Good

Surrey and Borders 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)
RXXHQ	Trust Headquarters	East Surrey Team – Kingsfield Centre	RH1 4DP
RXXHQ	Trust Headquarters	South West Surrey Team – Cassis House	GU2 7NR
RXXHQ	Trust Headquarters	South West Surrey Team – Aldershot Centre for Health	GU11 1AY
RXXHQ	Trust Headquarters	Mid Surrey Team – Ramsay House	KT19 8PB
RXXHQ	Trust Headquarters	Chertsey Team – Bourne House	KT16 OJL

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Surrey and Borders Partnership Foundation 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.

Where applicable, we have reported on each core service provided by Surrey and Borders Partnership Foundation NHS Trust and these are brought together to inform our overall judgement of Surrey and Borders Partnership Foundation 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Surrey and Borders Partnership NHS Foundation Trust community mental health services for patients with learning disabilities or autism as **Good** because:

- Staff were very positive about the quality of team work and mutual support.
- People who used the service and their carers told us they knew how to make complaints. The overwhelming majority also told us they did not feel they had any need to complain.
- Patients told us they liked working with staff from the service and felt staff always had time for them.
- Staff involved patients and relatives in planning patients' care and support. Care records showed that staff used professional interpreters when necessary to ensure that patients and their relatives could give their views and make decisions.
- Relatives were given the opportunity to speak privately to staff about any concerns about their caring role. They described a flexible service which responded very quickly when a decline in a person's mental health placed additional stresses on family and carers.
- The teams offered a range of nursing and psychological interventions to meet patients' needs and worked with them, their family and support networks to improve patients' mental well-being and quality of life.
- Care records included information on how patients' physical health was monitored. Staff ensured that all patients received appropriate physical health checks. This included patients who were prescribed medicines which required them to have physical health checks to ensure there were no adverse side effects.
- Relationships between clinicians from different disciplines were constructive and staff told us they felt they were encouraged to make an active contribution to case discussion.
- Care plans were comprehensive and included details of the person's background, social circumstances and health needs. Each person had a recovery and support plan which had information about the person's mental health needs, their physical health needs, the support they could expect from the team and how they wished to be supported towards recovery.
- Staff told us they received regular supervision and appraisals.
- Staff were competent and well-trained.

However:

- Across all services caseloads were being managed but not all services were using a consistent system. At the Kingsfield Centre and Ramsay House clinicians managed their own caseload size and the service relied on the individual clinicians' subjective views with no clear multi disciplinary team oversight.
- None of the six services had undertaken recent ligature audits for the consultation rooms. Staff felt that this had not been a risk up to the point of the inspection and used risk assessments to try to ensure that patients with high risk behaviours were seen in their own environments.
- The service in Aldershot did not promote a positive perception for patients with a learning disability who used the service. The waiting rooms were shared with the mainstream mental health services and were clinical and unwelcoming. The staff attempted to make the best of the environment but there was no appropriate signage or visible information suitable for people with learning disabilities.
- Staff in the community teams for people with a learning disability did not have mandatory training provided in basic issues of working with adults with a learning disability such as autism awareness.
- Staff across the services told us they had not been fully consulted about the proposed divisional changes and development of the new model of intensive support teams. Although they were positive about the direction of travel, staff consistently told the inspection team that they felt alienated from the change process. This had a significant impact on the morale of the staff teams. Staff told us they loved working in their teams and we observed passion in relation to working with the patient group. However, this was affected by the reported concerns regarding the lack of inclusion in the change process.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Staff training data showed 88% compliance in mandatory training for the community teams for patients with learning disabilities.
- Community nurses and psychologists told us they could easily contact a psychiatrist for urgent support and advice if there was a crisis. The psychiatrists we spoke to across all teams had on call systems in place to ensure there was always access to a psychiatrist when required.
- Staff worked with patients support networks to ensure they received their medicines safely.
- We saw evidence in all six services that there was a system for ensuring that staff "lone working" arrangements were being followed. Each of the services had a slightly different local protocol but all staff knew what to do in the event of an issue.
- Staff told us they were freely able to discuss any concerns about risks with their colleagues and received effective advice and support.
- Risk assessments included information on the factors which could increase a person's stress or anxiety and protective factors which helped to maintain their mental health.

However:

- The sites at the Kingsfield Centre and Cassia House did not have a daily fire record of all staff on duty for the entire building.
- We found across all services that caseloads were being managed but not all services were using a consistent system. At the Kingsfield Centre and Ramsay House we found that caseloads were managed by individual clinicians and were very reliant on the individual clinicians' subjective views with no clear multi disciplinary team oversight.
- None of the six services had undertaken recent ligature audits for the consultation rooms. Staff felt that this had not been a risk up to the point of the inspection and used individual patient risk assessments to try to ensure that patients with high risk behaviours were seen in their own environments.

