London Borough of Sutton

The Specialist Health Team for People with Learning Disabilities

Inspection report

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Date of inspection visit: 12 May 2021
Date of publication: 10/09/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

We undertook an announced inspection of the location called The Specialist Healthcare Team for People with Learning Disabilities. This location is registered to provide the regulated activity for 'treatment of disease, disorder, or injury' under the London Borough of Sutton provider. The Specialist Healthcare Team for People with Learning Disabilities is made up of two completely separate services; Sutton Health and Care 0-19 Children's Service and the Clinical Health Team for People with Learning Disabilities.

The provider is reviewing their registration as the registered name for this location does not accurately reflect the breadth of services provided. We will detail our findings separately under each service.

We only rated one service at this location; the Clinical Health Team for People with Learning Disabilities. This was because we carried out a focused inspection of Sutton Health and Care 0-19 Children's Service and only looked at two key questions. We cannot rate focused inspections when they have not been preceded by a comprehensive inspection. Sutton Health and Care 0-19 Children's Service had not been previously inspected at this location.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Inspected but not rated	**Sutton Health and Care 0-19 Children's Service** We did not rate this service as we only looked at two key questions and we had not previously rated the service for all five key questions. • The service had not submitted required notifications, for example any abuse or allegation of abuse in relation to a service user to the CQC, without delay. The service had not submitted any notifications to the CQC since the service opened in 2019. • The service did not have a robust staff training records system in place so managers could not track completion. • Lone working procedures were not robust. Staff told us that they had their own ways of ensuring their safety such as informally messaging colleagues via their mobile phone or telling a colleague when carrying out a home visit. The clinic rooms at Tweedale Children's Centre did not provide access to a panic alarm system and staff did not have access to a personal panic alarm that they could wear in the building or whilst working in the community. Following the inspection, the provider told us that they had plans in place to trial a personal panic alarm system and implement the devices by July 2021. • The service did not have robust plans in place to address the frequent occurrence of health visiting staff making initial contact with families who had experienced a miscarriage or child bereavement, despite the service being aware the issue had been ongoing for some years. This meant that there was an ongoing risk that expectant mothers and their families may be contacted by the team, leading to unnecessary distress, and upset that could have been avoided. • Incidents were not routinely discussed in team meetings. We reviewed samples of team meeting minutes from November 2020 to March

Summary of findings

2021 and were unable to find evidence that teams discussed learning from incidents. Some staff were not aware of any learning from incidents.

However:

- All families we spoke with were positive about the service. Families told us that they felt they had received a good service and the health visiting staff supported them. The service received positive feedback to their family survey in August 2020.
- The service had ensured that they had set up effective safeguarding systems to ensure that vulnerable children and their families were supported when the COVID-19 pandemic started. Staff worked hard to ensure children and families who were at risk were allocated to a health visitor.
- Staff ensured that they maintained a good standard of record keeping. Whilst we found a small number of gaps in patient records, mostly all records we reviewed provided important information relating to a child, young person, and their family. Safeguarding supervision records were comprehensive and of a high quality.
- Staff created new ways of sharing advice and support with families whilst the service were unable to offer face to face appointments and school nurses were unable to visits schools during the peak of the pandemic. The school nursing team had set up their own social media to reach young people.
- The service had a clear ambition for future ways of working. Senior leaders had a vision to become an integrated service and was in the initial stages of implementing an integrated model of care called 'Our Shared Children's Plan 2021-2023'. At the time of our inspection, the service was focused on supporting staff wellbeing and morale following a difficult year due to the COVID-19 pandemic.

Summary of findings

Community mental health services for people with a learning disability or autism

Requires Improvement

Clinical Health Team for People with Learning Disabilities

Our rating of the Clinical Health Team for People with Learning Disabilities went down. We rated it as requires improvement because:

- The service had not submitted required notifications, for example, any abuse or allegation of abuse in relation to a service user, to the CQC without delay. The service had not submitted any notifications to the CQC since the service opened.
- The service did not have a robust staff training records system in place so managers could not track completion.
- The service did not have a risk register or equivalent system for monitoring and mitigating risks to the service.
- The service did not collect feedback from patients in a timely manner; it did not systematically analyse the feedback it did collect.
- There was not a formal procedure in place for following up missed appointments.
- The service did not collect any data on team performance or have an audit system or similar in place.
- Service managers had limited oversight of patient care and treatment records and staff said they lacked guidance about where to store documents within the patient record system.
- The service did not have a robust system for screening or allocating referrals.
- The service did not have a robust system in place to share learning from incidents, complaints or concerns.

However:

- All relatives and care home staff we spoke with were positive about the service. They told us that they felt they had received a good service and that staff were kind and caring.
- Staff felt well supported by senior clinicians within their clinical teams.
- Staff worked well together in their clinical teams.
- The provider promoted diversity and inclusion.

Summary of findings

Contents

Summary of this inspection

Background to The Specialist Health Team for People with Learning Disabilities

At the start of the inspection there was no registered manager in place, although an application had been initiated shortly before the inspection took place. The last inspection of this service was on 23 May 2019 and we rated the service as good. At that time we only inspected the Clinical Health Team for People with Learning Disabilities.

Clinical Health Team for People with Learning Disabilities

The Clinical Health Team for People with Learning Disabilities is made up of staff from a range of health care professions. The team comprises community nurses, speech and language therapists, physiotherapists, clinical psychologists, behavioural analysts, music therapists and drama therapists.

The service provides support to people with learning disabilities with their health and well-being. The service provides this support to patients within their own homes, care homes or hospital. The service also works directly with professionals within GP practices, hospitals and care homes to support people with learning disabilities.

This service was inspected as the core service 'Community mental health services for people with a learning disability or autism' as this was the best fit in terms of CQC methodology.

