

Good 

Coventry and Warwickshire Partnership NHS Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Trust Head Office
Wayside House
Wilsons Lane
Coventry
Tel: 02476 362100
Website: www.covwarkpt.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYG	The Loft, Nuneaton	Community Learning Disability Team	CV11 5HX
RYG	The Railings, Rugby	Community Learning Disability Team	CV12 2AW
RYG	Oliver House, Solihull	Community Learning Disability Team	B37 7HJ
RYG	Whitnash Lodge, Leamington	Community Learning Disability Team	CV34 6ED
RYG	Wood End, Coventry	Community Learning Disability Team	CV2 1ST

Summary of findings

RYG	Ashby House	Ashby House	CV11 6XL
RYG	22 Gilliver Road	Shirley House	B90 2DS

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership 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 Coventry and Warwickshire Partnership Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership 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?

Requires improvement 

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 or autism as good because:

- Staffing levels were appropriate across the teams and caseloads were well managed to ensure patient safety.
- Initial triage assessments were completed within 24 hours of a referral being received by the service.
- Teams completed comprehensive risk assessments for all patients who received care and support from the service.
- Staff had completed mandatory training and had the knowledge and skills to meet the patients' needs.
- Staff reported incidents appropriately and there were systems in place to learn from incidents to improve practice.
- Patient records were stored on an electronic care record system that all staff used to access and update patient records.
- Care plans and reviews were person centred, holistic and in a format, the patient could understand.
- The acute liaison team provided support to local acute hospital staff to help them understand the patient's needs, like and dislikes during their stay and the intensive support team supported patients to remain in the community to prevent admission to learning disability inpatient wards.
- Staff had a good understanding and knowledge of the Mental Health Act and the Mental Capacity Act and applied the knowledge to practice.
- Staff treated patients, family members and carers with dignity and respect and fully involved them in all aspects of the patient's care.
- Patients and family members spoke highly of the care and treatment they received and said staff were always available for support between arranged appointments.
- Staff worked in partnership with external statutory and non-statutory agencies including local GPs, acute hospitals, police, local authorities, colleges, care providers, housing providers, and support networks to ensure the patient was supported to live in the community.
- The service had good governance systems in place to assess, monitor and improve service performance. Clinical audits were undertaken and practice was benchmarked against national guidance.
- Managers provided good leadership of the teams and were knowledgeable about the service. Staff reported feeling valued by the management team and supported in their roles.

However:

- There were long waiting lists for patients to access assessments. Patients had to wait up to 118 weeks for an occupational therapy assessment and up to 52 weeks for a psychology assessment. This was outside the 18 week national target.
- There was no emergency equipment at the respite units.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Staffing levels in the teams were appropriate to ensure patient safety.
- Records provided by the trust showed staff completed mandatory training and the service had achieved a compliance rate of 95%. For safeguarding adults and children and Mental Capacity Act training the compliance rate was 96%.
- All patients had a risk assessment completed at the initial assessment and records showed risk assessments were regularly updated.
- Staff knew how to recognise and report incidents through the trust electronic reporting system and the trust informed all staff of lessons learned from incidents via emails and newsletters. The teams discussed lessons learned as part of the weekly meetings.
- The robust lone working policy was in place and followed by all staff to keep them and patients safe.
- The trust reported no serious incidents for the service in the previous 12 months.

However

- Emergency bags in Ashby and Shirley Houses were not accessible to all staff.

Good



Are services effective?

We rated effective as good because:

- Patient care plans were holistic, patient centred, recovery orientated, and strength based and reviewed regularly. Care plans were stored securely in an electronic care record system. Patients received copies of their care plan in a format that supported their communication needs.
- Staff recorded consent to care and treatment in the 10 of the 12 records reviewed. We saw Mental Capacity assessments completed, decisions recorded in the care records and were in accordance to the Mental Capacity Act.
- The trust had a planned schedule of audits delivered by a central team and staff took part in clinical audits of their service to improve patient care and outcomes.

Good



Summary of findings

- Staff monitored progress of patients by using a range of outcome measures including Health Equality Framework, the Health of the Nation Outcome Scales and the Model of Occupation Screening Tool.
- Staff received regular supervision to monitor performance and caseloads, in line with trust policy and the trust reported 86% of staff had annual appraisals as of the 31 January 2017.
- Multi-disciplinary team meetings were held weekly to discuss referrals, allocation, patients' needs and increased risks were reviewed.
- Staff demonstrated a good understanding and good practice in adhering to the Mental Health Act and Mental Capacity Act.

Are services caring?

We rated caring as good because:

- Patients and family members we spoke with said staff were polite, treated them with respect, dignity and kindness.
- Patients and family members said the staff went above and beyond to support them and were very responsive to their needs between planned appointments. Patients said the staff supported them to maintain their independence in the community.
- Patients and family members were fully involved in planning the care of the patient and staff would access other agencies support to help the patient achieve their goals.
- Patients and family members were able to give feedback on groups they attended to improve them and patients were involved in the recruitment process for employing staff.
- Patients and family members knew how to complain and access the patient advice and liaison service.

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:

- There were long waiting lists for patients to access assessments. Patients had to wait up to 118 weeks for an occupational therapy assessment and up to 52 weeks for a psychology assessment. This was outside the 18 week national target.

However:

- The central booking system completed initial triage assessments within 24 hours of receipt and the service had processes in place to respond to urgent patient need.

Requires improvement



Summary of findings

- Patient and family members spoke highly of the responsiveness of the teams should they require support between planned appointments. The cancellation of appointments was rare and if it happened, new appointments were offered quickly, staff would contact them if they were delayed for a home visits and appointments for clinical reviews ran to time.
- The teams took active steps to engage with people who found it difficult to engage with the service. They worked with other services to provide treatment to patients that would cause the patient the least amount of distress and anxiety.
- Staff had the flexibility to offer appointments times and venues convenient to patients and family members.
- The service provided patients and family members with information on the treatments offered, support groups, advocacy services, patients' rights, and how to complain. This information was accessible in different formats including easy read and pictorial.
- Staff offered training and support for other professional to provide improved patient care.
- Patients and family members knew how to raise concerns and complain, if they needed to.

Are services well-led?

