

South Staffordshire and Shropshire Healthcare 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)
RRE4F	The Flanagan Centre	Community Learning Disability Team West	ST16 3AG
RRE4F	The Flanagan Centre	Intensive Support Team Learning Disabilities	ST16 3AG
RREX8	Oak House	Community Learning Disabilities Team Shropshire, Telford & Wrekin	SY3 8XQ
RRE11	Trust Headquarters	Community Learning Disabilities Team East	ST16 3SR

Summary of findings

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community mental health services for people with learning disabilities as good because:

- The trust had appropriate staffing levels across the teams and the caseloads were well managed to ensure patient safety.
- All of the teams completed patients' comprehensive risk assessments and reviewed and updated them as a multidisciplinary team on a regularly.
- Staff had completed mandatory training and had the skills and knowledge to meet patients' needs.
- Staff knew how to recognise and report incidents and the managers provided them with opportunities to learn lessons from incidents.
- Staff assessed and supported patients with their physical health care needs and monitored for any undesirable outcomes. Staff treated patients with respect and dignity and involved them in their care and treatment planning.
- Patients told us they were able and felt free to make a complaint and were confident that the trust would resolve them.

- Staff worked well with other external organisations such as GPs, acute hospitals, independent organisations, local authorities, police and housing associations to ensure that patients got the right support needed.
- The managers were knowledgeable and provided good leadership and support to the staff teams.

However:

- The care records we reviewed showed that staff did not consistently review, update, personalise and address all needs identified in the nursing care plan documentation.
- Staff did not always carry out assessment of capacity to consent in a consistent way in all teams. Some records where patients had been identified as lacking capacity had no documentation in place.
- There was a lack of resources to respond promptly and adequately to out of hours crisis situations. The out of hours service had no learning disabilities skilled staff that were available to respond to patients' needs.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The staffing levels in each team were appropriate to ensure patient safety.
- Records showed that mandatory training levels were above the trust target of 85%.
- Teams carried out risk assessments on every patient at the initial assessment.
- Training records showed that staff received safeguarding training; they demonstrated a good understanding of how to identify and report any abuse.
- The teams had an effective way of recording incidents, near misses and never events. They knew how to recognise and report incidents through the reporting system.

However:

- The interview rooms on all three sites were not fitted with personal safety alarms and that meant staff may not be able to summon help if required in an emergency.

Good



Are services effective?

We rated effective as requires improvement because:

- The care records we reviewed showed that staff did not consistently review, update, personalise and address all needs identified in the nursing care plan documentation.
- Staff did not participate in clinical audits. The team leaders were unable to show us records or action plans of audits that demonstrated staff used the findings to identify and address changes needed to improve outcomes for patients.
- The CLDT West had no capacity assessments in three care records reviewed. The CLDT East had two care records where patients had been identified as lacking capacity to care provided but there was no documented information on how capacity to consent or refuse care had been sought.

However:

- All teams completed comprehensive assessments for patients when admitted to the service.
- Records showed that the teams assessed and supported patients with their physical health care needs.

Requires improvement



Summary of findings

- Staff told us they had undertaken training relevant to their role. Staff received training in areas such as phlebotomy, diabetes awareness, epilepsy, clinical risk management and positive behaviour support.
- All teams had regular and effective multi-disciplinary team meetings that discussed patients' needs in detail to ensure that patients got the treatment they needed.
- The teams had good working links with the external organisations. They had effective partnership working with GPs, acute hospitals, independent organisations, local authorities, police and housing associations.
- The teams demonstrated good practice in adhering to the Mental Health Act (MHA).

Are services caring?

We rated caring as good because:

- We observed good interactions between staff and patients. Staff in all the teams spoke and behaved in a way that was respectful, kind and considerate.
- Patients and their families were highly positive about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with complex needs.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- Staff gathered the views of patients through regular surveys. The responses of patients were fed back to staff, to enable them to make service changes where needed.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- None of the teams had waiting lists for allocation of a care coordinator.
- Staff rarely cancelled appointments and where there were cancellations patients were seen at the earliest possible opportunity. Staff maintained their appointment times and when they were running late patients were informed.
- Staff provided patients with accessible information on treatments, local services, patients' rights, advocacy services, carer support, how the services were run and how to complain.

Good



Summary of findings

- The teams had information leaflets in different languages that were spoken by patients. This meant that non-English speaking patients could be informed of how the services were run.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.

However:

- There was a lack of resources to respond promptly and adequately to crisis care to manage complex needs and behaviour out of hours. The out of hours service had no learning disabilities skilled staff that were available to respond to patients' needs.
- The psychologists told us that there were no facilities in Burton and Tamworth to conduct therapy sessions with patients that were not able to visit Lichfield.
- One interview room at Mytton Oak did not have adequate sound proofing as we could hear the conversation from the room next to it.

Are services well-led?

We rated well-led as good because:

- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- Morale was good within the teams and staff told us that they felt supported by team managers.
- Staff felt confident to raise concerns with managers and that these concerns would be acted upon appropriately. We observed an open culture between staff and team managers.
- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes, and learning from them.
- The trust used key performance indicators and other measures to gauge the performance of the team. Where performance did not meet the expected standard action plans were put in place.
- Staff were participating in a range of quality improvement and innovative practice initiatives.