Are services effective?

Good

We rated effective as **good** because:

- The teams offered a range of nursing and psychological interventions to clarify patients' needs and worked with them,

their family and support networks to improve patients' mental well-being and quality of life.Patients and their relatives told us that staff were responsive and changed patients' care and support when necessary.Care plans were comprehensive and included details of the person's background, social circumstances and health needs. Each person had a recovery and support plan which had information about the person's mental health needs, their physical health needs, the support they could expect from the team and how they wished to be supported towards recovery.

- The services offered a range of pharmacological, psychosocial and psychological interventions for patients with learning disabilities who have mental health needs.
- Care records included information on how patients' physical health was monitored. Staff ensured that patients received appropriate physical health checks. This included patients who were prescribed medicines which required them to have physical health checks to ensure there were no adverse side effects.
- The teams all had a large amount of input from psychologists. Most teams had two senior psychologists within the multidisciplinary team. This meant that there was very good access to psychological interventions designed to identify, analyse and support understanding of behaviours that challenge services.
- Relationships between clinicians from different disciplines were constructive and staff told us they felt they were encouraged to make an active contribution to case discussion.

However:

Staff in the community teams for people with a learning disability did not have mandatory training provided in basic issues of working with adults with a learning disability such as autism awareness. The March 2015 Department of Health Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy identifies that NHS trusts must ensure autism awareness training is included within general equality and diversity training programmes for all staff working in health and care.

Are services caring?

Good

We rated caring as **good** because:

- Patients told us they liked working with staff from the service and felt staff always had time for them.

Summary of findings

- Staff involved patients and relatives in planning patients' care and support. Care records showed that staff used professional interpreters when necessary to ensure that patients and their relatives could give their views and make decisions.
- Relatives felt the intervention of the teams was geared to promoting patients' independence and self-confidence.
- Relatives were given the opportunity to speak privately to staff about any concerns about their caring role. They described a flexible service which responded very quickly when a decline in a person's mental health placed additional stresses on family and carers.
- Staff were aware of various sources of advocacy support which were available to patients and explained how they supported patients and their carers to access an appropriate advocate.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The services ran a duty system so there was always a designated clinician who managed the new referrals.
- Inclusion and exclusion criteria for the services were clear and focused on the complexity of patients' mental health needs.
- Patients told us they were able to choose when they had their appointments and staff were reliable and kept their appointments with them. We observed that staff were on time with their appointments.
- Staff told us they had received training on the implementation of the trust's complaints procedures and felt confident implementing them. People who used the service and their carers told us they knew how to make complaints. The overwhelming majority also told us they did not feel they had any need to complain.

However:

- The individual managers of the services used their own tracking systems to monitor the progress of referrals, including those which were not accepted, to provide clear data on the performance of the service. These systems were not standardised however and depended on the capacity of the managers. All of the managers we spoke to split their time between management responsibilities and clinical duties. None of them were full-time managers.
- The service in Aldershot did not promote a positive perception for patients with a learning disability who used the service. The waiting rooms were shared with the mainstream mental health

Summary of findings

services and were clinical and unwelcoming. The staff attempted to make the best of the environment but there was no appropriate signage or visible information suitable for people with learning disabilities.

Are services well-led?

Good

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

- Throughout the community teams for people with learning disabilities, all staff we spoke with were consistently positive and supportive of the trust's values and information was displayed in all offices
- Staff told us they received regular supervision and appraisal and systems were in place to make sure this happened.
- Appropriate risks were being put on the local risk registers by service managers and divisional managers. We saw evidence that action plans were identified and reviewed.
- The managers of the services told us they felt able to manage the services as they wished and were very positive about the contribution of all their staff teams.
- Staff told us the managers of the service were open to their ideas and there were opportunities for leadership development.
- Staff were very positive about the quality of team work and mutual support. We saw that team meetings provided a constructive learning environment for staff

However:

- Staff across the services told us they had not been fully consulted about the proposed divisional changes and development of the new model of intensive support teams. Although they were positive about the direction of travel, staff consistently told the inspection team that they felt alienated from the change process. This had a significant impact on the morale of the staff teams. Staff told us they loved working in their teams and we observed passion in relation to working with the patient group. However this was affected by the reported concerns regarding the lack of inclusion in the change process.

Summary of findings

Information about the service

The Surrey and Borders Partnership NHS Foundation Trust provides a community mental health service for patients over the age of 18 with learning disabilities living in the Surrey area. The service comprises six multi-disciplinary community teams split into two geographical areas, covering the east and the west of the county.

The community health based services for patients with a learning disability carry out assessments of patients' health and social needs. They help plan and arrange care and support for adults with learning disabilities and their carers. They also provide a range of specialist health services such as occupational therapy, physiotherapy, speech and language therapy, community nursing, psychology and psychiatry.