We rated well led as good because:

- Staff knew the trust's visions and values and embedded them in their practice, including the supervision model which was based on the trust's values.
- The teams had governance processes in place to monitor the effectiveness of service, which team leaders monitored and reported to senior managers.
- Staff received regular supervision and annual appraisals, in line with trust policy, and their mandatory training was up to date.
- Staff reported team morale was high, team working was very good, and they felt valued by their colleagues and managers.
- Managers encouraged staff to participate and contribute to quality improvement and innovative practice initiatives. Staff had been nominated and received the recognition from the trust for quality improvements via the 'Q awards'.
- Staff had opportunities for professional career development. The service had developed a strategy to invest in assistant practitioners and support them to qualify in their chosen discipline.

Good



Summary of findings

Information about the service

The community services for patients with a learning disability or autism support approximately 21,500 people in five locations across the trust based in South Warwickshire, North Warwickshire, Rugby, Coventry and Solihull.

Patients requiring support from the services are referred via a central booking service who carry out a triage assessment of need, which is discussed and prioritised at the weekly multi-disciplinary teams (MDT) meeting. The multi-disciplinary teams (MDT) include speech and language therapists, psychologists, psychiatrists, community nurses, managers, occupational therapists, physiotherapists and healthcare support workers.

The community teams support patients with a range of healthcare needs and provide specialist advice for patients with complex health needs and/or behavioural challenges. The teams are able to support patient with autism, mental health problems, dementia, learning disabilities to live in community settings. Physiotherapist provide support to patients who have mobility, posture and neurological conditions.

Ashby House provides respite care for adults 18 years and over with a severe learning disability, associated conditions and mental health needs. The unit comprises seven beds divided into two sections: High dependency unit with four beds and is predominately used for individuals with complex needs. The challenging behaviour unit has three beds used for individuals with behaviours that challenge. The staff team work in a multidisciplinary fashion providing planned overnight stays with 24 hour nursing care, day support and activities during their stay.

Shirley House is a respite service that provides 24-hour support for adults with a learning disability and complex health needs. The unit is nurse led and comprises 10 beds divided into two sections: Ivy with five beds and is predominately used for individuals with challenging behaviour and the Vines with five beds for individuals with complex healthcare needs and limited mobility.

Our inspection team

Our inspection team was led by:

Team Leader: James Mullins, Head of Hospital Inspection, (mental health) CQC

Inspection Manager: Paul Bingham, Inspection Manager, mental health hospitals CQC

The team that inspected the community mental health services for people with learning disabilities services consisted of one CQC inspector and three specialist advisors.

The team would like to thank all those who we met and spoke with the team during the inspection. People were open with the sharing of their experiences and their perceptions of the quality and treatment at the trust.

Why we carried out this inspection

We undertook this inspection to find out whether Coventry and Warwickshire Partnership Trust had made improvements to their community mental health services for people with learning disabilities or autism since our last comprehensive inspection of the trust in April 2016.

When we last inspected the trust in April 2016, we rated community mental health services for people with learning disabilities or autism as requires improvement overall.

Summary of findings

We rated the core service as requires improvement for safe, effective and well led and good for caring and responsive.

Following the April 2017 inspection, we told the trust that they must take action in the following areas:

- The trust must ensure that staff receive mandatory training, including safeguarding vulnerable adults and children training and training in the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust must ensure that staff received regular supervision and appraisal.

- The trust must ensure there is an effective clinical governance system in place to monitor patient care, risk assessments, care plans, and adherence to the Mental Capacity Act.

These related to the following regulations under the Health and Social Care (Regulated Activities) Regulations 2014:

- Regulation 11(1) (2) (a) HSCA 2008 (regulated activities) Regulations 2014.
- Regulation 17 (1) (2) (a) (c) HSCA 2008 (regulated activities) Regulations 2014
- Regulation 17 (2) (a) HSCA 2008 (regulated activities) Regulations 2014

How we carried out this inspection

To fully understand the experience of the 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 patient's needs?
- Is it well led?

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

During the inspection visit, the inspection team:

- visited Ashby and Shirley House, the Loft, Ivy House, the Railings, Whitnash Lodge and Wood End community services and looked at the quality of the environments. We did not visit Civic Centre, Coventry site as staff were moving to a new site.
- spoke with the interim head of services

- spoke with five team leaders, two managers, and two deputy managers
- spoke with 52 other staff; including nurses, occupational therapists, psychiatrists, speech and language therapists, physiotherapists, assistants, health care assistant, support workers, ward clerks, administrators and a behavioural therapist.
- reviewed 21 patient care records
- checked the medication charts of four patients
- visited three patients in their own homes and observed how staff were caring for patients.
- observed a focus group attended by 14 people including patients, service providers and advocacy services
- observed a patient case review
- spoke with nine patients who were using the service and 12 relatives and carers
- observed two multi-disciplinary team meetings, one psychology pathway meeting, one nursing handover, one Section 117 meeting, one psychiatry clinic and one nurse allocation meeting.

What people who use the provider's services say

We spoke with eight people who used the community learning disability or autism service and eight family members who told us:

- Staff treated them with dignity and respect. They felt listened to and the staff were kind, polite and the support received was excellent.

Summary of findings

- Staff were always available between scheduled appointments and would make additional home visits, when needed. Staff used a range of communications methods with patients so they understood the treatment available.
- They were invited to and attended clinical reviews and felt fully involved in their treatment, as they were given the opportunity to discuss medication, physical health needs and other interventions.
- They discussed and agreed their care and were given copies of their care plans in a format that they understood.

Good practice

During the inspection we found evidence of good practice by the service including:

- Staff had recognised some patients had increased levels of anxiety about feeling safe in their accommodation and their safety in crowds after a recent terrorist attack and a tower block fire. To help address patient's anxieties, staff produced information in easy read and pictorial formats to explain what had happened and how to stay safe.
- Staff had tried a number of options to support a patient to become desensitised to receiving physical health interventions required for the patient's continued wellbeing, without success. The staff gained agreement from the patient to have all the interventions carried out whilst under a general anaesthetic, which was needed for dental treatment. The team and other medical professionals synchronised their availability to allow all the interventions to be completed whilst the patient was under the anaesthetic.
- Staff were proactive in securing additional funding from outside the NHS to purchase sensory and communication aids to enhance the delivery of interventions and group work sessions on health lifestyles.
- Staff support local GP practices to increase their skills and knowledge on learning disabilities and autism patients and provided them with a comprehensive toolkit for them to refer to that included screening tools, physical health checks needs of the patient group, communication aids and epilepsy plans.
- Ashby and Shirley house provided personal place mats for patients. These highlighted any dietary needs of the patients including swallowing, drinking needs and food likes, allergies and individual routines and needs. Staff kept copies of these in the kitchen and ensured all staff were aware of the individual preferences especially for those patients who were unable to communicate their needs.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that waiting lists for patients to access assessments are reduced to within the national target of 18 weeks.
- The trust should ensure emergency bags in Ashby and Shirley Houses are accessible to all staff.