However:

- Staff did not have easy access to information on performance so that they could use it to develop active plans on improving performance in any areas identified.

Good



Summary of findings

- One staff told us that they do not feel confident that action would be taken to address the issues. They told us that they had previously raised concerns that were not resolved. We were told managers had not addressed reasonable adjustments in the work place for a member of staff.

Summary of findings

Information about the service

The community learning disability teams provided a specialist community based health service for people who have a learning disability or autism living in Staffordshire, Shropshire and Telford and Wrekin. Community nurses supported people to understand their health needs and get the treatment they needed. The community learning disability team west (CLDT West) was based at Flanagan Centre in Stafford and the community learning disabilities team east (CLDT East) was based at Friary Centre in Lichfield. The community learning disabilities team Shropshire, Telford & Wrekin (CLDT Shropshire, Telford & Wrekin) was based at Mytton Oak in Shrewsbury.

The intensive support team (IST) was based at Flanagan Centre in Stafford and provided extensive support to people assessed as having high needs or risk. IST offered home assessment and treatment services to avoid unnecessary admissions to inpatient services. The team also supported people with challenging behaviours or mental health needs to be assessed and treated at home where ever possible.

Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing Standards and Governance, West London Mental Health

NHS Trust

Team Leader: James Mullins, Head of Hospital Inspection (Mental Health), CQC

Our team was comprised of two CQC inspectors, one psychiatrist and one learning disabilities specialist nurse.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the Flanagan Centre at St Georges hospital, Mytton Oak in Shrewsbury and Friary Centre in Lichfield and looked at the quality of the environments,
- visited four patients in their own homes and observed how staff were caring for patients,
- spoke with 11 patients who were using the service and six of their relatives and carers,
- spoke with the three managers,
- spoke with two team leaders,
- spoke with 26 other staff members; including doctors, nurses, nursing assistants, psychologist, administrators, speech and language therapists and occupational therapists,

Summary of findings

- interviewed the matron with responsibility for the intensive support team,
- attended and observed two intake referral meetings,
- attended three clinical review meetings,
- looked at 24 care records of patients,
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us that they were treated with respect and dignity. Staff were polite, kind and willing to help.

Patients and their relatives told us that staff always visited them on time for their appointments.

Patients said they felt able to ring the team when they needed them but there was no support or help readily available in the evenings and weekends.

Patients told us that they discussed their care and treatment with staff and were given copies of their care plans.

Patients told us that they attended their clinical review meetings and were encouraged to involve their relatives if they wished to.

Patients told us that they were given information about the services.

Good practice

None applicable

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that staff consistently and regularly review and update nursing care plans. They must ensure that nursing care plan documentation is personalised and addresses all the needs identified in the assessment.

Action the provider SHOULD take to improve

Action the provider Should take to improve

- The trust should ensure that fixed or portable alarms are available for staff to use in all interview rooms where patients are seen so that staff are able to summon help if required in an emergency.
- The trust should ensure that staff participate in clinical audits and use the findings to identify and address changes needed to improve outcomes for patients.
- The trust should ensure that the CLDT West and CLDT East recorded capacity assessments for patients that have been identified as lacking capacity and demonstrate how capacity to consent or refuse care had been sought.

- The trust should ensure that there are resources to respond promptly and adequately to crisis care to manage complex needs and behaviour out of hours. They should ensure that patients get the right assistance and quick response out of hours from staff skilled in working with people with learning disabilities.
- The trust should ensure that there adequate facilities are provided to conduct therapy sessions with patients
- The trust should ensure that the interview room at Mytton Oak had adequate sound proofing to maintain confidentiality.
- The trust should ensure that staff have easy access to information on performance so that they could use it to develop active plans on improving performance in any areas identified.

South Staffordshire and Shropshire Healthcare 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
Mytton Oak Centre/CLDT Shropshire, Telford & Wrekin	Oak House (Mytton Oak)
The Flanagan Centre/Community Learning Disability Team West	The Flanagan Centre
The Flanagan Centre/ Intensive Support Team Learning Disabilities	The Flanagan Centre
The Friary Centre/ Community Learning Disabilities Team East	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.

Training records at time of the inspection indicated that 91% of staff had received training in MHA. Staff showed an

understanding of the Mental Health Act and the Code of Practice. There was only one patient on a Community Treatment Order (CTO) in CLDT Shropshire, Telford and Wrekin.

The documentation we reviewed for a patient on CTO was up to date, stored appropriately and compliant with the MHA. Consent to treatment and capacity forms were appropriately completed.

Detailed findings

Information on the rights of patients on CTO and independent mental health advocacy services were readily available to support patients. Staff were aware of how to access and support patients to engage with the independent mental health advocate when needed.

The explanation of rights was routinely conducted. This ensured that patients understood their legal position and rights in respect of the CTO. The patient on CTO confirmed that their rights under the Mental Health Act had been explained to them.