Sutton Health and Care 0-19 Children's Service

The Sutton Health and Care 0-19 Children's Service provided by the London Borough of Sutton provides care and support to children and young people aged zero to 19 and their families. The team have experience in child development and promoting good health. Sutton Health and Care is made up of a partnership, including the GP Federation for Sutton, the London Borough of Sutton, South West London and St George's Mental Health Trust, and Epsom and St Helier NHS Trust. The service comprises four primary care network teams that cover Carshalton, Wallington, South Sutton and Cheam, and Central Sutton. The team includes a school nursing team, health visiting team and a specialist safeguarding team. The registered provider of the service is the London Borough of Sutton.

The delivery model for the health visiting team is based on the nationally mandated Healthy Child Programme and the teams have links to Children's Centres, GPs and Early Help services.

The service supports children and families in their homes, children's centres, clinics, health centres, GP premises and in schools.

We visited Tweedale Children's Centre, Amy Johnson Children's Centre and Green Oak Children's Centre (Cheam Resource Centre).

How we carried out this inspection

This inspection took place during the COVID-19 pandemic. To minimise the risk of infection to patients, staff and our inspection team, we adapted our approach. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures.

Clinical Health Team for People with Learning Disabilities

Summary of this inspection

We carried out a comprehensive inspection of this service to check it was safe, effective, caring, responsive to people's needs and well-led.

We visited the service on 12 May and 25 June 2021.

Our inspection team comprised of three CQC inspectors, a specialist professional advisor and one expert by experience. During this inspection we:

- toured the office base which included the reception area, administration offices and meeting rooms
- reviewed electronic records detailing the care and treatment of 16 patients
- completed a telephone interview with one patient
- completed telephone interviews with five relatives
- completed telephone interviews with three paid carers working in people's homes
- completed telephone interviews with one senior leader, two managers and 13 clinical staff members
- looked at a range of policies, procedures and documents related to the service.

Sutton Health and Care 0-19 Children's Service

We carried out a focused inspection of the 0-4 years part of the service to see if it was safe and well-led.

We visited the service on 12 May 2021.

Our inspection team comprised of three CQC inspectors and one expert by experience. During this inspection we:

- spoke with six families who had used the service
- spoke with 25 clinical staff members including health visitors, school nurses and nursery nurses
- spoke with five senior leaders of the service including the head of children's service and the service manager.
- reviewed electronic records detailing the care and treatment of 17 patients
- reviewed seven safeguarding supervision records
- attended four child development clinics and one breastfeeding clinic
- looked at a range of policies, procedures and documents related to the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action a service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Clinical Health Team for People with Learning Disabilities

Action the service MUST take to improve:

- The provider must ensure that staff have the relevant and up-to-date skills and training to provide safe care or treatment to service users, including safeguarding training. (Regulation 18 (2)(a))

Summary of this inspection

- The provider must have a robust system in place to monitor staff compliance with statutory, mandatory and other training appropriate to their roles. (Regulation 17(2))
- The provider must have systems and processes that enable them to identify, assess and mitigate risks to the delivery of safe and high-quality care. (Regulation 17(2))
- The provider must have a robust mechanism to collect and respond to regular feedback from service users, carers and other professionals involved in the service user's care, in order to improve the service. (Regulation 17(2))
- The provider must have processes in place to assess, monitor, evaluate and improve the team's performance and treatment outcomes. (Regulation 17(2))
- The provider must promptly inform CQC of all events and incidents that are notifiable under the regulations. (The Care Quality Commission (Registration) Regulations 2009; Regulation 16; 18)

Action the service SHOULD take to improve:

- The provider should consider how they can share any lessons learned from incidents, complaints, concerns and safeguarding, service-wide.
- The provider should ensure all managers can access, navigate and review service users' care and treatment records and staff know where to store them.
- The provider should consider implementing a 'missed appointments' procedure.
- The provider should consider whether its current arrangements for managing referrals are sufficiently robust.

Sutton Health and Care 0-19 Children's Service

Action the service MUST take to improve:

- The provider must ensure that there is a robust training system in place that provides clear oversight of staff completion rates. (Regulation 12 (1)(2)c)
- The provider must ensure that lone working processes in place are robust and staff adhere to those processes whilst working alone in the community. (Regulation 12(1)(2)b)
- The provider must ensure that there is a robust plan in place to improve communication with system partners so that health visiting staff are aware of families that have experienced a miscarriage or bereavement. (Regulation 17 (1)(2))
- The provider must promptly inform CQC of all events and incidents that are notifiable under the regulations. (The Care Quality Commission (Registration) Regulations 2009; Regulation 16; 18)

Action the service SHOULD take to improve:

- The provider should ensure that staff have access to the right level of safeguarding vulnerable adults training, to support them when working with vulnerable adults.
- The provider should ensure that patient records are kept up to date and include essential information.
- The provider should ensure that as part of the team meeting agenda staff discuss learning from incidents and that the meeting minutes are made available to those staff who were unable to attend.
- The provider should ensure that staff understand which provider they should refer to for policies and training.
- The provider should ensure that staff record when they have cleaned clinical areas and equipment.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Community mental health services for people with a learning disability or autism	Requires Improvement	Good	Good	Good	Inadequate	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Inadequate	Requires Improvement

Community health services fo children, young people and families

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Community health services for children, young people and families safe?

Inspected but not rated

Mandatory training

Whilst the Sutton Health and Care 0-19 Children's Service provided mandatory training in key skills to all staff, the system in place to record mandatory training was ineffective and made it difficult to maintain oversight of completion rates. At the time of inspection, the training records available did not follow the provider's mandatory training guidance and showed large gaps in training such as infection prevention and control, data protection and basic life support. The school nursing team and the health visiting team that covered Cheam and South Sutton had the least up to date training records available. This meant that the provider could not be assured that staff were receiving mandatory training, which increased the risk of staff not following the latest national guidance when carrying out clinical duties.