Coventry and Warwickshire Partnership NHS Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
RYG	Wood End, Coventry. CV21 1AX
RYG	Whitnash Lodge, Leamington Spa. CV34 6SW
RYG	The Loft, Nuneaton. CV11 5HX
RYG	Oliver House, Solihull. B37 7HJ
RYG	The Railings, Rugby. CV21 2AW
RYG	Ashby House, CV11 6XL
RYG	22 Gilliver Road, Shirley House. B90 2DS

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.

The trust informed us it does not require the learning disabilities or autism community teams to undertake training in the Mental Health Act.

Staff we spoke to had a good understanding of the Mental Health Act and the Code of Practice and were able to apply their knowledge to practice. Staff were aware of the independent mental health advocate, how to access the service and supported patients to engage with them. Staff knew how to contact the trust's Mental Health Act administrator for advice, when required.

Detailed findings

Information on the rights of patients on a section of the Mental Health Act and independent mental health advocacy services were displayed in patient and staff areas.

We reviewed documentation of four patients subject to section of the Mental Health Act 1983 included Section 117 and a Community Treatment Order, were up to date, stored

correctly, and compliant with the Mental Health Act. The care records documented the explanation of rights was routinely conducted and the notes recorded the patient understood their legal position and their rights in respect of the section.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records provided by the trust for the 12 months up to the 31 January 2017 showed 94% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with demonstrated a good understanding of the Mental Capacity Act and the five statutory principles. Staff were aware of the trust policy, knew who the lead person within the trust who they could go to for advice.

The 15 care records we reviewed showed assessments of capacity to consent was of a consistent high standard across the teams. The records showed the capacity assessment was decision specific and used for significant decisions that affected the patient's wellbeing.

Staff told us they supported patients to make decisions and only when patients lacked capacity, were decisions made in the patient's best interest. Care records contained minutes of best interest meetings, documented consideration given to the patient's wishes, history, culture, feelings, and the least restrictive practice applied.

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

- Of the community services we inspected only Oliver House and the Loft had patient interview rooms. The Loft had alarms fitted in the interview rooms and staff at Oliver House carried personal alarms when seeing patient in the interview rooms. This meant staff were able to summon assistance from other staff members if required. Nurse call systems were in place within the respite units.
- The respite services had had clean and well-equipped clinic rooms. However, Ashby house had no emergency equipment on site and Shirley house had an oxygen cylinder with masks only. Monitoring records for the oxygen showed that checks had only been recorded from 26 June 2017. There were no emergency medicines for severe allergic reaction or defibrillators. Staff told us they would dial 999 for help in an emergency. This meant that emergency equipment and medicines were not readily available in an emergency as recommended by the resuscitation council. Staff told us they trained in basic life support. There were no clinic rooms on the other team sites.
- The sites visited looked tidy, clean, well maintained, clutter free and had cleaning schedules displayed on doors in the kitchens and toilet areas. External contractors cleaned the sites. We were unable to see completed cleaning rotas as the external contractor kept them off site.
- We saw hand washing guidance posters displayed in the toilet and kitchen areas and staff washing their hands, which showed staff followed infection control procedures.
- Environment risk assessments were carried out on all sites and any identified risks had action plans to address them. Records showed portable appliance tests and the electrical equipment were checked annually. Fire extinguishers had in date certificate of maintenance and we saw records of monthly confidential waste collection. The ear thermometer at Shirley house had the calibration test due September 2016 and not been followed up.

Safe staffing

- The community teams had a whole time equivalent (WTE) establishment of 116.83 staff. The teams consisted of qualified and unqualified nursing staff, consultant psychiatrist, occupational therapist, speech and language therapists, physiotherapists, art and drama therapist, social workers, technical instructor, administrators, and managers. The service used the Keith Hurst safer staffing tool to estimate the number of staff and grades required for each team. Ashby House had: 7.2 qualified nurses, 1.4 vacancies; 14.2 nursing assistants, no vacancies. Shirley House had: 7 qualified nurses, no vacancies; 18.8 nursing assistants, 5.1 vacancies.
- At the time of the inspection, the trust reported seven vacancies across the disciplines, excluding respite services. The trust reported vacancies for two speech and language therapists, two psychologists, two social workers and the other vacancy was split between the other disciplines. Some disciplines had additional staff including qualified and unqualified nursing (0.80), occupational therapists (0.28), and physiotherapist (1.21).
- Staffing levels were appropriate to ensure patient safety and records showed the number of staff on the duty roster matched the number of nursing assistants, nurses and other health professionals. Managers and staff said the teams had enough staff to deliver a safe service.
- For the period February 2016 - January 2017 average sickness rates for the community teams were 4.6% compared to 5.4% trust wide and under the trust target of 4.65%. In the same period, 11.4 staff left the team and as of January 2017, the overall turnover was 16.9%, compared to 13.8% trust wide. The sickness rate was 8.6% on Ashby House and 9.2% on Shirley House.
- Team managers told us that caseloads numbers varied due to the needs and complexity of individual patients, the higher the complexity the smaller the caseload. The average caseload for care coordinators was between 26 and 31. Staff discussed new referrals at the weekly multidisciplinary meeting and patients were allocated to a care coordinator with the most appropriate skill set to meet the patients' need. Staffing levels on the respite services were appropriate to meet the needs of patients.

Are services safe?

