Somerset Partnership 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)
RH5AA	Mallard Court	Taunton Community Team for Adults with Learning Disabilities	TA2 7PQ
RH5AA	Mallard Court	Sedgemoor and West Somerset Community Team for Adults with Learning Disabilities	TA6 5AT

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

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

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

Summary of findings

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 carried out this unannounced focussed inspection to see if the trust had met the concerns we raised in a warning notice following our comprehensive inspection of the trust on 8-11 September 2015.

We found Somerset Partnership NHS Foundation Trust had met the requirements of the warning notice because:

- There was a positive culture of considering risk in the service.
- Care records had comprehensive risk assessments and care plans that were detailed and met patients' needs.
- Staff were positive about the changes and committed to making them work.
- There was clear leadership in place. Senior managers had provided good oversight of the changes and supported staff well.
- The changes were being introduced in a no blame, learning culture.

However:

- Care plans were not available in a format that people who used the service could understand.

Summary of findings

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

Are services safe?

The requirements of the warning notice were met because:

- Risk assessments were comprehensive and identified all areas of concern for patients.
- Staff thought about risk as a team both in team meetings and at point of referral.

Are services effective?

The requirements of the warning notice were met because:

- All patients had holistic and detailed care plans that addressed known risks and areas of treatment that patients required.
- Multidisciplinary team meetings considered risk in a collaborative way.

However;

- Care plans were not available in a format that people who used the service could understand.

Are services caring?

We did not inspect this during our visit.

Are services responsive to people's needs?

We did not inspect this during our visit.

Are services well-led?

The requirements of the warning notice were met because:

- Managers were providing good oversight and had worked with the team to provide assurance that the new systems were working.
- Clear leadership was evident in the service. The trust's new chief executive had visited the service on a number of occasions including going out with staff on home visits.
- Staff morale was good and staff were positive about the changes.

Summary of findings

Information about the service

Somerset Partnership NHS Foundation Trust's learning disability service is a specialist service for adults with learning disabilities. There are four community teams for adults with learning disabilities (CTALD) across Somerset.

The teams included psychiatrists, community nurses, physiotherapists, occupational therapists, psychologists and speech and language therapists.

The CTALD are based in local authority premises and work closely with local authority social work teams in each of the four CTALD areas: Mendip, Sedgemoor and West Somerset, South Somerset, and Taunton.

Two teams work alongside the CTALD. The rapid intervention team is based in South Somerset and leads on assessment, treatment and expert intervention for people with learning disabilities who have highly complex behaviours that challenge and/or mental health need. The better health team works across all four CTALD. This team supports annual-health-checks and works with general practitioners to support people with learning disabilities. It also provides information, training and support on healthy lifestyle, health and medical conditions to people with learning disabilities as well as their, relatives and care providers.

The service was inspected in September 2015. We rated the service as inadequate due to our concerns about safety. We issued a warning notice requiring the trust to take action to ensure the safety, care and welfare of patients. This inspection was to assess whether the trust had complied with the warning notice. We found that it had and we have lifted the warning notice from the trust.

Our inspection team

The inspection was led by:

Gary Risdale, Inspection Manager

The team was comprised of:

One CQC inspection manager, two CQC inspectors and a specialist advisor with experience in delivering learning disability services.

Why we carried out this inspection

We carried out this unannounced focussed inspection to see if the trust had met the concerns we raised in a warning notice following our comprehensive inspection of the trust on 8-11 September 2015.

The warning notice was served under Section 29A of the Health and Social Care Act 2008 on the 25 September 2015. This was due to concerns about the safety of community mental health services for people with learning disabilities or autism provided by Somerset Partnership NHS Foundation Trust.

During the comprehensive inspection we were concerned that staff did not always respond appropriately to meet peoples' individual needs to ensure the welfare and safety of service users. These concerns included the lack of risk assessments, person-centred care planning, mitigation of risks, incident reporting and working with others where responsibility for care is shared or transferred.

The warning notice required the trust to conduct an immediate review of the services case load focusing on risk assessments with safety plans being put in place where necessary within six weeks of receipt of the warning notice. It also stated that it should be the start of a comprehensive review of the assessment and care planning in the service which should be completed within six months.

We completed this unannounced focussed inspection on 10 May 2016 to see if the requirements of the warning notice had been met.

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, during a comprehensive inspection we 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?

For this inspection we focussed on three of the five key questions: is care safe?, is it effective? and is the service well led? to see if the trust had addressed the requirements of our warning notice.

Prior to our unannounced inspection visit, the trust had been keeping us informed of the actions it had taken in response to the warning notice. We had also met senior members of the trust who had explained what they were doing to improve services.

During the inspection visit, the inspection team:

- visited two sites where community mental health services for people with learning disabilities or autism were based in Bridgewater and Taunton
- spoke with 10 members of staff
- reviewed the care records of 52 patients currently open to the service, focussing on risk assessments and care plans. We sampled records from both the sites we visited and also viewed electronic care records from the two sites we did not visit where trust also provides these services
- attended and observed a multi-disciplinary meeting.

What people who use the provider's services say

We did not speak to people who use the service during this visit.

Good practice

Senior managers were very visible, visiting the service often. They were supportive to the staff team and had led the improvements with a no blame culture. The head of division demonstrated a passion for change providing a clear direction for staff. The new chief executive of the trust had visited the service on a number of occasions including going out with staff on home visits. Staff were positive about this level of support and approach from the senior managers and had clearly responded well to it.

