CareQuality Commission

Good 🟢

Avon and Wiltshire Mental Health Partnership NHS Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Avon and Wiltshire Mental Health Partnership NHS
Trust,
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Website: http://www.awp.nhs.uk/

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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)
RVN1H	Trust Headquarters	Specialised PWLD Intensive Support Service Wiltshire	BA14 8JN
RVN1H	Trust Headquarters	Specialised LD Forensic Team	BS14 9BP

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS 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 Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS 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?	**Requires improvement**	🟠
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

Contents

Summary of findings

Overall summary

We gave an overall rating for community mental health services for people with learning disabilities or autism of good because:

- The services conducted assessments, including specialised risk assessments, at the appropriate time. Teams considered physical health needs and monitored them. Care plans were patient focused and staff were respectful of people using the service. Information was available in an accessible format and there was a patients forum that inputted in to the service that people could attend.

- There were good staffing levels and caseloads were appropriate. There was clear eligibility criteria and a referral pathways.

- The services regularly reviewed their practice; we saw evidence of learning from incidents, including changes in working practices. The intensive support team was reviewing their operating policy and referral procedure to ensure it met the needs of the people accessing the service. The forensic team had developed interventions from an evidence base, which met the identified needs of the people accessing the service.

However:

- The intensive support teams electronic record system did not have active risk assessments or contain all the required risk information. There was no effective procedure in place to mitigate this. Not all intensive support team care plans were uploaded on the electronic record system. Some people using the forensic service had not received their care plan in a timely fashion.

- Services did not have a full range of mental health professions in their teams.

- There were no recognised outcome measures in place and staff did not routinely give people information on how to make a complaint.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- The intensive support team used a different electronic notes system to the rest of the trust. The risk management system on this record was static and we saw an example that more comprehensive risk information was on the trust electronic record system.

However:

- Teams were either fully staffed or about to appoint staff to fill vacancies and caseloads were of a manageable size.
- All people had a risk assessment on referral.
- We saw evidence of learning from incidents, including changes in working practices.

Requires improvement ●

Are services effective?

We rated effective as **good** because:

- Staff carried out assessments of peoples' needs, at the appropriate time.
- Care plans were patient centred.
- Interventions were tailored to meet the needs of the individual people, this involved adapting group sessions for individual input and offering people the opportunity to take parting in specific modules of a treatment programme.
- Staff considered physical health care needs and the team ensured that appropriate assessments had taken place.
- Staff received supervision.
- The service manager was reviewing the referral process and the standard operating procedure of the intensive support team.

However:

- Not all intensive support team care plans were uploaded to the electronic record.
- There was no procedure in place to ensure all risk information was available to the intensive support team prior to them visiting a patient in their home. Not having enough information had led to a member of staff being injured.
- Neither service was using a recognised outcome measure to assess the services effectiveness.

Good ●

Are services caring?

We rated caring as **good** because:

Good ●

Summary of findings

- Staff acted appropriately with people and the person we spoke to said staff always treated them with respect.
- There was accessible information available.
- People were involved in developing their care plans.
- The teams knew of local advocacy services and checked if the people had been referred.
- There was a forum, which allowed people to be involved in service development and recruitment.

However:

- There were sometimes delays in people receiving their care plans.

Are services responsive to people's needs?

Good ●

We rated responsive as **good** because:

- There were clear eligibility criteria for both teams and clear focus for interventions.
- Staff members would visit people in their own homes or arrange a local venue to meet.
- Staff were based in a building with good disabled access.
- The staff had access to interpreters if needed.
- Staff continued to engage with people who did not attend appointments and would offer a variety of times and locations.

However:

- There was no information kept in relation to waiting times.
- Staff did not routinely give people information on how to complain.
- Staff had not recorded compliments on the trust system.

Are services well-led?

Good ●

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

- Staff were aware of the trust's values and recognised how they reflected their teams' values.
- Staff knew who the senior managers for their service where.
- Staff understood the trust`s safeguarding and whistle blowing procedures and felt confident in using them.
- Team managers were able to access an electronic system to monitor the services key performance indicators.
- Morale was good.
- The forensic team had developed new interventions based on an audited need.

Summary of findings

Information about the service

The Community mental health services for people with learning disabilities or autism consisted of two specialist services:

- The forensic team for people with learning disabilities was providing support to people with learning disabilities across Bristol who have, or are at risk of, offending. This service provides individual and group treatment programmes to address the offending behaviour of people referred. Referrals must be eligible for input from the local community team for people with learning disabilities.

- The Wiltshire learning disability intensive support team is a pilot project that started in January 2016. They provide additional support to people with a learning disability and a challenging behaviour to maintain their current housing tenancy or placement and following discharge from hospital. Referrals must be open to the local community team for people with learning disabilities.