Staff knew how to contact the Mental Health Act administrator for advice when needed. Staff told us that they received great support from the administrator.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records at time of the inspection showed that 94% of staff had received training in the MCA. Staff spoken with demonstrated a good understanding of MCA and could apply the five statutory principles.

Assessment of capacity to consent varied across the teams. Staff in CLDT Shropshire, Telford and Wrekin assessed and recorded patients' capacity to consent. Recording of capacity assessments was clear and thorough. The CLDT West had no capacity assessments in three care records reviewed. However, there was evidence in case notes that staff had considered capacity. Staff identified on one patient's initial screening that they lacked capacity but no assessment had been completed or best interest checklist. The CLDT East had two care records where patients had been identified as lacking capacity to care provided but there was no documented information on how capacity to consent or refuse care had been sought. However, we saw

some good examples on how patients' capacity to consent was assessed particularly by the doctors. These were done on a decision – specific basis with regards to significant decisions.

Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.

Staff understood and where appropriate worked within the MCA definition of restraint.

Staff were aware of the policy on MCA and knew the lead person to contact about MCA to get advice.

There were arrangements in place to monitor adherence to the MCA.

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 ward environment

- There were no alarms fitted in any of the interview rooms that we visited; this meant that safety was compromised. Most patients were visited at home but on occasions they were seen by staff at team bases. In order to mitigate the risk of having no alarms, staff saw patients in pairs if it was felt to be necessary. There had been no reported incidents as a result of the lack of alarms.
- Although there were no clinic rooms on the office sites, the teams had cupboards with equipment that nurses would take with them on home visits for undertaking basic physical health monitoring such as blood pressure monitoring equipment, thermometers, blood glucose monitoring equipment and weighing scales. Mytton Oak had a new portable electrocardiogram (ECG) machine. All the buildings had easy access to emergency equipment that was checked regularly such as automated external defibrillators and oxygen from the adjoining wards.
- The Flanagan Centre and Mytton Oak facilities were clean and well maintained. The Friary Centre was an older building that was previously used as a day centre and had furniture cluttered on the ground floor and the decor looked tired. Records showed that the environments were regularly cleaned.
- Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- Portable appliance tests were carried out for the equipment used. The electrical equipment was checked annually to ensure it continued to be safe to use and clearly labelled indicating when it was next due for service. All medical equipment used had stickers on them showing they had been checked and the date that they were next due for checking.
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- .
- .

Team; CLDT Shrops. Telf. & Wrekin; Intensive Support; CLDT E.; CLDT W.

Safe staffing

Est levels: Nurses ; 8 ; 4 ; 8 ; 9

Est levels: HCA's ; 4 ; 2 ; 0 ; 2

Vacancies: Nurses ; 2 ; 0 ; 1 ; 1

Vacancies: HCA's ; 1 ; 0 ; 0 ; 0

Sickness rate ; 5% ; 1% ; 5% ; 1%

Turnover ; 16% ; 0% ; 26% ; 16%

- The staffing levels in each team were appropriate ensuring patient safety. The number of staff on the duty roster matched the number of nurses, nursing assistants and other health professionals on shifts and we found that this was consistent.
- The teams had an average sickness rate of 3% compared to 4.6 trust wide for the period March 2015-February 2016. The staff turnover rate within the services was 16%; the CLDT East had 26% staff turnover which contributed to the high turnover for the service as a whole.
- The teams told us that they did not use agency or bank but arrangements were in place if the use of bank or agency staff was needed to cover staff sickness, leave and vacant posts to ensure patients' safety. Any urgent work that needed to be responded to quickly was covered by duty staff. Another clinician would cover if someone was absent for a long period of time. There was a locum doctor in the CLDT Shropshire, Telford & Wrekin.
- The CLDT teams had an average caseload of between 15 and 25 allocated per care co-ordinator. The team leaders told us that the caseload depended on the needs of each individual patient; the higher the level of complexity of the patients, the smaller the caseload was held. The patients were allocated to a care co-ordinator with the most appropriate skill set to meet their needs. The IST had nine patients on their caseload and worked as a team to meet the needs of the patients rather than manage individual allocated caseloads.

Are services safe?

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

- There were no patients waiting to be allocated a care co-ordinator. The caseloads and case allocations were discussed and regularly assessed in staff weekly meetings and in supervision.
- All of the teams told us that there was quick access to a psychiatrist when required between 9am and 5pm. The psychiatrists were available on site during working hours. However, out of hours there was learning disabilities on-call psychiatrist rota organised through Russell's hall hospital in Dudley.
- Records showed that the average rate for completed staff mandatory training for the teams was 91%; this was above the trust target of 85%.