Safeguarding

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had access to a supportive safeguarding team who were always available during core working hours to respond to frontline colleagues needing advice. The specialist safeguarding team regularly communicated and attended meetings with other agencies and senior safeguarding practitioners actively participated within Multi Agency Risk Assessment Conferences (MARAC). A MARAC meeting is a forum where local agencies discuss individuals at high risk of harm and abuse. It is an opportunity to develop a joined-up safety plan. The named nurse for children's safeguarding told us there had been no serious case reviews involving the team within the past 12 months.

Health visiting staff who held a caseload regularly received safeguarding supervision. We reviewed seven safeguarding supervision records and found they were of high quality, comprehensive in detail and easy to follow. Safeguarding supervision rates were up to date.

The service had an effective system in place to maintain oversight of the number of safeguarding's allocated to each health visitor. At the time of our inspection, we found that all looked after children (LAC) and children with child protection plans were all allocated to a health visitor. The 0-19 team leaders reviewed the allocations on a weekly basis.

Staff received mandatory level three safeguarding vulnerable children training but had not received mandatory safeguarding vulnerable adults training. Although the provider ensured that safeguarding vulnerable children training included the needs of adults, the lack of formal adult safeguarding training meant that the provider could not be fully assured that staff were able to identify and respond to the needs of vulnerable adults. Following the inspection, the provider acknowledged the need for additional training and had requested for staff to complete level 2 safeguarding vulnerable adults training by end of June 2021.

Cleanliness, infection control and hygiene

The service controlled infection risk well and staff used protective equipment to protect themselves and patients during appointments. Whilst the children's centres we visited was visibly clean, health visiting staff did not formally record when they had sanitised clinical areas after their clinic appointments. Health visiting staff told us that there was an informal understanding between colleagues that after each appointment staff would clean the equipment and clinical space used. This meant that staff could not be completely assured that the area had been sufficiently cleaned and could increase the likelihood of spreading infections.

Environment and equipment

Whilst the design, maintenance and use of facilities, premises and equipment kept children, young people and their families safe, staff did not have access to a panic alarm system whilst working in clinical areas or when working alone in the community. Staff working within the clinic rooms at Tweedale Children's Centre did not have access to a panic alarm system and generally staff did not have access to a personal panic alarm that they could wear. The clinic rooms were located at the end of a quiet corridor. Staff we spoke with had their own ways of ensuring their safety such as telling a colleague when carrying out a home visit or messaging the team via their mobile phone. The lack of robust system put staff at risk of not being able to escalate a concern when working alone. Following the inspection, the provider told us that they had plans in place to trial a personal panic alarm system and implement a device by July 2021.

Assessing and responding to patient risk

Staff ensured that most patient records were clear and up to date. Overall, we found that individual records were comprehensive and staff explained their clinical rationale. Staff recorded the handover process when a child transferred out of the service. Out of 17 records reviewed we found that five records had some recording issues. For example, one record did not include height and weight of a baby, another record did not include the father's details and in another record staff had not ensured that the alert had been changed from vulnerable child to a child in need. The gaps in records increased the risk of other professionals not having access to all information that should be available to them.

Staff identified and quickly acted upon most children and young people at risk. The provider had a clear system in place for ensuring that children, young people and families were reviewed and allocated to a specific care pathway such as universal, universal plus or universal partnership plus dependent on the level of need or risk. Team leaders of the health visiting teams carried out a triage of the new births daily and reviewed the health visitor allocations list on a weekly basis.

Staffing

Whilst the Sutton Health and Care 0-19 Children's Service was experiencing a high health visiting vacancy rate, the service had staff with the right qualifications, skills and experience to deliver a good standard of care and treatment to children, young people and their families. At the time of our inspection, 20% of the health visiting workforce was not in post due to unfilled vacancies and maternity leave. The provider was well sighted on the staffing issues and had put multiple controls in place to fill the gap in the short-term such as; offering part-time contracts to retired staff, employing agency health visitors and developing a programme for recruiting band 5 community staff nurses.

The impact of the staffing issues meant that teams had to prioritise families at risk and were not able to offer routine face to face antenatal contact with expectant mothers at 28 weeks pregnant. Staff instead sent a text message to

antenatal mothers at 18 weeks pregnant providing them with information about the service and contact details of the team. At the time of our inspection, the service was making an antenatal video which will be shared with expectant mothers going forward. The provider told us that this offer will be reviewed in September 2021 based on staffing capacity.

Team leaders assessed the size of their team caseloads regularly and, where possible, helped staff to manage the size of their caseloads. The service used a 'corporate caseload' model for the families on a universal caseload. Universal families received mandated Healthy Child Programme (HCP) contacts up until a child was two and half years old. HCP is used by health visitors to assess and monitor the welfare and key stages of development in children, young people and families. This is a national public health programme, requiring staff to screen, immunise, and review the development of children at specific points in their lives. The programme allows staff to identify risk of harm, disorder, ill health, or need for additional support. Cases were allocated to be covered by the whole team, sharing responsibilities for families instead of being held by individual practitioners.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date, stored securely and easily available to all staff providing care. Across the 0-19 service staff had created 'team planners', which held important information about all children or young people on the caseload or who were awaiting allocation. The team planners were accessible to all team members including teams that sat outside of the 0-19 children's service such as speech and language therapy, dietetics, occupational therapy, and physiotherapy. The electronic patient record system required password access with a smartcard to ensure security. Staff members had unique accounts to ensure professional accountability. Staff we observed were careful with confidentiality.

Medicines

The service used systems and processes to safely manage medicines. Health visitors in the team were qualified to prescribe a limited range of medicines. This is because they had undertaken qualifications to become community practitioner nurse prescribers. Health visitors told us that they did not frequently prescribe for children and would refer most families to their own GP. In the cases where they did prescribe, health visiting staff told us that this was mainly creams. The team had a clear system and policy in place for managing prescription pads issued to non-medical prescribers. Staff were required to attend a designated site to sign for and collect a new prescription pad. Health visitors were required to show a form of identity on collection and provide a clear log of prescriptions used. Pharmacy staff reviewed these logs to ensure prescriptions were being used as intended. A system was in place to manage lost or stolen prescription pads and ensured that a community notification alert was sent to local pharmacies.