Our inspection team

Chair: Maria Kane CEO Barnet, Enfield and Haringey Mental Health NHS Trust

Team leader: Karen Bennett-Wilson, Head of Hospital Inspection

The team that inspected this core service consisted of one inspector and one specialist advisor.

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?

During the inspection visit, the inspection team:

- visited both teams at their bases
- spoke with one patient
- spoke with the service manager and a team manager
- spoke with eight other members of staff including; including qualified and unqualified nurses, a psychologist, a psychology assistant and a social worker
- attended two community visits
- reviewed six care records

What people who use the provider's services say

The person we spoke with felt supported by the forensic team.

Summary of findings

Good practice

- The forensic community team has identified needs and developed interventions based on good practice and adapted them to be accessible for people with a learning disability.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve

- The provider must ensure that the intensive support team has an effective procedure in place to ensure staff have amalgamated all risk information available prior to visiting people.

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The provider should ensure that intensive support team provide care plans and risk assessments that develop with people changing needs.

- The provider should ensure staff upload all documents to the electronic record system in a timely fashion.
- The provider should ensure they keep information about waiting times and referral to community team times.
- The provider should ensure they can identify the outcomes of people accessing their services.
- The provider should review delays in people receiving care plans.

CareQuality Commission

Avon and Wiltshire Mental Health Partnership NHS 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
Specialised PWLD Intensive Support Service Wiltshire	Trust Headquarters
Specialised LD Forensic Team	Trust Headquarters

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.

- Only one member of staff had not received Mental Health Act training

- Staff we spoke with demonstrated a good understanding of the Mental Health Act
- At the time of our inspection the team did not have responsibility for managing people under the Mental Health Act

Mental Capacity Act and Deprivation of Liberty Safeguards

- Only two members of staff had not received training in the Mental Capacity Act

- Staff considered patients' capacity and ability to consent to treatment and we saw evidence in people's health records
- Staff were able to get advice on the Mental Capacity Act

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

- All interview rooms were fitted with an alarm system that alerts staff in the team office and in the central reception to an emergency. The forensic community team staff advised us that they rarely saw people at the service base and usually visited people at home. When staff did see them in the office they would arrange for a team member to respond to the alarm.
- The team had effective lone working processes. They operated a `buddy` system to be aware of staff whereabouts and had a code word that staff members could use when calling to the office to indicate they need assistance. This system was explained in the team induction.
- The intensive support team did not lone work.
- All areas were clean and well maintained. Neither team managed the cleaning and maintenance of the buildings. This was overseen by the locality mangers. Staff could escalate any concerns about the environment via the locality managers.
- There were antibacterial hand gel dispensers located throughout the office buildings.

Safe staffing

- The current staffing establishment was:
- Forensic Community Team:
- Qualified nurses 1.8 whole time equivalent (WTE)
- Psychologists 1.1 WTE
- Psychology assistant one WTE
- Administration staff 0.4 WTE
- At the time of our visit there was a psychology trainee working with the team three days a week.
- There were currently no vacancies and all staff had been employed by the team for at least 18 months.
- The staffing establishment was agreed when the team was set up ten years ago.
- There was currently no sickness management and no use of bank or agency staff.

The intensive support team for people with learning disabilities:

- Qualified nurses six WTE
- Unqualified nurses four WTE
- Current vacancies were one WTE qualified nurse and two WTE unqualified nurses. People had been employed for these posts; there were start dates for the unqualified nurses and the qualified nurse was awaiting pre-employment checks.
- The staffing model for the intensive support team had been reviewed since the service started in January 2016 to allow a senior nurse manager to be part of the team.
- The forensic team had 40 open cases at the time of our visit. Caseload sizes and staff capacity were manged via supervision. We saw evidence that supervision occurred regularly for all staff. The intensive support team had a caseload of six when we visited.
- There was a locum social worker employed at the intensive support team. There was no back or agency used by the forensic team. Caseloads would be reassessed and prioritised if members of staff were on long term sick leave.
- Access to a psychiatrist was via a referral to the local community team for people with learning disabilities or via on-call for emergencies.
- Mandatory training compliance was at 79% across both teams.

Assessing and managing risk to people and staff

- All people referred received a risk assessment following the initial referral. The forensic team used a number of recognised risk assessments in addition to the standard electronic care record, such as the HCR-20 and Armadillo risk assessment. Risk assessments were up dated when appropriate. Of the five risk assessments we reviewed all had been updated within the past three months. The intensive support team used a different electronic care record to the rest of the trust, which did not allow staff to updated risk assessment. Changes to risk assessments required staff to upload a new risk assessment. Staff had read only access to the main trust

Are services safe?