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

- Staff reported they managed their caseload effectively and felt they were able to offer sufficient time to patients and respond to a patient in crisis quickly. Staff told us that supervision and multi-disciplinary meetings were used to discuss patients on their caseload and they felt confident they could decline to take more patients on their caseload, if it felt unsafe. There were no waiting lists for case coordinators at the time of the inspection.
- The managers reported waiting lists from referral to assessment was outside the 18 week national target for occupational therapists at 118 weeks, psychologists at 52 weeks, and speech and language therapists at 25 weeks. The trust reported 67% of patients the occupational therapy waiting list were waiting for sensory integration assessments, a service they were not commissioned to deliver but are working with local commissioners to address the gap in service provision. Psychiatrists and nurses did not have waiting lists. Patients who are on a waiting list received low-level interventions from the nurse allocated as the patient's care coordinator.
- Psychiatrists were available Monday- Friday, 09.00-17.00 based on site within the teams. Outside core hours, an on-call rota arrangement operated.
- The trust reported 13 shifts (five for psychologists and eight for nurses) required cover by bank staff in the period February 2016 - January 2017 to manage sickness, vacancies or leave and the manager said the use of bank staff was rare and they did not use agency staff. However the trust reported agency staff were used, particularly for therapies.
- The trust reported staff mandatory training compliance of 96.6%, against a trust target of 95%, for safeguarding vulnerable adults (level 1,2 and 3), and safeguarding children (level 1 and 2) and training in the Mental Capacity Act (level 1) and Deprivation of Liberty Safeguards. Other mandatory training included infection prevention (level 1 and 2), basic life support, equality and diversity, fire safety, health and safety, information governance and manual handling objects had a compliance rate of 92.75% against a trust target of 95%. Mental Health Act training started in March 2017; completion rates were not available at the time of the inspection.
- We reviewed 12 care records and saw that all teams carried out risk assessments on every patient at the point of the initial assessment. Risk assessments were kept on an electronic system and 10 of the 12 risk assessments and management plans had been reviewed and updated to reflect changes in risks. The risk assessments we reviewed showed the staff encouraged and supported positive risk taking to address the identified risk. The other two risk assessments had not been update since March 2015 and July 2016, although the case notes recorded regular reviews of the patient by the care coordinator.
- Staff could flagged risk on the electronic case record system, alerting staff who accessed the patient care records of potential risks, such as violent or aggressive behaviour. Staff referred to the full risk assessment and management plan prior to meeting the patient.
- Staff attended the weekly team meetings and reviewed patients on waiting lists. If a patient's level of risk had increased, the team would agree the management of the risk that included prioritising the patients' treatment. We saw copies of the team meetings recording the action taken.
- We saw care plans included information from patient crisis plans. The plans informed patient, carers and staff what to do in an emergency. In the care records we reviewed, we did not see any advanced decisions. However, staff described being involved in discussions with acute hospital staff, patients and their families on whether a do not resuscitate instruction should be in place. This communication enabled acute hospital staff to understand the learning disabilities of a patient were not a reason to withdraw treatment.
- Staff described responding promptly to sudden deterioration in patient's health, as caseloads numbers were low enough to allow flexibility to change planned activities. Care coordinators told us patient needs were discussed with the intensive support team who offered support outside core hours of 09:00-17:00 Monday-Friday. The intensive support team worked flexibly including night and weekend cover to support the needs of individual patients. Consultant psychiatrists worked Monday-Friday and could respond to patient needs during these hours and operated an out of hours on-call rota at other times. Patients with learning disabilities were given contact details of social services and GPs as the service did not offer an out of hours crisis service.

Assessing and managing risk to patients and staff

Are services safe?

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

- The acute liaison nurse was able to support patients admitted to local acute hospitals. The role involved liaison between the care coordinator and the acute hospital staff to communicate the patient's needs, medication, likes and dislikes. This helped reduce the patient's anxieties and reduce any escalation of risk.
- A central booking system received all referrals, with an initial triage assessment completed on the day of receipt or the next day, if the referral was received at the end of the day. The initial triage identified risk for the patient and the urgency of the response required. For example, the speech and language therapists told us that urgent dysphagia referrals were seen within 24 hours. Otherwise, the weekly multidisciplinary team meeting discussed and allocated the patient to the discipline that could best meet the need of the patient. We observed these meetings and saw staff discussing patients on the waiting lists and the care coordinator gave updates on each patient, if need or risks increased, the team would arrange for a priority assessment to be completed.
- Training in safeguarding adults and children was completed by all staff and records showed staff were up to date in the training. Staff we spoke with described how they identified safeguarding concerns, used the electronic reporting system on the trust's intranet to report concerns or by telephone, if the issue was urgent. Staff told us safeguarding was discussed in supervision, at weekly meetings and with managers, when needed. The majority of the staff we spoke with knew the designated lead for safeguarding and felt confident in speaking with them, if needed. We saw information in the reception areas and interview rooms for patients, carers and visitors on how to keep safe and how to identify and report abuse. When we asked the trust for records of safeguarding alerts raised by the service, we were informed the local authority social services collated the data.
- The wards had appropriate arrangements for the management of medicines. All medication cards were

signed and dated to show that staff had given prescribed medicines to patients as prescribed. Where a patient had known allergies they were noted on the cards. Ashby and Shirley house had appropriate arrangements for medicine reconciliation with the patients and GPs on every admission. All medicines were clearly accounted for.

Track record on safety

- There were no serious incidents across all the teams in the twelve month period from May 2016 to June 2017.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew what incidents to report including near misses, slip, trips or falls, violent or aggressive behaviour and said they submitted incidents via the online incident reporting system. Staff described when incidents had been escalated through the trust; the trust took positive action swiftly.
- We looked at eight randomly chosen reported incidents during our inspection that confirmed efficient recording, follow-up, assessment by the manager and the closure process followed. The incidents and lessons learned were discussed at the multi-disciplinary team meetings and included in the minutes of the meeting and where appropriate followed up in supervision. The interim head of services attended team meetings monthly to discuss findings, themes and trends from incidents reported by the quality and safety group.
- Staff were aware of duty of candour and described how they were open and honest with patients and carers were mistakes made this would include apologising and feeding back to patients the learning from incidents.
- Staff and managers said that staff were offered a debrief and support if they were involved in or witnessed a serious incident. However, this service had very few incidents reported and what had been reported recently had been assessed as very low risk, such as losing an identification badge, which did not require a debrief.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- We looked at 21 care records of patients and saw all patients received an initial assessment on referral to the service and comprehensive assessment when allocated to a care coordinator. The comprehensive assessment was holistic and included safeguarding, physical, and mental health, medication, finance, social circumstances, support networks, communications requirements, lifestyle factors such as employment and education. Staff at Ashby and Shirley completed pre-admission assessments. These helped the patient and staff to understand the aims of the patients' treatment, to consider patient mix and whether individuals would be compatible.
- All care plans reviewed were personalised, holistic, recovery orientated, and the patient had determined their path to maintaining wellbeing, written in the first person, individualised and strength based. The plans included photographs of the patient, carer involvement, clearly identified goals detailing how the patient was to achieve them and who needed to support them. Staff at Ashby and Shirley house completed body maps on admission for every patient.
- Two of the 21 patient records reviewed did not have consent to treatment recorded, 12 did record consent and one record detailed the patient did not have capacity to consent. Twelve patients had received copies of their care plans, one had refused and two patient records did not evidence if the care plan had been given. The electronic care records did not allow for plans to be produced in formats suitable for the patients such as easy read. This meant staff had to duplicate work by recording the care plan on the system and then create the care plan again in a suitable format, then downloaded to the care records.
- The teams stored records securely in locked filing cabinets and secure computer systems. The trust issued staff with computer log in and passwords, which enable electronic records to be accessed by staff across all the trust sites.
- The dementia care pathway developed for people living with learning disabilities followed National Institute for Health and Care Excellence (NICE) guidance. The

pathway was a multi-disciplinary approach that used a range of baseline assessment tools to assess the severity of the patient's dementia that produced holistic package of care that included professionals and carers/families.