Each team works closely with statutory health and social care providers and voluntary and private organisations in their designated area. The services aim to engage with patients' individual support networks in order to enhance patients' mental wellbeing, independence and quality of life.

The teams can also help patients with learning disabilities gain access to a range of other specialist services such as health, education, day activities, respite care and employment opportunities.

The services were in the process of implementing a major service delivery change. This change was planned to move away from the separate more traditional community teams to a targeted intensive support team model. The new structure and systems were not in place at the time of our inspection.

Our inspection team

The team that inspected community mental health services for people with learning disabilities comprised one Care Quality Commission inspector, one psychologist and two learning disability nurses.

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 patients 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 patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients and carers at focus groups.

During the inspection visit, the inspection team:

- Visited six community teams that provide a mental health service for patients with learning disabilities.
- Spoke with 10 patients using the service.
- Spoke with 11 relatives of patients using the service.

Summary of findings

- Spoke with one supported living housing manager who had knowledge of the service.
- Interviewed the managers responsible for each of the teams.
- Spoke with 28 staff members including nurses, psychologists, occupational therapists, physiotherapists, psychiatrists and administrative staff.
- Attended and observed two multidisciplinary team meetings.
- Read the notes of two recent multidisciplinary team meetings.
- Observed six home visits and clinic appointments with staff.
- Reviewed 27 care records.
- Looked at a range of policies, procedures and other documents relating to the operation of the service.
- Reviewed staff supervision and training records in all services.
- Reviewed management information on the performance of the services.

What people who use the provider's services say

We spoke with ten patients who used the service across the six teams. We also spoke with 11 relatives or carers of patients who used the service.

Patients said staff were polite and friendly and involved them in planning their support. Staff took into account patients' learning disabilities and communication needs and had developed effective tools to fully involve them in developing plans for their care and treatment. Patients described how contact with the service had made them feel better and more confident. Patients said they were always treated with dignity and compassion by the staff from the community teams. They said they had been supported to find new leisure interests and to develop skills to help them find paid work.

Carers spoke positively about the kindness, compassion and responsiveness they received from all staff at the teams we visited. Carers said they were always given relevant information about the service in a format they could understand and were involved with their family member's treatment and regular reviews of their care.

Good practice

The services had developed their own range of 'easy read' leaflets and tools for patients to use.

We saw three of the teams using a Mental Capacity Act (MCA) app which enabled safe and consistent management of the implementation of the MCA. This app was being rolled out across all the community teams. This meant that staff could regularly assess and review patients' capacity to make specific decisions.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The trust should take action to ensure the community teams are involved in the change process and implementation of the intensive support team model.
- The trust should review the environment at the service in Aldershot to ensure it meets all current legislation regarding supporting patients with a learning disability with particular regard to signage and visible information.
- The trust should conduct a regular ligature audit of all environments where patients access the services premises.
- The trust should ensure that the Kingsfield Centre and Cassia House have a daily fire record of all staff on duty for the entire building.
- The trust should ensure that autism awareness training is included within general equality and diversity training programmes for all staff working in health and care.

Surrey and Borders 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
East Surrey Team, Bracketts Resource Centre	Trust Headquarters
East Surrey Team, Kingsfield Centre	Trust Headquarters
South West Surrey Team, Cassia House	Trust Headquarters
South West Surrey Team, Aldershot Centre for Health	Trust Headquarters
Mid Surrey Team, Ramsay House	Trust Headquarters
Chertsey Team, Bourne House	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.

Staff told us they had received mandatory Mental Health Act training as part of their induction training. The trust reported that 100% of staff had completed training in the Mental Health Act.

As a community based service, staff sometimes worked with patients who were subject to community treatment orders (CTO). At the time of the inspection we reviewed the notes for one patient on a CTO and found the paperwork to be in order. Staff could access support and guidance from the trust's Mental Health Act office.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff from all disciplines were able to explain to us the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). 88% of the staff across the six teams had up to date training in the MCA and DoLS.

The staff were aware of trust policies and procedures in relation to the MCA.

The care records we reviewed included reports and notes which showed staff understood how to assess and document patients' mental capacity to make specific decisions, for example in relation to their medicines.

The trust was piloting a MCA app in three of the services which supported the clinicians and the patients to have a consistent and thorough approach toward supporting choices.

Staff explained that it was the service's philosophy to work with patients to improve their understanding of their mental capacity needs in order to maximise their positive engagement with the teams.

During the inspection we observed that staff took time to explain treatment options to patients. They took care during home visits and clinic appointments to make sure patients understood specific decisions, by checking peoples' understanding and repeating information as necessary.

The health professionals we spoke with who were involved in capacity assessments were all aware that assessments were time and decision specific and there was a presumption of capacity unless evidence indicated otherwise.