Incidents

The service did not always manage incidents well. Whilst staff were confident in recognising and reporting incidents, we found that incidents were not routinely discussed at team level and the provider had not addressed an ongoing issue that was frequently reported as an incident. We reviewed the providers incidents log and found that on ten separate occasions over the past 12 months staff regularly reported that they had made initial contact with a family without knowing they had experienced a miscarriage, or their baby had died. Although the provider was working with the local maternity services and maternity transformation board to find a solution, there were no clear plans in place to resolve the issue. This meant that there was an ongoing risk that expectant mothers and their families may be contacted by the

team, resulting in unnecessary distress and upset that could have been avoided. We reviewed a sample of team meeting minutes from November 2020 to March 2021 from across the four PCN teams and found that there was no record of this incident being discussed. Incidents was not an agenda item. Eight out of 25 members of staff we spoke with were unable to share any learning from incidents and how practice had changed as a result.

Staff understood the term duty of candour. Providers of healthcare services must be open and honest with patients and other 'relevant persons' (people acting lawfully on behalf of patients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to provide examples of when they would offer support and apologise.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be classed as a never event. From January 2020 to May 2021, the provider did not report any never events relating to the 0-19 service.

Are Community health services for children, young people and families well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. At the time of when the Covid-19 pandemic started, 60% of staff of the Sutton Health and Care 0-19 Children's Service were redeployed as requested by the government. This meant that the service was not able to carry out their usual duties but ensured they prioritised children and families at risk. Leaders understood local issues and the needs of the diverse local population they served, as well as recognising the challenges within in their service such as staffing issues.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood how to apply them and monitor progress. The service was in the early stages of implementing an integrated model of care called 'Our Shared Children's Plan 2021-2023', with the aim for care to be co-produced with children, young people and their families. The provider had plans to engage staff through workshops to ensure they were involved in sharing their ideas on the vision of the service.

The provider had plans to pilot new models of care in order to improve the health and wellbeing of children, young people and their families. The provider had plans to implement social prescribing, which means finding non-medicalised solutions to experiences that are being caused by social and environmental factors. The plans included a menu of support to families such as 1:1 support, whether that be online or in a group, and to offer families a choice of statutory or voluntary sector support. The service was funded for two additional posts to support the social prescribing work and had planned to be available by September 2021.

Culture

Whilst some staff felt respected, supported and valued, others felt stressed and overwhelmed by the workload. The staff survey results from April 2021 recorded that out of 29 responses, 51% of staff felt that their workload had affected their wellbeing. Staff fed back that they wanted better communication from senior managers and that morale was generally low.

Staff were focused on the needs of children, young people and their families receiving care despite experiencing a challenging year due to the Covid-19 pandemic. The service promoted equality and diversity in daily work and provided some opportunities for career development. The service had a restoration plan in place to restore the service following the pandemic and a part of the plan was to restart career development opportunities such as developing school nurses to be able to complete mental health first aid training. The service had already begun to carry out restorative supervision sessions for staff.

Governance

Whilst most governance processes were working effectively within the service, there were areas of improvement that we identified during the inspection. The service did not have a an effective system in place for recording mandatory training completion, the provider had not put robust plans in place to address the frequent occurrence of health visiting staff making initial contact with families who had experienced a miscarriage or child bereavement, despite the provider being aware the issue had been ongoing for some years, and the service did not have a robust lone working system in place.

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. We reviewed a sample of meeting minutes from July 2020 to March 2021 which included a discussion about the 0-19 children's service and its performance. A separate children's assurance meeting was held on a monthly basis and chaired by the Director of Sutton Health and Care. At provider level information by exception was fed up to the Sutton Health and Care Alliance board. The board was stood down during the peak of the Covid-19 pandemic, however the assurance meetings maintained oversight.

Due to the provider delivering a service within a partnership, staff found it difficult to know which provider to refer to for training and policies. Some staff we spoke with were not clear where they should receive their training from. For example, from the local authority (London Borough of Sutton) or the local acute hospital. Staff fed back within the April 2021 staff survey that they felt there was mixed messages from the provider. The lack of guidance meant that there was a risk that staff would not be able to access the correct information for their service.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact such as high health visiting vacancy rates. The service recorded their key risks on a local risk register. As a result of the Covid-19 pandemic, overall performance of the team decreased but the service had worked hard to ensure that children, young people and families requiring safeguarding support were allocated to a health visitor. Health visiting key performance indicators (KPIs) demonstrated that the service maintained a high rate of new birth contacts and six to eight-week baby reviews. However, the team were unable to maintain developmental reviews at the beginning of the pandemic. KPI data was sent to commissioners and other agencies such as Public Health England.

Although audits formed part of the provider's assurance framework, most clinical audits had been suspended apart from personal protective equipment and hand washing audits. Following the inspection, the provider told us that clinical audits had been paused over the past 12 months due to staff redeployment and prioritisation of resource. The service planned to review their audit cycle to ensure the audits carried out going forward were meaningful and improved patient outcomes.

Information management

Whilst the provider routinely collected performance and training data, the data reports were not always accurate and reliable. For example, the service had a poor training record system in place that did not maintain accurate records of completed staff training. This meant that team leaders could not maintain clear oversight and address any gaps in staff training. At the time of our inspection, we found large gaps in mandatory training data including infection control and data protection. Following our inspection, the provider acknowledged that the system was not effective.

All members of staff had access to up-to-date information about young people's care and treatment. In teams where patient record systems were not shared with external colleagues, staff ensured that documents were handed over verbally and followed up via email. Team managers had access to information about the performance of the service. For example, incidents and staffing. Both school nursing and health visiting completed a monthly quality dashboard which was reviewed quarterly at the children's assurance meeting.