Best practice in treatment and care

- The staff told us they followed national guidance from the Department of Health, National Institute for Health and Care Excellence (NICE), Royal College of Psychiatrists to inform trust policy and practice. For example, in response to prescribing issues identified in 'NHS England and Royal College of Psychiatrists Faculty Report (FR/ID/09) the psychiatrists introduced a medication reduction strategy for patients prescribed antipsychotic/antidepressant to manage behaviour. The process follows National Institute for Health and Care Excellence (NICE) guidance on the review, reduction, or stopping of psychotropic drugs for people with learning disabilities. In addition, the multi-disciplinary team supported patients during the reduction of medication with strategies to support behavioural change. As part of the process, the psychiatrists delivered educational sessions, in conjunction with services users, to increase the understanding of GPs on how patient may present during a reduction and the psychiatrists provided a support helpline for GPs.
- Patients had access to psychological assessments and therapies as part of their treatment. The psychology team offered a number of interventions including cognitive behavioural therapy, narrative therapy, and cognitive analytical therapy. Psychologists stated they contributed to patient risk assessments and developed positive behaviour support plans and we saw these documents in patient records.
- The teams supported patient to live as independently as possible this included offering practical support for patients to undertake work placements, volunteering roles, attend college and secure employment. They worked with social workers to claim the correct state benefits for patients and the teams had developed strong links with local organisations to support patients to access meaningful activities.
- 20 of the 21 care records we reviewed had comprehensive physical health assessments completed. In Ashby house there was a specialist physical health

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.

care nurse based on site. The records showed staff liaised with GP's to deliver the physical health needs of a patient including regular blood tests and physical health checks. Staff told us they supported GP's to undertake physical health monitoring as this built the GP's skills and knowledge of the patient's needs. The psychiatrists wrote to GP's after seeing the patient to inform them of any changes and requested specific interventions to address identified physical health needs including blood tests. The psychiatrist had access to blood tests results taken by the GP via a secure electronic system. The psychiatrists stated that if required they would undertake basic physical health checks including blood tests.

- Care records showed staff monitored progress regularly and used a range of outcome measures for patients including the Health Equality Framework, the Health of the Nation Outcome Scales (HoNOS), the Model of Human Occupation Screening Tool (MoHOST), the Goal Attainment Scaling (GAS).
- The trust had a planned schedule of audits delivered by a central team that included audits of Mental Health Act paperwork and infection control. The teams undertook local audits specific to the service provided including an audit of bipolar disorder in adults attending the community learning disabilities service, health records, supervision, appraisals.

Skilled staff to deliver care

- The teams comprised of a full range of learning disabilities disciplines to meet the needs of patients including qualified and unqualified nurses, consultant psychiatrist, occupational therapist, speech and language therapists, physiotherapists, psychologists, administrators. The staff had a wide range of experience working with the patient group and had the relevant qualifications to carry out their roles.
- On starting in role all staff completed the trust induction and then undertook a local induction, which included shadowing experienced team members before working independently. Staff told us the induction process was appropriate to their needs. Unqualified nursing staff also completed the care certificate.
- Staff supervision was in line with trust policy, which stated staff must receive supervision every six to eight weeks. Managers had a system in place to monitor

supervision had taken place within the timescales and data provided by the trust showed a supervision compliance rate of 108% for the period 1 February 2016-31 January 2017. The 15 supervision records we reviewed showed the supervision was of good quality, values based and comprehensive. Staff at Ashby and Shirley had regular monthly team meetings that included reflective practice sessions, incident reviews and in house training. They set aside a day each month where there were no admissions to the units to facilitate this and include all staff members. Staff said the reflective sessions helped them to work out better strategies for managing situations as a team.

- We reviewed local records, which showed all staff had annual appraisals in place and we saw evidence of the goals set in the appraisal reviewed in the supervision sessions. However, data provided by the trust showed the completion rate, as of the 31 January 2017 was 86% against a trust target of 95%. The staff attended weekly multi-disciplinary team meetings and monthly discipline specific meetings.
- Staff we spoke with told us continued professional development was encouraged and supported by the trust. The appraisal process identified training and development that included specific courses and supervision notes documented progress on staff development. Staff told us they had opportunities to receive training including positive behavioural support plans, autism, and epilepsy. Health care assistant staff at Ashby and Shirley house were trained to administer oral medication and peg feeds. We saw a power-point presentation delivered by a staff member to teams on the learning from training during the monthly protective learning sessions.
- We saw evidence in supervision records of managers addressing poor performance during supervision. If poor performance continued, managers said they would gain support from human resources.

Multi-disciplinary and inter-agency team work

- Regular and effective multi-disciplinary meetings took place weekly, meetings were attended by the whole team. The meetings had a standard agenda that included referrals, allocations, waiting lists, incident reports and learning, safeguarding, risk warning updates, clinical, operational and service updates,

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changes to national and local guidance and policies, audits, complaints and compliments, patient and carers feedback and reflective practice. We attended two of these meetings, and saw staff held detailed discussions about the patient and identified the most appropriate professional lead to address the needs of the patient. During these meetings, staff were respectful, patient-centred and looked at the holistic needs of the patient not just the intervention the team could offer.

- During the inspection we saw evidence of good working relationships with teams across the trust including joint working with child and adolescent mental health service that had developed transitional plans for patients who had reached 18 years old and transferred to the adult learning difficulties team.
- The intensive support team attended team meetings every week to discuss patients they were supporting to prevent inpatient admission. The acute liaison nurse role was to ensure the patients' needs were fully understood by the acute hospital staff, to act as a liaison between acute staff and the care coordinator whilst the patient was in hospital and a discharge plan was in place. We saw that staff from the community teams, liaised closely with staff at Ashby and Shirley house in arranging and organising respite for patients.
- Staff told us they worked with a range of professionals to support the patient including joint working with the police to keep patients safe in their community and support those at risk of radicalisation from groups supporting terrorism. Staff said they had good working relationships with many others that included care home staff, social services, GP practices, acute hospital staff and the care records document many examples of joint working.
- To develop the knowledge and understanding of patients with learning disabilities or autism, local GP practices were given a resource pack. The pack included screening tools, protocols for annual health checks, details on additional health needs for people with learning disabilities, epilepsy management plans, Mental Capacity Act and consent information and communication aids that included signs and symbols to be used with patients.