Staff in the care homes we spoke to told us that the staff who worked in the community mental health services for patients with learning disabilities regularly advised them on the use of Deprivation of Liberty Safeguards when issues arose regarding their patients. Teams were used as a resource to promote good practice in the use of the MCA in this respect.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- All six community teams had access to appropriate interview rooms. The interview rooms were not routinely fitted with alarms, apart from Aldershot Centre for Health, where interview rooms are shared with the community mental health teams. Staff in most of the services felt that alarms were not necessary due to the nature of the clients they supported. The risk assessments we saw indicated when patients required additional support. However, staff could be at risk without access to alarms if patients unexpectedly displayed violent or aggressive behaviour.
- All services had cleaning schedules in place which demonstrated that the premises were being cleaned regularly and to a good standard.
- The sites at Kingsfield Centre and Cassia House did not have a daily fire record of all staff on duty for the entire building. Multiple services worked out of these buildings but there was no overall list of staff in the building. The service operated a system so that each department had responsibility for an area of the building but there was no overall list of staff in the building which could be provided to police and fire services in an emergency situation.
- None of the services had designated clinic rooms. However, we noted that calibrated medical equipment was available for staff if it was required.
- None of the six services had undertaken recent ligature audits for the consultation rooms. Staff felt that this had not been a risk up to the point of the inspection and used individual patient risk assessments to try to ensure that patients with high risk behaviours were seen in their own environments.

Safe staffing

- Staff turnover within the services was high. Eighteen staff had left the service between 1st October 2014 and 30th September 2015.
- Clinical staff told us their caseloads enabled them to spend enough time with each person. For example, the caseloads for community nurses were similar across the services and averaged 25 to 30 patients. Across all services caseloads were being managed but not all services were using a consistent system. At the Kingsfield Centre and Ramsay House, caseloads were managed by individual clinicians.
- Community nurses and psychologists told us they could easily contact a psychiatrist for urgent support and advice if there was a crisis. The psychiatrists we spoke to across all teams had on call systems in place to ensure there was always access to a psychiatrist when required.
- The trust reported no use of agency or bank staff to cover vacancies or sickness across the services. This meant that the staff team was consistent and knew their patient group well. Many of the staff we spoke to had worked for the trust a long time.
- Most of the services had average levels of staff sickness running at 3.6% compared to trust wide which was running at 3%. However within the acute general hospital liaison service there were relatively high levels of sickness running at 6%. These sickness vacancies were covered by existing staff but this meant the staff in the hospital liaison service reported they felt under pressure to cover across the five hospital sites.
- All of the teams we visited had a clear list and understanding of the staffing numbers that were required to meet the needs of the patients they were supporting and the managers could clearly identify where the vacancies were across the services.
- Staff training data showed 88% compliance in mandatory training for the community teams for patients with learning disabilities.

Assessing and managing risk to patients and staff

- Staff told us they always used a risk screening tool as part of the initial assessment of patients who were new to the service. The tool clarified any risks to the person, staff or the public. These, and more detailed assessments of the potential risks to patients' health

Good

Are services safe?

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

and safety, were stored in easily accessible computer based care records. Of the 27 sets of care records we reviewed, 25 had risk assessments in place and were up to date and reflected patients' current circumstances.

- Staff told us they were able to discuss any concerns about risks with their colleagues and received effective advice and support. Risk assessments included information on the factors which could increase a person's stress or anxiety and protective factors which helped to maintain their mental health and keep them safe. For example, a person's risk assessment explained that 'arguing with friends' could precipitate a mental health crisis. The protective factors identified included that the person should have contact with a residential support worker with whom they had a good relationship and could talk about these difficulties.
- Staff were clear on what to do in the event of raising a safeguarding concern. All of the staff offices visited had clear flow charts which detailed who to contact in the event that a safeguarding issue was identified. The staff had completed the trust mandatory training on this topic. The staff gave examples of where safeguarding concerns had been raised in respect of suspected financial abuse and the actions that had been taken. We attended a multidisciplinary handover discussion at Ramsay House where safeguarding issues were identified, discussed and referrals made where they were needed. Care records demonstrated that staff had ensured appropriate referrals were made to the local authority and that they worked in partnership with other organisations to ensure patients were safeguarded.
- Staff told us they followed the trust 'lone working' policy when planning home visits, which ensured that any risks were identified and managed. We saw evidence in all six services that there was a system in place to ensure that staff "lone working" arrangements were followed. Each of the services had a slightly different local protocol but all staff knew what to do in the event of finding themselves in a difficult or risky situation.
- Staff worked with patient support networks to ensure they received their medicines safely. For example, a patient's care plan showed a community nurse had arranged, with their consent, for their support worker to prompt them to take their medicines regularly. Minutes of care programme approach meetings showed that family members were invited to participate and were given information about how patients responded to their medicines. The minutes also showed that issues around side effects were discussed with patients and their carers.