The service had not submitted required notifications to the Care Quality Commission, such as any abuse or allegations of abuse in relation to a service user. Since the service began in 2019, the provider had not submitted any statutory notifications to the CQC. It is the responsibility of the provider to understand their regulatory duties and submit notifiable incidents without delay.

Engagement

The service routinely offered families and carers an opportunity to feedback about the service through surveys. The last family survey was carried out in August 2020 and received 505 responses. Ninety one percent of families said that they had received support from the health visiting service and 87% said that they found the contact useful. We spoke with six families who had used the service and felt able to raise concerns about their care without fear.

Staff did not always feel that senior leaders were visible and approachable to talk to. Senior leaders acknowledged that there was a need to strengthen and develop the brand of Sutton Health and Care and engage staff in the process. Staff told us that communications were not team specific and all staff within the partnership would receive the same email communications. The director for Sutton Health and Care sent out a weekly newsletter to ensure that specific staff groups understood the information that was related to them. At the time of our inspection, the service had plans to address the issue by recruiting a dedicated staff member to support communications of the service.

Staff had found creative ways of sharing advice and support with families whilst the service stopped face to face groups and appointments during the pandemic. Individual staff members had created videos for the health visiting social media page that included advice on child safety and toilet training. The school nursing team had set up their own social media in order to reach young people.

Learning, continuous improvement and innovation

Community health services fo children, young people and families

Inspected but not rated

All staff were committed to continually learning and improving services. Staff had a good attitude towards identifying areas for improvement and ensuring changes were made. The service had set up a pilot programme that focused on integrated ways of working with children aged zero to five years. There was a shared goal of moving children's centres towards a place that was seen as a family hub, that offered a range of support such as debt advisors and independent domestic violence workers. The programme was evaluated quarterly and reported to the children's assurance meeting.

Leaders encouraged innovation and participation in research. The service had employed a public health strategist in order to support the service to understand how they could develop the service for the future. The service was carrying out a study over the next five years that involved speaking with mothers and their families who had given birth within the last 12 months. The study aimed to look at understanding families needs and experiences of the service.

Community mental health services for people with a learning disability or autism

Requires Improvement

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Inadequate

Are Community mental health services for people with a learning disability or autism safe?

Requires Improvement

Our rating of safe went down.

Safe and clean environment

Staff followed infection control guidelines, including handwashing and the use of personal protective equipment during appointments. Staff had access to sufficient personal protective equipment to minimise the risk of cross-infection and to enable them to follow current national guidance in respect of COVID-19. All staff had been offered a COVID-19 vaccine.

Patients were supported by the service within their own homes, care homes or hospital. Patients were not seen on provider premises, so we did not inspect these areas.

Safe staffing

The service had enough staff to provide a safe service, although there were vacancies at the time of the inspection. The service had two vacancies in the nursing team, two vacancies in the psychology team and no occupational therapy staff in post. Managers used long-term locum staff to cover three roles in the service within the speech and language therapy and psychology teams.

The provider was well sighted on the staffing issues and had put some basic controls in place to mitigate these. The provider signposted high-risk psychology referrals to other services and used existing nursing staff to cover the vacant nursing roles.

Nursing staff

The vacancies in the nursing team meant that the team was only able to cover the liaison nursing role on a part time basis. This was normally a full-time role, based at an acute hospital, to provide support to patients with a learning disability throughout their hospital admission and discharge, as well as providing support to staff on the wards. Staff felt that the impact of this vacancy meant they worked more reactively and they could not implement effective strategies to support patients on the wards in a timely manner.

Medical staff

The service did not employ medical staff.

Mandatory training

The mandatory training courses provided did not reflect the range of courses recommended by Skills for Care for this type of service. Therefore, staff had not received appropriate mandatory training. Those who had received some mandatory training were not always up to date with their refresher training.

Service managers did not have a robust system in place to record and monitor mandatory training and did not alert staff when they needed to update their training. The provider's mandatory training programme included just two mandatory courses and did not include other training to help meet the needs of patients and staff.

At the time of inspection, the service provided us with two separate staff training records that listed 20 members of staff. Of these, four staff were no longer employees of the service and two current staff were not listed. Some managers in the service had not completed any mandatory training.

Six members of staff had no record of face-to-face or e-learning since 1 January 2019. Less than 10% of staff had completed courses in health and safety, equality and diversity, infection prevention and control and COVID-19. Only 50% of staff had completed training in the Mental Capacity Act and 10% of staff had completed training in Deprivation of Liberty Safeguards (DoLS).

The two staff training records showed conflicting information on staff compliance with the provider's mandatory training courses on 'Data Protection' and 'Workshop to Raise Awareness of Prevent (WRAP): Safeguarding against radicalisation and extremism'. The first training record stated no staff members had completed Data Protection training, whilst the second record said 19 of 20 staff had completed it. The first training record said four out of 20 staff had completed WRAP, whilst the second record said 13 of 20 staff had completed it. It was unclear which record was most reliable.

The service had an ineffective training system in place, which meant the provider could not be assured that staff were receiving training appropriate to their role. This increased the risk of staff not following the latest national guidance when carrying out clinical and other duties.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well, although the relevant information was not available on our first visit to the service.

Community mental health services for people with a learning disability or autism

Requires Improvement

We visited the service on 12 May and 25 June 2021. On the first day we reviewed the care records of 11 patients. However, the team manager could not provide us with full access and we only located one risk assessment, so we had to return to the service to carry out further checks. On the second day we reviewed the care records of five random patients and were given full access to the system.

Staff carried out a range of risk assessments for each individual patient and documented these in the patient care record. These included risk assessments related to continence, skin integrity, falls, malnutrition, mental health needs and altered states of consciousness, such as epilepsy. When risks were identified, staff put plans in place to address them.

At our second visit all five patients had a detailed risk assessment in relation to COVID-19 in place. This covered the identification of specific risks and actions in place to mitigate the risks, including infection prevention and control measures and waste disposal. Staff provided detailed information for carers and support staff regarding the best personal protective equipment to use, social distancing, transport use and cleaning.