Adherence to the Mental Health Act (MHA) and the Mental Health Act Code of Practice

- Mental Health Act training figures were not available from the trust at the time of inspection. However, staff

we spoke with had a clear understanding of Mental Health Act and Code of Practice and guiding principles. At the time of inspection, the teams reported they had three patients on guardianship orders and one patient on a Community Treatment Order.

- We reviewed the Mental Health Act documentation, which was compliant with the Mental Health Act, up to date, stored appropriately. The care record for the patient on a Community Treatment Order included a Consent to Treatment form and we saw capacity forms in other patients records, all completed appropriately.
- Staff told us how to contact the Mental Health Act administrator for advice and support, when required. They also told us the administrator was responsible for completing audits to ensure the MHA was applied correctly and the documentation was correct.
- Information on independent mental health advocacy services was displayed in the reception areas of the two sites with patient access and in the staff areas. Staff said they would be support patients engaged with the service to access advocacy.

Good practice in applying the Mental Capacity Act (MCA)

- Data provided by the trust showed the team's compliancy rate for training in the Mental Capacity Act was 94%, as of the 31 January 2017. However, only 33% of Ashby house staff were up-to-date with Mental Capacity Act training. Staff we spoke with had a good understanding of the Mental Capacity Act and could describe the five principles.
- Staff demonstrated their knowledge of Mental Capacity Act and said they supported patients to make appropriate decisions. They gave examples of decision specific assessments they had completed on patients who lacked capacity. They said they arranged best interest meetings invited multi-disciplinary team members, the patient, family members, carers, and other relevant parties. Staff said the meeting focussed on the least restrictive practice applied to keep the patient safe and minutes recorded the decisions and actions made. Completed Mental Capacity Act assessments and minutes were stored in the care records we viewed.
- Ashby and Shirley had made 87 Deprivation of Liberty Safeguards (DoLS) applications between January 2017 and June 2017. Eight of them were authorised. At the time of our inspection, most patients there were subject

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to DoLS within the respite units. In four of the other 15 care records reviewed, we saw documented two Deprivation of Liberty Safeguards applications for patients completed by staff and two care notes referring to applications made by the care provider. The paperwork was correctly completed and stored.

- Staff were aware of the trust's Mental Capacity Act policy and knew who to contact within the trust for advice on the Mental Capacity Act.
- The trust had arrangements in place to monitor adherence to the Mental Capacity Act.

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

- During our inspection we observed excellent interactions between staff and patients in one clinic, three home visits, one acute hospital visit, one focus group, during telephone calls and in a reception area. Staff were polite, treated patients with kindness, dignity and were respectful at all times. Staff were considerate, supported the patient to contribute by allowing them time to give their views and raise any concerns. Staff checked the patient understood what had been said and agreed to.
- The patients and carers we spoke with told us staff were kind, treated them with respect, staff listened to them and were always available to offer support. Patients said they were consulted and involved in their care plan and were very positive about the service they received.
- Staff had a good understanding of how to protect information when visiting patients and how to maintain confidentiality when discussing patients' care during the visits.

The involvement of people in the care they receive

- Our review of records, interviews with patients, family members, and carers, observation of practice evidenced that patients were involved in all aspects of the care received including care planning, clinical reviews, risk assessments and positive behavioural support plans. Patients and family members told us the treatment was all about the patient and they were fully involved in all aspects of the treatment offered.
- During a clinical review, we observed patients offered choices so they could make decisions about their care, involved in reviewing their care plan and reviewing risks, they were encouraged to take steps to maintain their independence, and signposted the patient to other community based support. Patients and family members expressed views and received appropriate responses. Family members told us the psychiatrist telephoned them after the clinical review to ask if they had any further questions. Ashby and Shirley house staff completed pre-admission phone calls prior to each admission. This involved speaking to carers, GP and any community workers involved with the patient ensuring

that the care plans and risks were up to date. All carers we spoke with informed us that they were invited to attend review meetings, received regular updates from the multidisciplinary teams on the wards and were kept up to date on every part of the patient's care plan. Patients and carers had copies of easy read care plans suitable to each individual's preferred method of communication.

- We spoke with 21 patients and family members during the inspection and all spoke highly of the service. They said the staff 'went above and beyond' to support them, giving examples of staff attending the patient's home within 15 minutes of the family member contacting the service. Patients who had attended the autism group gave very positive feedback, as they better understood their condition, the impact it had on their life and gave them skills to develop new strategies to manage negative behaviour.
- We saw patient's comment cards in therapy areas and in reception, all were positive about the treatment and service received. Thank you cards and letters from patients and their families were displayed in staff only areas to maintain confidentiality.
- Staff said they were aware on how to access advocacy and supported patients to access advocacy. We saw leaflets in the reception areas and in staff areas advertising advocacy services. The leaflets were available in easy read format. Patients and their families told us they could access advocacy, if needed.
- Patients were involved in the development and delivery of the service by completing surveys, giving feedback on groups they attended and during focus groups. Patients co-facilitate groups and been involved in the recruitment process for employing staff.
- Patients and family members said they knew how to complain and access the patient advice and liaison service.
- In consultation with patients and family members the teams had developed a range of group work programmes that offered advice and information on healthy lifestyles and choices, a group focusing on social interaction, exercise, mood and memory, other groups include a walk and talk, my autistic spectrum condition and a cancer awareness group. Separate men and women's health groups cover a range of topics including

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sexual health, keeping safe and internet safety. An autism training group for parents and carers had been developed and delivered to increase understanding of autism. Shirley house conducted quarterly coffee mornings to gather carers' views on the service and guest speakers were invited to attend. For example Solihull carers, skin viability nurse and safeguarding.