Track record on safety

- Between 27 May 2014 and 20 October 2015 there were 78 serious incidents recorded by the trust, of which one incident related to the community teams for patients with a learning disability.
- Staff told us they had received training on the trust's incident reporting system and understood how to use it. The trust sent out lessons learnt bulletins to all staff to inform them of incidents that had happened across the trust to support learning from incidents.

Reporting incidents and learning from when things go wrong

- Staff teams were open with patients when they made a mistake. In patients' care records we saw evidence that letters had been sent out when there had been errors made in relation to communication regarding outpatient appointments.
- Staff said the team received information from the risk management team about the learning from incidents which occurred elsewhere in the trust. They said relevant information was regularly discussed at team meetings in order to decide how to make any necessary improvements to the service.

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

- Staff provided patients with holistic assessments which aimed to identify factors which impacted on their mental health needs and precipitated any challenging behaviour. The teams offered a range of nursing and psychological interventions to clarify patients' needs and worked with them, their family and support networks to improve patients' mental well-being and quality of life.
- Patients and their relatives told us that staff were responsive and changed patients' care and support when necessary. For example a family member told us that staff were able to change treatment and implement a course of psychological interventions specifically aimed at grief work when their family member had a reaction to a situation in their immediate family.
- We looked at 27 sets of care records across the six sites we visited. All of the care plans we looked at showed staff had worked with patients and their support networks to make a holistic assessment of patients' mental health needs. Overall, it was clear from care records that assessments were completed in a timely manner.
- Information was stored securely and was available to staff when they needed it in an accessible format. However the trust had recently introduced a new electronic records system called System One and data was still in the process of being transferred at the time of our inspection. This meant that staff had to constantly refer to guidance information to locate documentation. Although this was cumbersome, staff across all teams managed the process effectively.
- Care plans were comprehensive and included details of the person's background, social circumstances and health needs. Each person had a recovery and support plan which had information about the person's mental health needs, their physical health needs, the support they could expect from the team and how they wished to be supported towards recovery.
- Relatives and formal and informal carers told us they were fully involved in the assessment process if patients consented to it. Patients told us that staff communicated well with them and took their time and were patient when gathering information.
- Care records included referrals the team had made to speech and language therapists in order to begin the process of establishing ways of communicating with the person. Patients and relatives told us that the team always attempted to involve patients in their assessment using non-verbal methods of communication, such as using pictures, if necessary.

Best practice in treatment and care

- Staff encouraged patients to develop a healthy lifestyle. Patients were supported to attend activities and support groups which promoted physical exercise and good health. Where patients had specific health conditions, such as diabetes, there was reference to this in their support plan in terms of how they were supported to keep healthy. The services liaised with GPs to ensure any follow up actions related to physical health care were made in relation to monitoring patients' health.
- The services offered a range of pharmacological, psychosocial and psychological interventions to patients with learning disabilities who have mental health needs. They described a working environment where colleagues assisted them with patients' care and treatment by regularly reviewing complex situations. Staff told us they had received funding to access external training courses to enhance their skills
- Staff told us they could easily access a pharmacist for advice in relation to patients' medicines if this was required. Medical staff told us that the services were totally committed to avoiding any unnecessary use of medicines.
- Care records included information on how patients' physical health was monitored. Where patients were prescribed medicines which required them to have physical check-ups to ensure there were no adverse side effects, staff had set up arrangements for ensuring these took place. The team liaised with patients' GPs to explain how their physical health should be monitored.
- Relatives confirmed that the service offered a range of interventions to patients. They said psychiatrists were

Are services effective?

Good

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

careful in their use of medicines and the services involved them in developing solutions to manage patients' challenging behaviour. All the relatives we spoke with told us the service had helped them to understand their family member's challenging behaviour and how to respond to it.

- The teams all had a large amount of input from psychologists. Most teams had two senior psychologists within the multidisciplinary team. This meant that there was very good access to psychological interventions designed to identify, analyse and support understanding of behaviours that challenge services.
- The service worked collaboratively with other agencies and was efficient in ensuring patients received joined-up care. It was clear from care records that staff had effective input from speech and language therapists and occupational therapists as part of their teams.
- Patients and their relatives consistently told us that their care and support came from a range of agencies and was well co-ordinated by the services. This included arranging support for patients to find employment, suitable accommodation and to access welfare benefits.