Assessing and managing risk to patients and staff

- All teams carried out risk assessments on every patient at the initial assessment. We looked at risk assessments in 24 sets of electronic care records and found that these were robustly recorded; particularly in IST. The IST also had detailed positive behaviour support plans in place for all patients. Six out of eight records in CLDT West had up to date risk assessments but one had no assessment of risk documented.
- The records reviewed showed that staff completed crisis plans which were integrated into the care plans. The plans informed staff, carers and patients on what to do in the event of an emergency. Advance decisions were always considered and recorded where appropriate.
- All the teams had a duty system that could respond promptly to sudden deterioration in people's health during working hours from 8.30am to 5pm on weekdays. The IST worked its hours around the needs of their patients. They had flexible arrangements to work evenings and weekends to ensure that the needs of individual patients were met. There was no out-of-hours crisis for people with learning disabilities; patients were given information to contact their GPs, social services out of hours or emergency services. We observed duty workers in all three teams who provided support to patients in a timely manner.
- We asked patients and carers to share their experience of accessing help in crisis. Those people who had used the duty system had been able to get help quickly and easily during weekdays between 9am and 5pm. Response was prioritised according to risk presented.

However, this was not the case out of hours. Patients and carers told us that it was difficult to obtain the most appropriate assistance out of hours and it was only through the GP, social services emergency duty team or A&E. They told us that there was no learning disabilities professional service out of hours. The patient experience survey carried out between April 2015 and March 2016 was responded to by 152 patients and showed that 72% of patients had been told how to get help if needed in the evenings and weekends.

- The teams monitored patients on waiting list according to their risk to ensure that those with high needs were prioritised. Patients presenting as high risk from the initial assessment were immediately and timelines to respond were agreed. For example, dysphagia patients were seen within 10 days.
- Records showed that staff received safeguarding training. Staff demonstrated a good understanding of how to identify and report any abuse and were able to give us examples of how they would respond to safeguarding concerns. There was information about awareness and how to report safeguarding concerns displayed around the team bases. Staff knew who the designated lead for safeguarding was and knew how to contact them for support and guidance. We observed safeguarding being discussed in multi-disciplinary team meetings and staff at CLDT Shropshire, Telford & Wrekin told us that they received regular updates on safeguarding from the safeguarding lead. We looked at the quality of recording of safeguarding information in three sets of electronic case notes and found that this was clearly documented. Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients, relatives and staff on how to report abuse. Patients and their relatives told us that they felt safe with staff from all the teams.
- All staff were aware of the lone working policy. The teams had established systems for signing in and out with expected times of return so that staff whereabouts were known at all times. Staff had mobile phones and receptionists kept contact sheets for staff with their personal details including details of their car. Staff saw patients in pairs where the risk was deemed to be high.

Are services safe?

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

- All teams did not store any medicines. All medicines were given through patients' GPs and staff supported patients to ensure that they had all medicines they required. Nurses

Track record on safety

- There were nine serious incidents across all the teams in the twelve month period from March 2015 to February 2016.
- In April 2015, a serious incident involving the death of a patient occurred in the CLDT East team. The clinical team investigated the incident and used it as a case study for learning lessons and developed an action plan to address the key issues from the investigation. The root cause analysis investigation identified that more robust joint working could have made a difference. We saw that the trust had made several recommendations and had changed the way they worked in partnership with acute hospitals in order to improve joint working between services.

Reporting incidents and learning from when things go wrong

- The trust used the electronic system 'Safeguard' for incident reporting. Staff were able to demonstrate how to use this and could give examples of what should be reported.

- Incidents sampled during our inspection showed that staff reported all incidents that should be reported.
- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made. Incidents were discussed with patients and their families where appropriate. Patients told us that they were informed and given feedback about things that had gone wrong.
- Staff were able to explain how learning from incidents was shared with all staff. Learning from incidents was discussed in staff meetings, via emails, business meetings and through a learning lessons newsletter.
- All learning disabilities team leaders and managers attended clinical governance team meetings where lessons learnt from incidents were shared so that they could be circulated to staff in the teams.
- We saw evidence that teams had introduced changes to working practice as a result of feedback from serious incident investigations. For example, staff had improved communication with acute and primary care services following the death of a patient with a learning disability within an acute hospital setting.
- Staff were offered debrief and support after serious incidents.

Are services effective?