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electronic record system and we were shown an example of how the level of risk and types of risk presented by a patient differed between the systems. In the example we were shown a risk of physical aggression was not recorded on the system used by the intensive support team but was on the other system.

- The forensic team were in the process of adding crisis plans to the electronic record system for all their patients.

- The forensic team monitored patients on their waiting list and alert the appropriate service if a patient experienced deterioration in their health. The intensive support team did not have a waiting list.

- Staff were trained in safeguarding and were able to explain what, when and how to report safeguarding issues.

- The intensive support team did not practice any lone working.

Track record on safety

- There had been one serious incident in the past 12 months. A member of staff had been injured. The service was undertaking an investigation at the time of inspection.

Reporting incidents and learning from when things go wrong

- Staff told us that the intensive support team had tried to respond to referrals, as soon as the team received a referral. This had led to an incident when staff had visited a person without gathering all the necessary information to ensure the safety of the staff team. Following this incident, the intensive support team no longer responds to requests for an immediate visit and ensures the necessary information is gathered in advance of any visit. During our visit, we were aware of referrers requesting immediate visits and the staff team following the agreed protocols.

- The forensic team had ensured that all people open to them had a contact identified on their record for none forensic issues.

- The team discussed incidents and learning from incidents at team meetings, in supervision and during reflective practice meetings.

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

- We reviewed seven individual care records and identified that the team carried out an assessment of individual in a timely manner.

- We reviewed six care plans and found that they were person centred and identified where people had been involved. Some included quotes from the person.

- When reviewing the records of people in the intensive support team we saw that staff did not have all the information needed to provide safe care. The electronic note system, used by the intensive support team, did not have a risk assessment or a standard place for risk information to be kept.

- The electronic record used by the intensive support team would generate an email to advise staff working with the patient that a new piece of information had been added to the patient's record. However, this would be emailed to the team's email address so individual staff would not necessarily receive this information.

- Staff told us that they would review the main trust electronic record system for any information that may not be included on the intensive support teams system but the service did not have a protocol in place to ensure this had happened. We saw care plans that staff had not yet uploaded to the electronic system.

Best practice in treatment and care

- The forensic team offered a range of forensic specific interventions, such as a sex offender treatment programme. Staff planned programmes and interventions to meet individual's needs. Staff were able to explain where they had used parts of a treatment package to meet individual need.

- When receiving a referral staff checked, there had been a physical health assessment. The services would refer to the local community teams if an additional physical health assessment was required or if a physical health need had changed. Training was available for physical health needs and we saw a care plan for the management of a person's physical health.

- Neither team used a recognised outcome measure to review their input. However, the forensic team did send out a questionnaire before and after an episode of care to assess the effectiveness of the service.

Skilled staff to deliver care

- Neither service had a full range of professional disciplines within the teams. However, each team was able to access additional support, such as occupational therapy, psychology and psychiatry, via the local community learning disabilities team. The intensive support team was a pilot project and was in the process of reviewing its mix of disciplines and banding of staff. At the time of the inspection, the commissioners had agreed funding for qualified and unqualified nurses in permanent positions. The service had a locum social worker in post and the service manager felt that this had added to team skills. Both teams have a mix of experienced and less experienced staff.

- Staff were recruited to both teams who had the necessary skills to work in these services. Staff needed to request additional specialised training and this was dependent on available funding. The manager of the forensic team told us that staff regularly attend relevant conferences.

- We saw records that showed all staff received supervision. At the time of our visit, 87% of staff had completed an annual appraisal.

- Neither team reported needing to address poor performance. Both managers were able to explain the performance management process.

Multi-disciplinary and inter-agency team work

- Both teams had regular team meetings, which all members attended. We saw records of the forensic team meetings. Staff also advised us that the intensive support team had recently had a team development week.

- Referrals for both teams come via the local generic community learning disabilities teams. We saw discharge letters that the team sent back to the community teams that gave a comprehensive review of the forensic teams input.

- We were advised that the intensive support service was in the process of developing its admission and

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.

discharge procedures with the local community learning disabilities teams. At the time of the inspection, the service manager advised us that the local community team staff were not clear on their role and the appropriate time to refer to them. The service manager had arranged for their staff to visit allocation meetings to address this issue and the services standard operating procedure was being reviewed.

- The teams would conduct assessments with members of the generic community learning disabilities teams and other appropriate agencies such as the police.

Adherence to the MHA and the MHA Code of Practice

- Only one member of staff had not received Mental Health Act training across both teams.

- Both services would ensure that people had consented to the services involvement and we saw this recorded in their care records.

- The generic community learning disabilities teams managed all other aspects of the Mental Health Act.

Good practice in applying the MCA

- Only two members of staff had not received Mental Capacity Act training across both teams.