Skilled staff to deliver care

- The teams comprised staff from the mental health disciplines of community nursing, psychiatry, psychology, occupational therapy, art therapy,dieticians, physiotherapy, speech and language therapy. The Kingsfield Centre team also had access to a podiatrist within their service structure.
- All staff we spoke with had received a trust induction before they started in their role.
- All staff told us they received regular supervision and yearly appraisals. Records we looked at confirmed this. Trust data indicated that an average of 75% of staff had received regular supervision over 12 months prior to the inspection.
- Trust data indicated that 83% of staff working in the community team for people with learning disabilities had received an appraisal in the last 12 months
- Staff had met the trust's targets for mandatory training. The community teams had an average of 88% completion of mandatory training compared to a trust average of 76%. This included training in safeguarding, the Mental Health Act and the Mental Capacity Act. Staff records we looked at confirmed this. There were weekly team meetings which were well organised with the full participation of all the disciplines in the team.
- There were mixed views from staff on the value of e-learning, which they felt compromised mandatory training. Some staff felt that e-learning was not suited to their learning style and felt that information was difficult to retain.
- Staff in the community teams for people with a learning disability did not have mandatory training provided in basic issues of working with adults with a learning disability such as autism awareness. The March 2015 Department of Health Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy identifies that NHS trusts should ensure autism awareness training is included within general equality and diversity training programmes for all staff working in health and care.
- Professional staff received appropriate specialist training. A community nurse told us that they had attended a number of internal and external courses to develop their skills. The managers of the services also attended regular meetings with colleagues from the other teams in the service to develop their professional and managerial skills.
- Staff told us their work performance was regularly reviewed by their managers. They were aware of trust policies and procedures for managing poor staff performance.

Multi-disciplinary and inter-agency team work

- The weekly multi-disciplinary team meetings were fully attended by staff. However there was an inconsistent approach toward the structure of the meetings across all services. Cassia House and Aldershot had a very well organised and structured agenda in place which consisted of new referrals, allocations and assessments, discharges, urgent updates and complex case discussion, incidents and safeguarding, complaints and clinical governance issues. This was not shared across all services.

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.

- Relationships between clinicians from different disciplines were constructive and staff told us they felt they were encouraged to make an active contribution to case discussion.
- Each team had administrative staff who told us they felt part of the team and were confident of their role.
- All the teams worked closely with the local GPs to identify people that might have a higher risk of requiring extra support in the community and then built up a support network around them involving the voluntary sector if necessary. This meant that the community teams worked very collaboratively with the local healthcare providers both public and private but also including the voluntary sector.

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

- Information from the trust indicated that staff compliance with the Mental Health Act training was 100% compared to 73% across the whole of the trust. Staff we spoke to had a basic understanding of the implementation of the Mental Health Act which was appropriate to their role.
- In addition, staff told us they had mandatory Mental Health Act training as part of their induction to working at the trust. As a community based service the staff sometimes worked with patients who were subject to community treatment orders. At the time of the inspection we came across one patient on a CTO whose paperwork we found to be in order. Staff told us they could easily contact the trust's Mental Health Act office for guidance.

Good practice in applying the Mental Capacity Act

- Staff from all disciplines were able to explain to us the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). 97% of the staff across the six teams had up to date training in the MCA and DoLS.
- The staff were aware of trust policies and procedures in relation to the MCA.
- The care records we reviewed included reports and notes which showed staff understood how to assess and document patients' mental capacity to make specific decisions, for example in relation to their medicines.
- We also saw in three of the services that the trust was piloting a MCA app which supported the clinicians and the patients to have a consistent and thorough approach toward supporting choices.
- Staff explained that it was the service's philosophy to work with patients to improve their understanding of their mental capacity needs to maximise their positive engagement with the teams.
- During the inspection we observed that staff took time to explain treatment options to patients. They took care during home visits and clinic appointments to make sure patients understood specific decisions by checking their understanding and repeating information as necessary.
- The health professionals we spoke with who were involved in capacity assessments were all aware that assessments were time and decision specific and there was a presumption of capacity unless evidence indicated otherwise.
- Staff in the care homes we spoke to told us the staff in the community mental health services for patients with learning disabilities regularly advised them on the use of Deprivation of Liberty Safeguards (DoLS) when issues arose regarding their patients. In this respect the teams were used as a resource to promote good practice in the use of the MCA.
- The 27 care records we reviewed included reports and notes which showed staff understood how to assess and document patients' mental capacity to make specific decisions, for example in relation to their medicines.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff we observed on visits and in appointments were respectful, responsive and provided appropriate support. We accompanied staff on visits from all services and found the support and treatment offered to people was of a consistently high quality.
- Patients told us they liked working with staff from the service and felt staff 'always had time for them'. A carer told us about how the service had taken into account the patient's background and culture and developed a package of individualised support which addressed the patient's complex needs and promoted the whole family's wellbeing.