Staff had completed a detailed personal risk profile for all five patients whose records we reviewed on the second day of our visit. These included the risks and the actions taken to manage the risks, such as the use of specialist equipment. Some people using the service also had an emergency response plan in place.

Serious risks were flagged on the front page of each patient's electronic care record, if appropriate. For example, where a patient had a specific eating and drinking plan in place this was flagged. Two patients diagnosed with epilepsy had detailed plans flagged to mitigate the risks in the event of a seizure.

Safeguarding

Staff had not completed appropriate safeguarding training. At the time of the inspection, only six of 20 staff listed on the service's staff training record had completed safeguarding vulnerable adults training. Managers in the service had not completed any safeguarding training.

However, staff knew how to identify patients at risk of, or suffering, significant harm. Staff knew how to make a safeguarding referral at provider level and who to inform if they had concerns. Staff had access to a supportive safeguarding team who were always available to respond to frontline colleagues needing advice.

Records showed that safeguarding issues had been discussed in team meetings within the last year and staff had made safeguarding referrals when required. Safeguarding issues were recorded for one patient related to an incident in their placement. This had been investigated by the safeguarding team and the concerns upheld. Action had been taken to safeguard the person.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear and up to date, but the team manager could not access them, nor were they stored consistently.

On the first day of inspection we were unable to find full care and treatment records on the provider's electronic patient records system. When we asked for assistance from a team manager, they were unable to locate care plans and risk assessments for patients. However, when we re-visited the service on the 25 June 2021, a senior manager was able to locate these for us to review. In the interim period we had spoken with staff who had confirmed these records did exist.

Community mental health services for people with a learning disability or autism

Requires Improvement

However, staff also told us that patient information was stored in two different systems and they were not sure which system was meant to be used for which documents. Staff were not clear where to record essential information and could not always find the most up-to-date information about patients when they needed it. Staff told us the provider's electronic record systems were not designed for storing health information.

Medicines management

The service did not prescribe, administer or store medicines.

However, nurses maintained oversight of people's medicines in terms of their effectiveness in controlling symptoms and recorded this in their clinical health reviews.

Track record on safety

The service had a good track record on safety. There had been no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

There were no effective service-wide systems in place to discuss learning from issues that did occur or concerns raised (or relevant incidents external to the service). Incidents were mainly shared in profession-specific team discussions. As a result, the service may have missed opportunities to make improvements.

However, staff were confident in recognising incidents and reported them appropriately. Incidents were formally recorded, investigated and monitored at provider level.

Are Community mental health services for people with a learning disability or autism effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff completed a comprehensive assessment of people's needs and a detailed clinical health care plan addressing those needs for all five patients whose records we reviewed on our second visit to the service. Staff regularly reviewed and updated care plans when a patient's needs changed.

Assessments covered people's physical, behavioural and emotional needs. All the care plans were individualised, holistic and focused on maximising the person's quality of life.

Care and support plans covered a range of areas, including nutrition, personal hygiene and dressing, being able to use their home safely, personal relationships and engaging with the community.

Community mental health services for people with a learning disability or autism

Requires Improvement

Care records documented how people were able to communicate, the best way of communicating with them, at what time and in what circumstances.

Staff told us that positive behaviour support plans were in place for patients that needed them. Staff and carers told us that care plans and positive behaviour support plans were regularly reviewed and updated when patients' needs changed.

Staff told us that they ensured all patients admitted to hospital had an up-to-date hospital passport.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. These included behavioural support and creative therapies. For example, patients had received regular music therapy virtually during the pandemic.

Staff delivered care in line with best practice and national guidance. The physiotherapy team provided postural care management programmes and long-term support for patients in line with national guidance.

Staff understood how best to apply individual patients' positive behavioural support plans. The service had a behaviour therapist and one of their main roles was to ensure that positive behaviour support plans were in place and that staff, relatives and carers understood how to respond to distressed behaviour. Staff made sure patients had support for their physical health needs, either from their GP or other community health services. We saw an annual health check had been carried out within the last 12 months for four of the five people whose records we reviewed.

Staff used technology to support patients. For example, patients were supported to participate in virtual music therapy. Instruments were provided in their home or care homes and the music therapist facilitated the session through a video call. Carers told us this had been exceptionally helpful during the COVID-19 pandemic.

Staff confirmed that the service did not use recognised rating scales, or similar, to assess and record patients' care and treatment outcomes.

The service did not take part in clinical audits, benchmarking or quality improvement initiatives. This meant that managers in the service did not systematically identify areas for improvement.

Skilled staff to deliver care

The service did not have a full range of specialists to meet the needs of the patients. The service had two vacancies in the nursing team, two vacancies in the psychology team and no occupational therapy staff in post. However, the service referred on to specialists as needed.

The service model did not include dietetics or psychiatry posts, if people needed access to these services they were referred on.

Staff were experienced and qualified for their roles. However, service managers could not demonstrate staff kept up-to-date with training appropriate to their role. There were no records to show staff had completed recent training or other learning in learning disabilities, autism and positive behaviour support. Staff had professional qualifications but need refreshers to keep up-to-date and maintain the requirements of their professional registration.

Each new member of staff received a full induction to the service before they started work. Staff spoke highly of the induction programme.

Staff received annual constructive appraisals of their work and regular clinical and operational supervision of their work.

Staff attended regular team meetings and arrangements were in place to pass on information to those who could not attend.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. For example, records showed that nursing, physiotherapy and music therapy staff had come together to provide support for one person.

The service held regular multidisciplinary meetings to discuss patients. These meetings did not include regular discussion of some aspects of quality and safety within the service. Staff from different disciplines also had their own regular meetings to discuss patients and improve their care.

Staff had effective working relationships with other teams in the organisation, such as the provider's safeguarding team.