Requires improvement 

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 looked at 24 electronic care records and saw that staff had completed a comprehensive screening tool for 22 new patients to the service. These covered all aspects of care as part of a holistic assessment such as social circumstances, finance, safeguarding, physical health, mental health, medication, communication, and personal information and life style factors. Staff also completed hospital passports, nutritional assessments and communication passports.
 - We reviewed 24 electronic care records and saw that staff did not consistently review, update, personalise and address all needs identified in the nursing care plan documentation. However, patients were involved in discussing the care plans. In the CLDT East; we found that one patients' nursing care plan had not been reviewed since February 2015, another had not been reviewed since April 2015 and two of the records had no care plans in place at all. In the CLDT West we found that six out of eight care plans were not person- centred and did not include patients' views; a further two had not been reviewed on dates set. In the CLDT Shropshire, Telford & Wrekin; we found that four out of seven care plans were not detailed enough to address the full range of needs identified in the holistic assessment. The care plans lacked specific goals, with no detailed interventions and patients' views. The IST staff had completed care plans that were up to date, comprehensive, personalised and recovery orientated and were involved in the care planning.
 - All teams stored information and care records securely in locked cupboards and secure computers. Records were well organised and different team members could access patients' records when needed. The trust used 'RIO' electronic record systems and staff told us that they had problems with easy read care plans and showing that patients had signed their care plans on RIO. The teams used easy read from word and uploaded into RIO. The managers told us that they were working with the information technology department to improve the system.
- The doctors had access to information from National Institute for Health and Care Excellence (NICE) guidance updates that they shared with the clinical team. We saw information on patients' medicines based on NICE guidance which included information shared with GPs on health checks required for patients on certain medication. The doctors wrote concise entries in the case notes that shows they follow NICE guidance when prescribing medication and associated monitoring of medication; for example, patients who were prescribed antipsychotic medication.
 - Patients could access psychological therapies as part of their treatment. For example, anxiety management, cognitive behavioural therapy and family therapy were offered as part of the services.
 - The teams offered practical support for patients with voluntary jobs, housing and benefits. The teams had strong links with an organisation ran by and for disabled people that supported patients with any support needed, information and legal advice.
 - Staff considered physical healthcare needs routinely. We looked at 24 sets of electronic healthcare records to check if physical healthcare was monitored. Twenty two out of the 24 records demonstrated that staff had carried out an evaluation of physical health. Staff completed physical health checks at the point of referral. The doctors wrote letters to GPs that included NICE guidelines to request that routine blood tests and ECGs were carried out for patients on antipsychotic medication. Nurses monitored blood pressure and weight but all other physical health checks were managed by GPs. There was a system for ensuring annual health checks were undertaken which included dysphagia assessments, epilepsy and nutrition and hydration where needed. The CLDT Shropshire, Telford & Wrekin had two full time acute liaison nurse that supported and facilitated patients' hospital appointments and worked closely with the acute hospitals, dentists and GPs. The managers told us that they were in discussions with commissioners to replicate this provision across all of the teams.
 - Staff completed the Health Equality Framework as an outcome measure for patients. The occupational therapist used the Model of Human Occupation

Best practice in treatment and care

Are services effective?

Requires improvement 

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.

Screening Tool (MoHOST) to monitor progress and recovery. Staff monitored progress regularly in care records and recorded data on progress towards agreed goals in each patient's notes.

- The trust carried out a range of clinical audits to monitor the effectiveness of the service provided. These audits included health records, infection control and supervision. However, the team leaders were not able to show us records or action plans of these audits on their sites. They were not able to give any identified areas of improvement from the audits and there was no evidence that the teams used the findings to identify and address changes needed to improve outcomes for patients. Staff and team leaders told us that they did not participate in clinical audits and it is one area that they felt that they need to improve upon. They told us that audits were carried out at trust level and they did not see the results in order to address the improvements required.

Skilled staff to deliver care

- The CLDT Shropshire, Telford & Wrekin had a full range of learning disabilities disciplines including psychologists, doctors, speech and language therapists, physiotherapists, nurses, nursing assistants and occupational therapists. The CLDT West, CLDT East and IST did not have physiotherapists, speech and language therapists and dietetics within the teams but were able to access these professionals from the primary healthcare services. The IST were in the process of recruiting a social worker.
- All of the teams had experienced and appropriately qualified staff. The teams were mostly made up of band six nurses which reflected their level of experience. All staff in the IST were trained or still undergoing intensive training in positive behaviour support. The teams also included nurse prescribers.
- The teams had developed a clinical role for mental health liaison nurse through their clinical effectiveness groups to support the staff in mental health acute wards to look after patients with learning disabilities that had been admitted to the acute wards. We were told that the role was created to provide training, support and work alongside staff from acute wards so that they were able to support patients with learning disabilities that were admitted to the wards through the crisis team.

- New staff received appropriate trust and a local team induction. This involved shadowing experienced staff before they could work on their own. Unqualified staff were able to complete the care certificate. Staff told us that they received an appropriate induction.
- We saw records that showed the team leaders provided regular and good quality supervision to staff. There was an electronic recording system that recorded dates of supervision which enabled the team leaders to ensure regular supervision was taking place. The teams had access to regular team meetings weekly and monthly.
- Annual appraisals were consistently carried out; the average rate between march 2015-february 2016 was 86%
- Doctors told us that continuing professional development was supported by the trust and they had attended different sessions with other medical staff. Non-medical staff told us they had undertaken training relevant to their role. Staff were trained in ECG, phlebotomy, diabetes awareness, epilepsy, clinical risk management and positive behaviour support.
- Managers addressed issues of staff performance in a timely manner through management supervision and they were supported by human resources team when required.

Multi-disciplinary and inter-agency team work

- Regular and effective multi-disciplinary team meetings took place. These meetings involved all different professionals within the teams and other external professionals. We attended two multi-disciplinary team meetings and looked at 24 records of previous ones. The discussions held addressed the identified needs of the patients such as risk and safeguarding concerns; they were also patient-centred and respectful.
- We attended two intake meetings where referrals were discussed and found them to be effective. Staff held detailed holistic discussions and identified the professional responsible for taking lead to address any needs that were identified.
- The teams had a good working relationship and shared information effectively. We saw that the IST attended CLDT meetings and the mental health liaison nurse had regular contact with the acute mental health inpatient wards. They shared information effectively about

Are services effective?