The involvement of people in the care that they receive

- Staff involved patients and relatives in planning patients' care and support. Care records showed that staff used professional interpreters when necessary to ensure that patients and their relatives could give their views and make decisions.
- Staff worked with patients to enable them to understand as much about their own needs as possible and worked with other agencies to support patients to become more independent.
- Relatives felt the intervention of the teams was geared to promoting patients' independence and self-confidence.
- We observed outpatients appointments at Bourne House and saw that patients were given information about treatments and medication including side effects and had time to ask questions.
- Staff provided patients with recovery and support plans in an accessible format. However we were unable to see any as the electronic versions on System One were in a staff format. It was clear from the plans that patients had given their input in terms of their personal recovery goals and how they wished to achieve them. Patients and carers told us they had received a copy of their care plan.
- Relatives were given the opportunity to speak privately to staff about any concerns about their caring role. They described a flexible service which responded very quickly when a decline in a person's mental health placed additional stresses on family and carers.
- The services supported carers to access carers' assessments through the local authority and advocacy services when required.
- Staff were aware of various sources of advocacy support which were available to patients and explained how they supported patients and their carers to access an appropriate advocate.
- Patient and carer feedback on the service was collected by the trust using an iPad available in the service receptions. There was also a paper copy available for people to be able to feedback if they did not feel comfortable using the iPad.

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 services ran a duty system so there was always a designated clinician who managed the new referrals. They screened new referrals to ensure they met the service's inclusion and exclusion criteria. In each of the services, representatives from the teams and from across all disciplines met together either weekly or two weekly to confirm the acceptance of referrals. Accepted referrals were then passed to the relevant clinician to arrange an initial assessment. If referrals were identified as high risk the receiving clinician prioritised them for action.
- The teams engaged with people who found it difficult to engage with the services. Two people would visit where risk assessments showed this was beneficial. Visits were able to be arranged outside the home, if a person wished this.
- Generally patients were seen within six weeks of referral for an assessment in accordance with the trust target. Named care co-ordinators were then allocated at care planning meetings to ensure there were no waiting times for patients. Referrals for psychological interventions could wait for longer than this, sometimes for up to ten weeks, depending on the availability of therapists. A community nurse told us that it was normal, whilst patients were on a waiting list for psychology, that the psychology teams would give appropriate professional guidance to the rest of the team. This meant that patients received appropriate support whilst they were awaiting psychological intervention. Relatives described a service that was able to respond promptly when they contacted them and did not raise any concerns about the staffing of the service.
- The individual managers of the services used their own tracking systems to monitor the progress of referrals, including those which were not accepted, to provide clear data on the performance of the service. These systems were not standardised however and depended on the capacity of the managers. All of the managers we spoke to were acting on a part time manager capacity, this meant that they split their time between management responsibilities and clinical duties. We were told this was in part due to the restructuring of the community teams for people with learning disabilities.
- None of the teams was commissioned to provide a 24 hour service. Outside of office hours there was a learning disabilities on call psychiatrist and learning disabilities on call manager who liaised as appropriate. For example, if someone who has learning disabilities needed access to psychiatric intensive care inpatient admission, the on call senior managers for both mental health and people with learning disabilities liaised with each other. They arranged a response as soon as possible from the community team for people with learning disabilities to support any admission to a mental health inpatient setting. We observed this pathway in practice during the course of the inspection when it was identified an adult with a learning disability was admitted to the adult ward, the nursing staff was observed to attend the ward and offer support to the ward staff.
- People in mental health crisis were also supported by the home treatment teams.In addition all people had access to the trust crisis line.
- Inclusion and exclusion criteria for the services were clear and focused on the complexity of patients' mental health needs.
- Across the services we were told about the steps the teams took to engage with several patients who avoided contact with the services. It was evident that staff were flexible in their ways of working with these patients and took time to locate them in the community and try to establish a relationship with them.
- Most patients attended clinic appointments with their family or a support worker so attendance rates were good. Care records showed that when patients were not at home for a planned home visit staff made follow-up telephone calls and used their knowledge of the person's social network to make contact with them.
- Patients told us they were able to choose when they had their appointments and staff were reliable and kept their appointments with them. We observed that staff were on time with their appointments.

Are services responsive to people's needs?

Good

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

The facilities promote recovery, comfort, dignity and confidentiality

- We saw information racks in all waiting areas that had a variety of leaflets informing patients and carers about local services including Patient Advice and Liaison Services, advocacy, concerns and complaints and "you said, we did" boards were seen in some of the waiting rooms.
- The teams all had identified interview rooms in the services. The services were clean and appropriately furnished apart from the Kingsfield Centre which was in the process of moving to a more appropriate building because the interview rooms were not appropriately sound proofed.
- The waiting rooms in Aldershot, which were shared with the mainstream mental health services were clinical and unwelcoming and did not promote a positive perception for patients with a learning disability who used the service. The staff attempted to make the best of the environment but there was no appropriate signage or visible information suitable for people with learning disabilities.