- Staff assessed capacity as to whether people could agree to the treatment they had offered. Staff referred other capacity issues back to the generic community teams.
- Staff were aware of where to get advice regarding the Mental Capacity Act.

Are services caring?

Good ●

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

Our findings

Kindness, dignity, respect and support

- We observed two interactions with people and noted the staff acted appropriately at all times, showing the people respect. We spoke with one person and they stated that the staff always treated them respectfully.

- The service provided accessible booklets relating to treatment groups for people.

The involvement of people in the care they receive

- We reviewed six care records and identified that people were involved in developing their care plans. We saw

quotes from people and goals were developed with the patient. People were given copies of their care plans. However, we did identify in two care records that there had been a delay in people receiving them. Staff advised us that this was because the patient had not made themselves available to receive them.

- The service were aware of local advocacy services but stated that most people referred to them would already have an advocate in place.

- There was a patient's forum, which people could attend to give feedback on the service they received. People involved in the forum were able to take part in recruitment of staff.

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

- The service did not keep data relating to waiting times. The forensic team manager explained that they did not have set target time, due to the nature of the service and people referred may need to wait for new groups to start before treatment could begin. Referrals would be categorised as urgent and non-urgent and the service would prioritise initial assessments on this basis. The intensive support team would attempt to respond to all referrals within 24 hours and records we reviewed reflected this.

- Both teams' eligibility criteria was for the person to be receiving treatment from the local community team for people with a learning disability. People must also have an identified specific need that would require specialist input from the team.

- The forensic team offered appointments close to the person`s homes. Staff would agree times and did not discharge people who do not attend appointment. The intensive support team visited people in their own homes who usually have staff support or are currently in hospital. Staff did not report issues with people cancelling appointments.

- The forensic team worked between 0900 and 1700 hrs but would offer some flexibility outside of these hours Monday to Friday. The intensive support team worked from 0800 – 2000 hrs seven days a week.

The facilities promote recovery, comfort, dignity and confidentiality

- The forensic team was based in a building in which they had access to a wide range of rooms. However, due to the large geographical area they covered they would organise most appointments outside of their base. The intensive support team worked in a modern flexible working environment they did not meet people at their base as they would review people in their own homes.

- Services had information in accessible formats, which included information about making complaints, treatments and an annual report on the service. Teams put photographs of the staff on the bottom of letters. Neither team gave complaints forms out as standard at the initial appointment.

Meeting the needs of all people who use the service

- Both services were in buildings that were accessible to disabled people.

- Staff could access interpreters or information in a language other than English from the trust.

Listening to and learning from concerns and complaints

- The services had not received any complaints at the time of our visit. The forensic service had received some compliments but had not logged these on the trust system.

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

- Both teams were aware of and were able to explain the trusts visions and values. The forensic team had developed their own vison and values based on the trusts. The intensive support team were developing their own.

- Staff were aware of who senior managers were. We were made aware of plans for the senior managers to visit the forensic team.

Good governance

- Both services had access to the trust governance systems for supervision and training. We saw evidence that supervision occurred and included discussion about relevant topics.

- Staff were able to explain what actions they would take if they were concerned about safeguarding issues. Staff gave examples of when the services had needed to raise concerns and the actions they had taken.

- Team managers advised us they had enough authority to do their jobs and they gave us examples of this. For example, reviews of staffing mix and operating procedures.

- The forensic team conduct an audit of care plans to check the quality and that staff member had reviewed them appropriately.

- We did identify that two discharge letters had not been upload onto the electronic patient record. The manager advised us they would address this.

- The trust used an electronic system, which contained information on key performance indicators (KPI's) which enabled teams to see how their individual service performed. However, waiting and referral times were not recorded here.

- During the first 12 months of the intensive support team, the service was collecting data to measure its performance against in the following year. These KPI's included the number of referrals, number of admissions to hospital, number of discharges, number of physical interventions used, number of Mental Capacity Act assessments and number of Mental Health Act assessments.

Leadership, morale and staff engagement

- Sickness rates across both services were 2%.

- All staff knew how to use the whistle blowing procedures and we saw posters advising staff of what to do. All staff we spoke with said they would feel able to raise concerns or make a complaint to the team managers.

- Morale was reported as good in both teams.

- Staff were able to explain how they would address the duty of candour but had not needed to do so.

Commitment to quality improvement and innovation

- The services were not currently involved in any national quality assurance schemes.

- The forensic team had published a number of papers in academic journals about their work including about providing forensic services for people with learning disabilities.

- The manager of the forensic service had identified an increase in referrals relating to domestic violence. They arranged an audit that confirmed this.

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Ensure that the intensive support team has an effective procedure in place to ensure staff have all available risk information prior to visiting patients. Information was not stored in a manner that ensured the team had all necessarily information prior to visiting. Regulation 17: 2(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement actions

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.