Requires improvement 

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.

patients likely to move between services. Patients transferred between teams were discussed in detail before the transfer was made and continued to support each other when needed.

- The teams had good working relationships with the external organisations. They worked closely with independent social care providers to support them and gather information about risks, clinical needs and discharge planning. They worked together with social services, care providers and carers to review the risk assessments and care plans within the care programme approach process and facilitated safe discharge. The acute liaison nurse in Shropshire had strong links with the GPs, dentists and acute hospitals. They had effective partnership working with GPs, hospitals, local community facilities, local authorities, police and health commissioners.

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

- Training records indicated that 91% of staff had received training in MHA. Staff showed an understanding of the Mental Health Act and the Code of Practice and guiding principles. There was only one patient on a Community Treatment Order (CTO) in CLDT Shropshire, Telford and Wrekin.
- The documentation we reviewed for a patient on CTO was up to date, stored appropriately and compliant with the MHA. Consent to treatment and capacity forms were appropriately completed.
- Information on the rights of patients on CTO and independent mental health advocacy services were readily available to support patients. Staff were aware of how to access and support patients to engage with the independent mental health advocate when needed.
- The explanation of rights was routinely conducted. This ensured that patients understood their legal position and rights in respect of the CTO. The patient on CTO confirmed that their rights under the Mental Health Act had been explained to them.

- Staff knew how to contact the Mental Health Act administrator for advice when needed. Staff told us that they received great support from the administrator. The MHA administrator carried out audits to check that the MHA was being applied correctly.

Good practice in applying the Mental Capacity Act

- Training records showed that 88% of staff had received training in the MCA. Staff who we spoke with demonstrated a good understanding of the MCA and could describe the five statutory principles.
- Assessment of capacity to consent varied across the teams. Staff in CLDT Shropshire, Telford and Wrekin assessed and recorded patients' capacity to consent. Recording of capacity assessments was clear and thorough. The CLDT West had no capacity assessments in three care records reviewed; however, there was evidence in case notes that staff had considered capacity. Staff identified on one patient's initial screening that they lacked capacity but no assessment or best interest checklist had been completed. The CLDT East had two care records where patients had been identified as lacking capacity to care provided but there was no documented information on how capacity to consent or refuse care had been sought. However, we saw some good examples on how patients' capacity to consent was assessed particularly by the doctors. These were assessed on an individualised basis with regards to significant decisions.
- Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest whilst recognising the importance of their wishes, feelings, culture and history.
- Staff were aware of the policy on MCA and knew the lead person to contact about MCA to get advice.
- There were arrangements in place to monitor adherence to the MCA.

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

- We observed different interactions between staff and patients in three home visits, four clinic appointments and during telephone calls. Staff interacted with patients in a polite and respectful way; they were considerate and willing to support patients. Staff showed that they knew and understood the individual needs of their patients and we observed that they took their time to explain things to patients and were very responsive and reassuring.
- We spoke to 11 patients and six carers; all gave us a positive feedback about how staff behaved towards them. Patients and families were complimentary about the support they received from the staff and felt staff provided the help they needed. Patients and their families told us that staff treated them with respect and dignity. Staff were polite, kind and encouraged them to make choices about their care and treatment.
- Staff showed a good understanding of how to maintain confidentiality when they held discussions about patients' care and how they protected information when out on visits.

The involvement of people in the care they receive

- Our observation of practice, review of records and discussions with patients and their relatives confirmed that patients were actively involved in their CPA and clinical reviews, care planning and risk assessments. We observed a patient clinical review at Mytton Oak and saw that the patient was involved in making decisions about their care and that they were offered choices. Staff encouraged patients and relatives to freely express their views. Patients told us that their views were listened to. Staff used different methods to give information at a level that patients could understand. We went on a home visit with a nurse in Lichfield and they went through an easy read care plan with the

patient. Patients were given copies of their easy read care plans if they wished. Staff encouraged patients to maintain and develop independence. For example, patients were encouraged to take their medicines independently and make informed choices about their lifestyles.

- Staff encouraged patients' relatives and friends to be involved in care planning with the consent of patients. Family members' views were taken into account in care and treatment plans. The IST provided a high level of support to families and carers in the form of spending time supporting and advising on ways to manage and reduce behaviours that challenge. The assistant practitioners spent time working with families and carers in their own homes and offered short breaks to families. The learning disability psychology services in Shrewsbury ran a group called 'families team' which offered psychological support to patients their families and carers.
- Staff were aware how to access advocacy services for patients. Families, carers and patients were given easy read leaflets that contained information about advocacy services. Patients and their families told us that they could to access advocacy services when needed.
- Patients were involved in decisions about their service. The trust produced a video to assist people with learning disabilities to take part in interviews for staff recruitment.
- The teams conducted patient surveys to gather their views. The results were analysed to formulate trends and themes in order to enable staff to make changes to the service where needed. There were forms regularly given to patients when they visited the teams for meetings and to give feedback or raise any issues. The managers addressed any actions and fed back to patients. In addition, the teams had a suggestion box where patients and relatives could post suggestions about how the service was run.