Feedback from the meetings was analysed to formulate trends and themes to enable staff to make changes to the service where needed and published in their newsletter. At Ashby house, they were piloting the Triangle of Care, a quality initiative to improve the carer experience.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- All admissions onto Shirley and Ashby respite units were planned. There was a set pre-admission procedure involving assessment, pre-admission visits and calls. Professionals or carers could make referrals. Once accepted, patients were allocated respite days over the year and there were several ways this could be taken, with flexibility for individual circumstances or emergencies. Stays were pre-planned, named nurses could be allocated to work with their patients and gender mix of staff could be planned.
- The service had a 28-day target from referral to initial assessment and from assessment to treatment. There were no waiting times for psychiatrists and nurse care coordinators.
- Target times from referral to assessment were not being met by other team disciplines. From the records, we saw occupational therapists had the longest waiting list of 118 weeks, psychologists up to 52 weeks, speech and language therapists reported up to 25 weeks from referral to assessment. Managers and staff said recruitment to posts and long-term sickness had affected the team meeting targets.
- The records we reviewed showed assessment to treatment was immediate or within two-four weeks across teams except for speech and language therapists, which was reported a 13 week wait for interventions except dysphagia, under the 18 week national target.
- The central booking service received all new referrals; initial assessments completed on the day of receipt or the next day, if received late in the day. We saw priority was given if a patient had urgent needs, such as dysphagia. A speech and language therapist would assess within 24 hours of the initial referral..
- The trust monitored waiting times centrally and the latest report for 2017/18 had not captured this service's waiting lists. We spoke to the interim head of the service who assured us the trust were aware of the local plans in place to address the occupational therapy waiting list. The interim head of service had come in to post six months ago and held meetings with the leads for each discipline where they discussed the impact of recent changes to practice had on reduction of waiting lists. The weekly multi-disciplinary team meeting discussed and documented waiting times for their service within the minutes of the meeting.
- The patients had access to the trust's crisis team, if required and the teams said they made sure the patient was aware of their GP and social worker contacts. The intensive support team worked outside core opening times to support patients with additional needs. This support enabled patients to remain in the community and prevented admittance to in-patient facilities.
- Patients and family members spoke highly of the responsiveness of the service. They said staff answered telephone calls promptly and staff responded to the needs the same day. Patients and family members said they had received home visits within the same day of ringing the teams and one family member said the psychiatrists had been at the patient's home within 15 minutes of contacting the team.
- The service had clear inclusion criteria: services provided in the community to people over the age of 18 with learning disabilities, had complex health needs unable to be met by mainstream services. Services included assessment of the learning disability, support with complex health needs such as epilepsy, autism, physical disability, dementia, complex behavioural challenges and mental health problems including mood disorders, anxiety and schizophrenia.
- Staff offered appointments at times convenient to patients and family members. Patients and family members reported they saw staff at venues suitable to the patient that included home, day services, college and where available at the team offices. Patients said it was very rare for staff to cancel an appointment. If staff or the patient cancelled appointments, they rearranged them quickly and within a few days of the original appointment. Staff said they used a range of ways to engage with patients if they did not attend their appointments such as telephone calls, letters to patient, contacting the referrer for updates for further information.
- The team took active steps to engage with people who found it difficult or are reluctant to engage with the service. For example, we were told of a very anxious patient who required a number of interventions for health issues. The team had supported the patient to

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practice de-sensitising techniques to address their anxiety, without success. With the full involvement of the patient, family and advocate it was agreed the patient would be anaesthetised for a short period allowing for dental work, blood tests, a physical health check, podiatry and a ultrasound scan to be completed. This multi-disciplinary approach caused the patient the least distress to achieve the best outcome.

- We observed patient's appointments running to time during home visits and during a clinical review session. Staff told us they would contact a patient if they ran late for an appointment.
- We observed a section 117 meeting and reviewed the care records. The care plan identified the aftercare services provided and who would provide the service for the patient. The psychiatrist, as the responsible clinician, undertook timely reviews of the patient and the care notes recorded the reviews.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of patients were seen at venues away from team bases. Three of the five community sites offered therapy rooms and interview rooms, which could accommodate one to one sessions or group meetings. The therapy rooms were fit for purpose, adequately soundproofed, and wheelchair accessible. If a patient required treatment or physical examinations arrangements would be made with the patient's GP or offsite at the medical review with the consultant.
- Ashby and Shirley house had full range of rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities. There was a fully equipped sensory room at Ashby and Shirley house. This was a specially designed room for people with limited communication to develop a person's senses particularly those on the autistic spectrum.
- Ashby and Shirley house each had a clinic room however, they did not have an examination room with a couch. Shirley and Ashby had equipment in place such as tracking hoists and specialist-bathing equipment; additionally there was a mobile hoist available for those patients who had physical and mobility needs.
- Ashby and Shirley house had quiet areas to meet with visitors. Respite patients had access to well maintained outside space including a sensory garden at Shirley house.

- Patients had access to a range of information on how the services were run, treatments offered, patients' right, how to complain, advocacy services, local services, patient and carers groups, and support networks. Information was displayed on noticeboards in the reception area and in therapy rooms. Staff told us they provided information to patients when they visited them at other venues.

Meeting the needs of all people who use the service

- The two sites that offered appointments at the team base had disability access to all patient areas including group rooms, therapy rooms, and toilets. Ashby and Shirley house had facilities available for patients with mobility difficulties who required disabled access. Each ward had an adapted bedroom with toilet and shower facilities for disabled patients.
- Ashby and Shirley house patients had personal place mats. These highlighted any dietary needs of the patients including swallowing, drinking needs and food likes, allergies and individual routines and needs. Staff kept copies of these secure in the kitchen and ensured all staff were aware of the individual preferences especially for those patients who were unable to communicate their needs.
- Information was available in easy read, pictorial formats and staff could access the information in other languages from the patient advice and liaison services, when needed. This meant non-English speaking patients could receive information of how services were run and what services offered.
- Staff we spoke to told us they accessed interpreters and sign language services. They booked the relevant service prior to therapy sessions, home visits, clinical reviews and case reviews.
- The service had a comprehensive range of communication tools to support patients with their needs that included electronic, visual and sensory aids. The range of tools had increased recently after submitting and securing additional funding from a local source outside of the NHS.
- Staff developed hospital passports for patients to use when admitted to acute hospital. On admission, the patient gave staff the passport so hospital staff had helpful information that included medication, likes and dislikes, preferred ways to communicate. The service

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also provided the acute liaison nurses to support acute hospital staff during the admission process and treatment offered on a ward. This helped the staff manage the patients care, supported better communication between the patient and acute staff, and allowed the acute liaison nurse to arrange post care discharge for the patient.