Areas for improvement

Action the provider SHOULD take to improve

The trust should ensure that care plans have a version that is available in a format that patients who use the service can understand.

Somerset Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sedgemoor and west Somerset CTALD	Trust HQ
Taunton CTALD	Trust HQ

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff routinely considered the mental capacity of each patient and this was recorded appropriately in all the records we reviewed.
- On our previous inspection in September 2015 we found that there was not always clear evidence in the care records to show that, where appropriate, mental capacity had been taken into consideration by staff before a decision about delievering care and treatment was taken. However, during this inspection we found that staff had demonstrated, in all the records reviewed,that they were considering whether a patient had capacity to consent to any interventions. Families and/or carers were involved in the decision appropriately. This was reviewed every time a new episode of care started or when care plans were changed and was then clearly recorded.
- If a patient had limited capacity their views would still be noted. For example, it was recorded that one patient did not have verbal communication but could indicate their agreement to the planned physical health interventions by body gestures. The capacity assessment stated that staff should be aware of what the gestures meant and clarify with the carers who knew the patient well if they were unsure of the meaning.

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

Assessing and managing risk to patients and staff

- We reviewed 52 care records across all four teams within the service. Risk assessments were comprehensive and identified all risks for individual patient needs. For example, some patients had risk assessments focussing on their physical health needs and the risk to them, whilst others had risk assessments looking at patients' behaviour that challenged; such as risk of violence. If a patient had multiple risks including to themselves and others, risk assessments were grouped according to the needs making them easy to follow and understand.
- Risk assessments were clearly written and easy to understand. Relevant current and historical information was used appropriately to illustrate the reasons for the concern, including information from other providers. Risk assessments were rated appropriately for the level of concern.
- Clinicians within the service reviewed the risk assessments appropriately following significant events or change in circumstances that could affect the level of concern. For example, a patient who moved from one social care provider to another resulting in an increase in behaviours that challenge led to a new risk assessment being completed.
- Staff assessed safeguarding concerns well, putting in plans to manage situations that put patients at risk or where they would be a risk to others. For example, where patients were at risk of exploitation due to their learning disability.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Care plans were detailed and holistic. In all 52 records, care plans covered all areas of identified need for patients. For example, one patient had care plans in place to manage their vulnerability and risk of exploitation as well as another care plan to address their risk of violence.
- Carers were involved in choosing what interventions the care plans delivered. Where patients had the ability to make their choices known then these were taken into account.
- Care plans were in place for patients waiting for assessment and identified how risks could be managed whilst waiting.
- However, care plans were very technical and task driven. Care plans were not personalised other than the addition of the word "you". There was little evidence of care plans being adapted into "easy read" format or social stories (these are methods of communicating plans to people who have communication difficulties). As the service worked with a significant number of patientswho could not communicate verbally so it would be usual practice to use those formats or equivalent. Therefore care plans were not available in a format people who used the service could understand.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team had a a clear focus on risk which was shared with other agencies. The service held regular "rapid response" meetings with social care staff from the local authority. There was good attendance from the multidisciplinary clinical team. The meetings reviewed referrals, discharges, caseloads and incidents. Communication between the health staff and social care staff was good and a shared approach to risk was evident.

Good practice in applying the Mental Capacity Act

- Staff routinely considered the mental capacity of individual patients and it was was recorded appropriately in all the records we reviewed.
- On our previous inspection in September 2015 we found that there was not always clear evidence in the care records to show that, where appropriate, mental capacity had been taken into consideration by staff before a decision about delievering care and treatment was taken. However, during this inspection we found that staff had demonstrated, in all the records reviewed,that they were considering whether a patient had capacity to consent to any interventions. Families and/or carers were involved in the decision appropriately. This was reviewed every time a new episode of care started or when care plans were changed and was then clearly recorded.
- If a patient had limited capacity their views would still be noted. For example, it was recorded that one patient did not have verbal communication but could indicate their agreement to the planned physical health interventions by body gestures. The capacity assessment stated that staff should be aware of what the gestures meant and clarify with the carers who knew the patient well if they were unsure of the meaning.

Are services caring?

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

Our findings

We did not inspect this during our visit.

Are services responsive to people's needs?

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

Our findings

We did not inspect this during our visit.

Are services well-led?

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

Our findings

Vision and values

- Senior managers were very visible, visiting the service often. They were supportive to the staff team and had led the improvements with a no blame culture. The head of division demonstrated a passion for change providing a clear direction for staff.
- The new chief executive of the trust had visited the service on a number of occasions including going out with staff on home visits.
- Staff were positive about this level of support and approach from the senior managers and had clearly responded well to it.

Leadership, morale and staff engagement

- Clear leadership was evident in the service. Managers provided good oversight and worked with the team to provide assurance that the new systems were working.
- Staff morale was good. Although they acknowledged that it had been difficult following receipt of the warning notice and publication of our report they accepted changes were needed and felt good progress had been made.
- Staff were positive about the changes and felt that the service was now safer. Staff reported that the trust had introduced the changes and training by providing support to the staff.Staff told us they were appreciative of the no blame approach to addressing the issues within the service. Staff were complimentary about the support they had received from the the head of division and the new chief executive.