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 & discharge

- Target times for referral to assessment were 14 days for urgent and high referrals; four weeks; intermediate referrals eight weeks and 14 weeks for standard referrals. If referral is urgent a duty worker made contact with patient or referrer to assess priority of need within one working day. We saw that priority was given to patients with urgent needs immediately. The duty worker added the referral to intake list for review by the multidisciplinary team at the next meeting no more than seven days from receipt of referral.
- The community teams operated a duty worker system between 9am and 5pm that responded promptly to any referrals received. Each team allocated a qualified staff on duty from 8.30am until 5pm on weekdays. Referrals to the teams came from GPs, families, colleges, social services and self-referrals to duty staff for triage. The teams had a multidisciplinary intake approach to all referrals. All referrals were reviewed by a clinician within two hours of receipt if an urgent or immediate action is required. When urgent referrals were made to the teams, a joint screening process was carried out between CLDT and IST. The joint screening informed consideration of what involvement is needed from the CLDT and also considered whether a referral to IST was required. Referrals were only seen between 9am and 5pm weekdays. The IST referrals were seen within 24 hours if a referral was received within normal working hours. The average waiting times for referral to assessment in the 12 month period from April 2015 to March 2016 was 31 days for CLDT Shropshire, Telford & Wrekin, and 31 days for CLDT East, 10 days for IST and 33 days for CLDT West. The average waiting times for assessment to treatment in the same period was three days for CLDT Shropshire, Telford & Wrekin, and 29 days for CLDT East, 15 days for IST and 40 days for CLDT West.
- The teams responded on time and effectively when patients required routine care between 9am and 5pm weekdays only. There was a lack of resources to respond promptly and adequately to crisis care to manage complex needs and behaviour out of hours. The out of hours service had no learning disabilities skilled staff that were available to respond to patients' needs. All patients in crisis out of hours were asked to contact their GPs or social services. The IST was able to arrange their staff around the needs of the patients on their caseload. They ensured that patients likely to be at increased risk out of hours were supported. The team was very flexible in that they could make staff available in the evenings and weekends to ensure that patients' continued to get adequate support when going through difficult times.
- There was a clear inclusion criterion which stated that services would be provided in the community to people with learning disabilities who were over 18 years old, had complex health needs and had difficulties that cannot be fully met within mainstream services. Services included assessment of learning disability, support with complex health needs such as physical disability, epilepsy, autism, dementia and mental health problems that included mood disorder, schizophrenia and anxiety and complex behavioural needs that challenged the services.
- The teams took active steps to engage with patients who were reluctant or found it difficult to engage with their services. The teams offered patients opportunities to be seen where they felt most comfortable such as at home, the team base, day services or colleges. These patients were discussed in team meetings and strategies were put in place on how to best engage them. The teams also discussed patients who did not attend appointments and took proactive steps to re-engage with these patients such as cold calling, repeated phone calls and follow up discussions with the referrer. They contacted patients the day before to remind them of their appointment.
- Staff set up appointments in a way that was flexible to patients. Appointments were discussed with patients to check the best suitable times for them and they were able to express choices regarding the time of next appointment.
- Appointments were not cancelled unnecessarily and where there were cancellations, patients were seen at the earliest possible opportunity. Patients told us that they were always seen on time and any cancellations were explained to them and seen at the next available appointment. The clinic and home appointments that we observed ran on time.

Are services responsive to people's needs?

Good 

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

- The teams maintained their appointment times and when they were running late; patients were informed. Patients told us that staff were reliable and arrived on time to their appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The teams had easy access to equipment such as defibrillators, oxygen cylinders and masks for emergency use when needed although none of the locations had clinic rooms to examine patients. There were enough therapy rooms to conduct one to one or group sessions. The Friary Centre had a multi-sensory room where patients spent time with the occupational therapists engaged in therapeutic programmes. The psychologists told us that there were no facilities in Burton and Tamworth to conduct therapy sessions with patients that were not able to visit Lichfield.
- One interview room at Mytton Oak did not have adequate sound proofing as we could hear the conversation from the room next to it. The other interview rooms were appropriately designed and located for the purposes of clinical interviews.
- The teams provided patients with accessible information on treatments, local services, patients' rights, advocacy services, carer support, how the services were run and how to complain.

Meeting the needs of all people who use the service

- All the areas visited by patients had an environment that had full disabled access.
- The teams had information leaflets in English and were available in easy read and pictorial format. Staff told us that leaflets in other languages could be made available from patient advice and liaison services when needed. We saw that information on how to get information in other languages was readily available to staff and patients; this meant that non-English speaking patients could be informed of how the services were run.

- The teams had access to interpreters when needed and staff were able to tell us how they could access interpreting services.

