We did not see any evidence of lessons learnt from the wider trust at a team level The trust advised that safety alerts, serious incident briefs and sharing of information are emailed to staff. In addition to this there was a variety of clinical governance meetings on a bi-weekly and monthly basis where lessons learned from incidents, and complaints were discussed. However, the staff team were not aware of these.

Safeguarding procedures were in place and staff followed these. However, clients were not always receiving capacity assessments in line with the Mental Capacity Act Code of Practice. Staff did follow the Mental Health Act policy and procedure.

Leadership, morale and staff engagement

Both teams for community mental health services for people with learning disabilities or autism reached 60% compliance for clinical supervision between 31 July 2015 and 31 July 2016. This was 20 percent lower than the trust score of 80% for the same period. Teams for community mental health services for people with learning disabilities or autism did not have any staff suspended between 18 September 2014 and 27 September 2016.

We did not see any evidence that a staff survey specific for this service had been completed in the last 12 months. The survey staff were asked to complete was a trust wide survey, which the most recent results had not been published for at the time of our inspection. However, there had been several changes within the teams; these had been discussed with staff. Staff told us they felt that managers listened to them and felt supported.

Staff reported they did not feel bullied or pressured in their role and they felt confident about taking any concerns, complaints or safeguarding to their line manager in order to keep clients safe.

Are services well-led?

Good

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We saw that the physiotherapists within the service had been running events in July 2016 to work with staff teams on exercise demonstrations. They encouraged staff to take care of their own health needs and take time away from their desk to exercise. The aim was to reduce staff sickness by making staff aware of how to reduce risk and injuries happening at work.

Commitment to quality improvement and innovation

Staff used pictures to show how to work with individuals, this allowed for consistent practice and we saw consent was obtained to use them.

The posture management assessment clinic had allowed staff to work long term with clients to enable them to have good outcomes with their posture.

The speech and language team won a Care Coordination Award for innovation from the Care Coordination Association for a project called “Improving service user care through effective learning and development” in October 2016. They worked with a private provider to ensure they could manage clients who had dysphagia in a way that treated the client with dignity and ensured they were safe.

The service had implemented new pathways including rapid response and dementia. Staff were encouraged to identify and develop pathways for staff to follow that would improve the service for clients.