Staff had effective working relationships with external teams and organisations. The team referred patients to other external health professionals as needed. Staff worked closely with care homes and supported living staff to enable patients to receive the best care to meet their needs.

Good practice in applying the Mental Capacity Act

Staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles. However only 10 of the 20 staff members listed on the provider's training record had received training in the Mental Capacity Act and only two had received training in the Deprivation of Liberty Safeguards (DoLS) since January 2019.

The provider had a policy on the Mental Capacity Act on their internal website. Staff were aware of the policy and had access to it.

Staff assessed and recorded capacity to consent appropriately and in detail. They did so on a decision-specific basis in four of the five patient care records we reviewed.

Staff took steps to enable patients to make their own decisions. Staff had recorded the views of one patient who was able to communicate their thoughts about a future placement and took account of these.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. The care records of two patients showed that best interests' meetings had taken place with people who knew them well to make decisions about their future care and placements.

The service did not monitor how well it followed the Mental Capacity Act. There were no audits in place to check the application of the Mental Capacity Act. This meant that the service could not identify and act if they needed to make changes to improve.

Community mental health services for people with a learning disability or autism

Requires Improvement

Are Community mental health services for people with a learning disability or autism caring?

Good

Our rating of caring stayed the same. We rated it as good, because:

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness and provided help and advice at the time they needed it.

Patients told us that staff were friendly, kind and helpful. Carers told us that staff were enthusiastic, keen to help and provided extraordinary care. Carers told us staff were quick to respond to emails and calls and always pointed them in the right direction. Records showed that staff knew patients well and were positive and caring in their approach to their care, always looking for ways to improve people's lives and experience of care.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Carers told us that staff provided social stories, counselling and reading material to help them and patients understand their diagnosis, care and treatment.

Staff directed patients to other services when appropriate and supported them to access those services if they needed help.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear of the consequences.

Involvement in care

Staff informed and involved patients, families and carers appropriately in the design of care and treatment interventions.

Involvement of patients

Records showed that staff involved patients in decision making where possible and advocated for them. For example, staff advocated on behalf of one patient with the person's support staff, encouraging them to take them out of the home more often. Another patient had been actively encouraged to contribute to their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Involvement of families and carers

Community mental health services for people with a learning disability or autism

Requires Improvement

Carers told us they felt involved in care planning and their relative's care plan was reviewed annually. Records showed that staff involved family members in the care of the person and in decisions about their care and treatment. Staff involved relatives in the development of care plans. Staff had kept in touch with relatives through regular telephone calls and virtual meetings during the pandemic. The views of relatives and carers were recorded.

Carers told us that staff were supportive and knowledgeable and tailored information to their family members' needs. For example staff provided information in an easy-read format.

However, the service did not routinely involve families or patients in decisions about the delivery of the service nor did it offer them the opportunity to give feedback on the service through surveys or community meetings. The service manager told us they did ask for feedback from carers and patients, however, the people we spoke with said they were not asked. Staff told us that people were asked for feedback at the end of their contact with the team, so this may explain why current patients and their families had not been asked for this information.

Are Community mental health services for people with a learning disability or autism responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access. It had simple but clear inclusion criteria which described the patients who were eligible for the service. The inclusion criteria stated that patients had to have a learning disability, be over 18 years of age and have a GP in the borough.

However, a senior manager told us that the inclusion criteria needed further refinement. Staff also felt that it was not always clear why referrals were sometimes accepted or rejected by the service.

The service did not use any system to help monitor referrals nor were there any key performance indicators around target times for seeing patients from referral to assessment and assessment to treatment. One team manager was in charge of screening all referrals to the service. Staff told us this made it difficult for other senior clinicians to discuss and respond to referrals which may have been appropriate for their specific profession.

Whilst staff tried to contact people who did not attend appointments there was no clear policy or procedures for missed appointments.

Staff supported patients when they were transferred between services. Carers told us that when they moved out of the area or moved to another home, the service continued to see their relative until they were able to access local services.

Facilities that promote comfort, dignity and privacy

Patients were supported by the service within their own homes, care homes or hospitals. Patients were not seen on provider premises, so we did not inspect these areas.

Community mental health services for people with a learning disability or autism

Requires Improvement

Meeting the needs of all people who use the service

The service made adjustments for people with disabilities, communication needs or other specific needs. For example, the service provided information on treatment and local services in a variety of accessible formats so the patients could understand it more easily. Patients' accessible information needs were recorded in four out of five patient care records.

Listening to and learning from concerns and complaints

Managers told us that no complaints have been received in the last 12 months. Patients, carers and relatives were not sure of the complaints policy when we spoke with them but said they felt comfortable raising any issues or concerns with the service. Carers told us that the service had always responded when they had raised any concerns in the past.

Managers told us that lessons learnt from complaints were discussed in the managers' meetings. If they felt it was something the team would benefit from, learning would be shared more widely to improve the service.

However, meeting minutes showed that managers did not routinely share and discuss concerns and complaints or the associated learning at service level. As a result, opportunities to make improvements may have ben missed.

Are Community mental health services for people with a learning disability or autism well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate, because:

Leadership

Although senior clinicians led the frontline delivery of the service well, team managers did not understand the statutory responsibilities that arise from running a registered service and how to comply with the relevant regulations. Oversight had lapsed when a previous registered manager had left the service.

Although the head of service had a good understanding of the purpose of the service, not all team managers did. They could not explain clearly how the teams from different disciplines were working in a coordinated way to provide high quality care, despite presenting themselves as a multi-disciplinary team. The individual professions worked well in their separate teams but multi-disciplinary working was often the result of staff initiative, rather than a service-wide approach.

Some staff felt some managers lacked visibility in the service and they had mixed views on whether they were approachable or not. There was recognition at a senior level that stronger leadership was needed in the service with more focus on quality of both practice and delivery of the service.

Staff were very positive about the senior clinicians within the service and described them as thoughtful and supportive.