Meeting the needs of all people who use the service

- Patients told us the service met patients' needs in relation to their disabilities. Staff told us how they took into account patients' learning disabilities and any other disabilities they had when assessing and planning their care. For example, assessments included details of patients' communication needs and any sensory impairment they had. Care plans included information on the support patients needed to understand information, participate in decision making and attend appointments.
- All clinics had level access with disabled parking nearby. This made them easily accessible for patients and their relatives if they had physical disabilities.
- Staff said they had easy access to a professional interpreter service if this was needed.
- Information about the services was available in 'easy read' english using non standardised approaches. Staff said it could be translated into any language if required.

Listening to and learning from concerns and complaints

- People who used the service and their carers told us they knew how to make complaints. The overwhelming majority also told us they did not feel they had any need to complain. One person who had complained told us their complaint had been resolved very quickly. There were leaflets which contained information about making comments, compliments and complaints available in all sites.
- There had been one complaint about the community teams for people with a learning disability over the 12 months leading up to the inspection. There were 20 compliments about the services during the same period.
- Staff told us they had received training on the implementation of the trust's complaints procedures and felt confident implementing them.

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

- Throughout the community teams for people with learning disabilities, in all areas and all grades, staff we spoke with were consistently positive and supportive of the trust's values. Information on the values was displayed in all the teams' offices.
- Staff told us they knew senior managers in the organisation because they attended meetings with them and they visited the team offices. Staff received regular emails and a newsletter to inform them of trust updates.

Good governance

- Systems were in place to ensure that staff received mandatory training, were supervised and appraised and were able to prioritise direct care activities. Incidents were reported and learnt from.
- The managers of the service had ensured the safety and effectiveness of the service. Staff were competent and well-trained and improvements were made to the services as required. Multidisciplinary team meetings were observed to be inclusive for all disciplines and were open and constructive.
- Staff across the services told us they had not been fully consulted about the proposed divisional changes and development of the new intensive support team model. Although they were positive about the direction of travel, staff consistently told the inspection team that they felt alienated from the change process, which had a significant impact on the morale of the staff teams. Staff told us they loved working in their teams and we observed passion in relation to working with the patient group. However, this was affected by the reported concerns towards the lack of inclusion in the change process.
- Safeguarding, Mental Health Act and Mental Capacity Act were agenda items on multidisciplinarymeetings. We found good awareness of safeguarding protocols across the teams and mental capacity procedures were adhered to and were embedded in daily practice for all staff.
- Appropriate risks were being put on the local risk registers by service managers and divisional managers and we saw evidence that action plans were identified and reviewed.
- Managers in the service had a set of trust wide performance trackers that related to issues such as staffing levels, sickness management, supervision, compliance with mandatory training and record keeping. Managers we spoke with told us these trackers were used to identify areas of strength and weakness in the services and were useful tools in ensuring the quality of the service they were providing. They said they received appropriate assistance from their managers when areas for improvement were identified.
- The managers of the services told us they felt able to manage the services as they wished and were very positive about the contribution of all their staff teams.

Leadership, morale and staff engagement

- Staff told us leadership programmes were available within the trust and were available to all staff that showed an interest in such development. One member of staff we spoke with had recently been on such a course and was positive about the support they had been given to attend.
- There was a high level of job satisfaction in all the teams. However this had been negatively affected by the lack of knowledge of the plans for the implementation of the intensive support team model.
- Staff did not raise any concerns about bullying and harassment with us during the inspection.
- Staff told us they had received training on whistle-blowing and understood how they would be protected from victimisation if they raised a concern.
- Staff said the managers of the service were open to their ideas and there were opportunities for leadership development.
- Staff were very positive about the quality of team work and mutual support. We saw that team meetings provided a constructive learning environment for staff.
- Staff told us that teams provided student placements to trainee psychiatrists, psychologists and community nurses. They commented that this helped to create a

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.

positive and open learning environment that permanent staff also benefitted from. Some of the staff we spoke to had trained in the team and had subsequently applied for a job there.

Commitment to quality improvement and innovation

- The trust was heavily involved and committed to dementia research and was currently involved in or had applied for the following areas of research:
- Remodelling to deliver outcomes of Future Service Model / Community Team People with Learning Disability Senate model.
- Improving access to psychological therapies work.
- Continued piloting of BADS-ID, Measure of Everyday Planning and Surrey and Hampshire Living with Others.
- Continued data collection for Quality Outcome Measure for Individuals with Dementia.
- New format for Positive and Proactive Support Plans.
- Mental Capacity Act Assessment Tool.
- Alcohol research.
- Plan to re-audit content of supervision for qualified staff.
- Testing against Royal College of Speech and Language Therapists 5 Good Communication Standards.
- Pilot of new multidisciplinary team complex needs pathway in the Mid team – which was a finalist in the Positive CARE awards, which is the Surrey and Borders internal recognition award .
- New dementia information packs devised by the multidisciplinary team had just been completed.
- The trust had also introduced Crisis Café's around the county that adults with a learning disaibility were able to attend in the event of experiencing a crisis in their mental health whist out in the community.