Listening to and learning from concerns and complaints

- There had been no formal complaints in the 12 month period from March 2015 to February 2016 for any of the teams. Information about complaints was held centrally by the trust. The CLDT Shropshire, Telford & Wrekin service had recorded eight informal complaints in the last 12 months. Staff had dealt with seven of the complaints at a local level and kept a log of these complaints; one of which was still under investigation at the time of our inspection. The team received 31 compliments from June 2015 to Dec 2015. The compliments varied; themes included access to easy read documentation, inter agency working and staff support to families and carers.
- The teams had information on how to make a complaint and patients were given this information. Patients could raise concerns with staff anytime. Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. Patients told us that they could raise any concerns and complaints freely.
- The patient experience survey carried out between April 2015 and March 2016 was responded to by 152 patients and showed that 86% knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them. Staff were aware of the formal complaints process and knew how to support patients and their families when needed.
- Our discussion with staff and records reviewed showed that any learning from complaints was shared with the staff team through staff meetings and lessons learnt bulletin.

Are services well-led?

Good 

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

Our findings

Vision and values

- The visions & values of the trust were displayed throughout the team bases. Staff agreed with and were familiar with the trust's values which were also linked to the teams' objectives.
- Staff knew who their senior managers were and told us that they regularly visited the teams.

Good governance

- The trust had effective governance processes to manage quality and safety; the team leaders used these methods to give assurances to senior management in the organisation. There was a clear operational structure and governance arrangements. Managers were experienced and knowledgeable and demonstrated strong leadership of the teams.
- Staff received mandatory training and team leaders had a clear system for monitoring compliance and identifying areas of poor performance against trust training targets.
- All teams received regular supervision. There was an electronic monitoring system that recorded dates of supervision which meant that managers were able to ensure that supervision was taking place on time.
- The trust encouraged staff to learn lessons from incidents, complaints and patients' feedback. In addition to discussions that took place in staff meetings, the risk management team circulated the 'Learning Lessons Quarterly Bulletin' to staff with detailed information on lessons learnt from different trust services.
- The trust had a safeguarding lead and there was good awareness of safeguarding procedures. Safeguarding was discussed in multi-disciplinary team meetings and clearly documented. The trust had an MHA administrator that ensured staff had the right support to enable them to apply the MHA procedures correctly. Staff had a good awareness of the MHA and the MCA.
- Staff did not participate in clinical audits used to monitor the effectiveness of the service provided. They did not use the findings to identify and address changes needed to improve outcomes for patients.

- The team leaders provided data on performance to the trust consistently. All information provided was analysed at team and directorate level to identify themes and trends. The information was used to improve the quality of service provided. The teams captured data on performance such as CPA reviews, caseloads, waiting times, did not attend and cancellations of appointments. The performance indicators were discussed at business meetings and monthly clinical quality review meetings. However, this information was held centrally by the trust and staff did not have easy access to this information so that they could use it to develop active plans on improving performance in any areas identified.
- The team leaders felt they were given the freedom to manage the teams and had administration staff to support the teams. They stated where there were concerns, they could be raised; and where appropriate placed on the organisation's risk register.

Leadership, morale and staff engagement

- The sickness and absence rate in the 12 month period from March 2015 to February 2016 was 3%; this was lower than the trust average rate of 4.6%.
- The team leaders reported that there were no bullying or harassment cases within the teams.
- Staff knew how to whistleblow and told us they would feel confident in doing so if necessary. However, one staff told us that they do not feel confident that action would be taken to address the issues; they told us that they had previously raised concerns that had not been resolved.
- We observed an open culture between staff and team leaders.
- The teams had all undergone a number of changes over the previous 12 months. This included a service redesign, closure of learning disabilities inpatient beds, introduction of the IST and a new electronic records system. It was acknowledged that the amount of change had been difficult but morale was good and staff told us that they felt supported by team managers.
- Opportunities for leadership development were available. The teams had structures that supported career development. The team leaders were trained in leadership courses such as coaching skills, leading teams and management skills for middle managers.

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.

- The teams were cohesive and supportive of each other. Staff were respectful of each other's roles and we observed that staff contributed fully in team meetings.
- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes and learning from them. Incidents were discussed in staff and business team meetings.
- The CLDT Shropshire, Telford & Wrekin had used away days to discuss ideas for improvement and feedback on service provided. Staff in all the teams felt able to take ideas to their managers. Staff were able to give feedback on the service and input into service development through their staff meetings.
- The clinical psychologists were involved and had just published their research on 'professionals' attitudes towards hearing voices and people with learning disabilities'.
- Nurses from the learning disabilities directorate were participating in a Cambridge University randomised controlled study: Improving outcomes in adults with epilepsy and intellectual disability: A cluster randomised controlled trial of nurse led epilepsy management.
- The learning disabilities directorate had developed four clinical effectiveness group (CEG) that utilised the knowledge, skills, expertise of all clinicians in partnership with the stakeholders, patients and family carers to help plan the services. The CEG focussed on four pathway groups to develop what training staff needed to do their job best and measure the outcomes of they do in physical health, mental health, autistic spectrum conditions and positive behaviour support.

Commitment to quality improvement and innovation