Vision and strategy

Community mental health services for people with a learning disability or autism

Requires Improvement

The service was going through a period of change and not all staff were clear about the changes and how they applied to the work of their team,

The service was undergoing a transformation. Staff were mixed in their views about how managers of the service had communicated the vision of the transformation programme and whether they had adequate opportunities to contribute to discussions about the future of the service. Most staff were unclear how the changes would affect their specific role in the service and which roles would continue when the transformation was complete.

Culture

Most staff felt respected, supported and valued. They felt positive about working in their clinical team.

Most staff felt they could raise any concerns without fear of retribution. However, they told us they were unaware of any outcome when concerns had been raised about leadership within the service.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its daily work. Staff told us that the provider had Black, Asian and minority ethnic (BAME), LGBT+, Youth, Disability and Carers' networks which were promoted in the service.

The service supported staff to complete 'Uncomfortable conversations' training about racism following the Black Lives Matter movement.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at service level and that performance and risk were not always kept under review by team managers managers as they lacked systems and data to do this effectively. This was mitigated by better oversight at clinical level.

The service did not always make notifications to external bodies as required. Managers told us that they were not aware of the requirements to notify CQC without delay of certain incidents, including the death of a patient and abuse or allegation of abuse in relation to a patient. The service had not submitted any statutory notifications to the CQC since it registered.

The system in place to record and monitor staff training was ineffective. The list of mandatory training courses was partial and records did not show when they were completed or when they were due for renewal, which made it difficult to maintain oversight of completion rates or gaps in staff training. The current system did not provide an accurate record of all staff training completed.

The system for cascading learning from complaints, concerns and incidents service-wide was not as robust as it could have been. Staff told us there were discussions about incidents and concerns at profession-specific meetings, but it was not clear how this learning was shared across the wider team.

The systems and procedures in place to review, monitor and learn from deaths and safeguarding referrals were under-developed. When this took place it was due to good practice within a profession rather than a service-wide approach.

Community mental health services for people with a learning disability or autism

Requires Improvement

The service did not participate in clinical audits. As a result, team managers could not be assured that staff were compliant with the provider's policies and procedures. Senior managers recognised the lack of audits was an omission and planned to discuss how to address this gap.

Management of risk, issues and performance

There was an over-reliance on anecdotal evidence about risk, issues and performance within the service rather than systematic review.

The service did not maintain or have access to a risk register, or equivalent, at service level. Staff were not aware of the provider's risk register and whether the service featured on it. Staff did not have a way of escalating concerns about risk when required. Managers acknowledged there was no overall risk register but felt that risks were known and held in the different disciplines within the service.

Staff told us of allegations of abuse that had been referred to the local authority safeguarding team but not notified to CQC. The provider received a list of deaths of people living in the borough each month, which one staff member then used to close the electronic record for any patient in receipt of any of the provider's services. Information around deaths was not monitored at service level.

However, the provider had a business continuity plan in place, which contained plans for emergencies, for example adverse weather.

Information management

The service did not collect or analyse data about patient outcomes or the performance of the service. There were no key performance indicators or measurements of clinical outcomes. Therefore, managers did not have access to the quality and safety data required to provide robust oversight of the service.

Whilst staff had access to the information technology equipment needed to do their work, records were not saved consistently. Staff stored information in two different systems. Staff did not have clear guidance on where to record, store or how to access essential patient information, which meant that staff may not have been able to find important information about patients when needed.

Engagement

The service did not use feedback effectively to improve the quality of the service provided. The head of service told us carers and patients had the opportunity to give feedback about the service, although carers we spoke with said they had not been asked to give feedback. A team manager stated that patient feedback was sought at the end of treatment, which was not effective as patients often used the service for long periods of time. The head of service acknowledged that the feedback received was not reviewed or analysed systematically to inform improvements in the service.

Learning, innovation and continuous improvement

Music therapists had creatively adapted the way they worked with patients during the pandemic and had also introduced mandolas as part of group music therapy. Families gave positive feedback about the way patients had been able to engage remotely with music therapy sessions.

Community mental health services for people with a learning disability or autism

Requires Improvement

The service did not use quality improvement methods or complete any audits of its work.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Sutton Health and Care 0-19 Children's Service • The provider must ensure that there is a robust training system in place that provides clear oversight of staff completion rates. (Regulation 12 (1)(2)c) • The provider must ensure that lone working processes in place are robust and staff adhere to those processes whilst working alone in the community. (Regulation 12(1)(2)b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services Clinical Health Team for People with Learning Disabilities and Sutton Health and Care 0-19 Children's Service • The provider must promptly inform CQC of all deaths that are notifiable under the regulations. (The Care Quality Commission (Registration) Regulations 2009; Regulation 16)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Clinical Health Team for People with Learning Disabilities • The provider must ensure that staff have the relevant and up-to-date skills and training to provide safe care or treatment to service users, including safeguarding training. (Regulation 18 (2)(a))

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Clinical Health Team for People with Learning Disabilities • The provider must have a robust system in place to monitor staff compliance with statutory, mandatory and other training appropriate to their roles. (Regulation 17(2)) • The provider must have systems and processes that enable them to identify, assess and mitigate risks to the delivery of safe and high-quality care. (Regulation 17(2)) • The provider must have a robust mechanism to collect and respond to regular feedback from service users, carers and other professionals involved in the service user's care, in order to improve the service. (Regulation 17(2)) • The provider must have processes in place to assess, monitor, evaluate and improve the team's performance and treatment outcomes. (Regulation 17(2)) Sutton Health and Care 0-19 Children's Service • The provider must ensure that there is a robust plan in place to improve communication with system partners so that health visiting staff are aware of families that have experienced a miscarriage or bereavement. (Regulation 17 (1)(2))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Clinical Health Team for People with Learning Disabilities and Sutton Health and Care 0-19 Children's Service • The provider must promptly inform CQC of all events and incidents that are notifiable under the regulations. (The Care Quality Commission (Registration) Regulations 2009; Regulation 18)