- Staff developed communication passports with patients, when required. Communication passports are designed to pull complex information together into an easy-to-follow format, which the patient can share with others to enable their communication needs to be met.
- To increase the skills and knowledge of carers and agencies working with patients the service offers Makaton signing groups, positive behavioural support training and provide acute hospital training to nominated staff to support patients with learning difficulties during their stay in the acute hospital.
- Staff provided information on services offered to patients at a level and format they could understand and we saw examples of how information tailored to answer patient concerns and reduce their anxieties. For example, the Loft displayed information in reception about the recent a terrorist attack and a large fire in a London tower block. The information was in easy read format, explained what had happened, and was used to reduce anxiety the patient had. The focus group we observed in Solihull gave time to allow patients to discuss how the attack and fire had made them feel and voice their concerns. Staff responded appropriately to address the concerns and reduce the anxiety of patients who attended the focus group.

Listening to and learning from concerns and complaints

- The trust reported two formal complaints between 1 February 2016 – 31 January 2017 for the community learning disability or autism service. One complaint was filed incorrectly and was forwarded to the correct agency. The second complaint had five elements of concerns, the trust after investigation reported one element upheld, one partially upheld, three not upheld.
- The trust reported no complaints had been referred to the Ombudsman in the previous 12 months.
- Patients and family members we spoke with said they knew how to complain that included raising concerns locally or through the patient advice liaison service.
- Staff we spoke with described the complaint procedure and said they would support patients and family members to make a complaint at a local level or through the patient advice and liaison service. Staff at Shirley and Ashby house told us they were open to receiving both positive and negative feedback and ward managers discussed complaints and shared any learning from them with staff in one-to-one sessions or handover. Team meeting minutes at Shirley and Ashby house noted discussions about complaints, incidents and lessons learnt.
- The trust reported 67 compliments received by the service from 1 February 2016 – 31 January 2017.
- The trust sent emails to all staff on lessons learned from complaints. The interim head of service attended multi-disciplinary team meetings monthly to discuss learnings from complaints and the weekly multi-disciplinary team meetings agenda included learning from complaints item. We reviewed minutes of the meetings and saw review of practice to embed the learning in practice.

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 vision and values of the trust were displayed clearly in the team sites. Staff we spoke to said they agreed and promoted the trust's values. Staff said the team objectives reflected the trust objectives and the values were embedded in everything they did including supervision, as the template used was value based.
- Staff knew who the most senior managers were in the organisation and that they had visited the teams.

Good governance

- The trust had governance processes in place to manage quality and safety: team leaders and clinical leads used the processes to monitor the service effectiveness and report to the senior management. The service had a clear governance and operational structure.
 - The service had undertaken a review of the activity and interventions offered to patients and had recently completed a restructure of the teams. The leads had worked with the teams to produce a new referral criteria and checklists for specialist interventions. The teams had produced defined pathways, clear outcomes and time limited sessions that had resulted in the reduction of the number of patients on waiting lists. For example, the occupational therapy waiting list had reduced from 196 weeks to 118 weeks since May 2016
 - Managers and lead clinicians were experienced and knowledgeable and provided strong leadership of the teams.
 - Staff had received the required mandatory training and the team leaders monitored compliance as part of the monthly audit process. Team Leaders had systems in place to notify staff three months in advance of required training updates to allow staff time to book places and arrange cover for their work.
 - Staff received yearly appraisals and supervision in line with trust policy of every six-eight weeks. Team leaders had monitoring systems in place to make sure staff were supervised and annual appraisals had been completed. Supervision included a process to address poor performance.
- Staff we spoke with knew how to report incidents and said the trust encouraged staff to learn lessons from any incidents, patient feedback, and complaints. The trust circulated lessons learned newsletter to all staff by email. The interim head of services attended multi-disciplinary team meetings to feedback lessons learned from the quality and safety forum, where the team discussed changes to practice to that incorporated the learning.
 - Staff were encouraged to participate in clinical audits to improve practice and effectiveness of the service and to monitor adherence to national guidelines.
 - Staff had a good understanding of safeguarding procedures and knew who the lead was for the trust. Staff attended the multi-disciplinary team meetings discussed and documented safeguarding. Staff discussed safeguarding within supervision. Staff had a good understanding of the Mental Health Act and Mental Capacity Act and knew who the leads were for the trust should they need further support.
 - All staff we spoke to had a very good understanding of the lone working policy. The teams had developed robust systems to monitor staff movements throughout the day that included signing in and out of the sites, informing reception and manager of expected time of return, if not returning to base the member of staff phoned in to state they were safe and on their way home. All staff were issued with mobile phones and the trust had started issuing tracker systems to all the community teams, which was monitored via the computer system. Staff used electronic diaries that showed all appointments and all the team accessed each other's diaries. The receptionist had contact sheets that captured personal details and included details of the member of staff car. A buddy system was in place and used if a patient was deemed too high a risk to be seen by lone staff. Staff working in the respite services were aware of personal safety and how to safely manage risk to themselves and others.
 - The trust used key performance indicators to gauge performance of the team. The trust produced monthly performance reports for each service from data input by the staff and team leaders. The information provided in the reports enabled the trust to identify themes and trends and allowed individual services to monitor performance in key areas and develop plans where

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issues were identified. Each site that we visited had performance reports on noticeboards in staff areas and team leaders said they discussed performance at team meetings.

- Team leaders said they felt they had sufficient authority to manager their teams and the authority to make decisions relevant to the teams. However, they felt the recent changes to the administration structure did leave the teams without enough admin support. This meant the staff had more admin in their roles, which reduced time spent on patient care.
- Staff told us they would submit any item for the risk register through their manager or interim head of service.

Leadership, morale and staff engagement

- At the time of inspection the trust had proposed a restructure of community service provision. The consultation process was delayed due to staff requiring clarification of roles. During the clarification stage, nurse leads had undertaken the team leader roles. The trust was due to announce who had secured substantive team leader posts week commencing 3 July 2017.
- The restructure of the service had not affected team morale as staff said they loved working in the teams and felt passionate about the work they did. They said they felt supported by their managers and the interim head of service and the worked collaboratively for the best outcome of the patients.
- Staff told us they had a great sense of job satisfaction; they loved their roles and felt valued by the team and management for their contribution to the team.
- The team leaders provided the leadership of their teams, monitored, and reported on the performance of the disciplines within it.
- The sickness and absence rate in the 12 months from February 2016-January 2017 for the service was 4.6%, lower than the trust average rate of 5.4%.
- The service reported no bullying and harassment cases within the teams. Staff we spoke with said they never felt bullied or harassed and valued the management and team members.

- Staff knew the trust had a policy on whistleblowing and were aware of the procedure to follow, if required. Staff said they felt able to raise concerns without fear of victimisation and the said they felt the trust and their managers would support them to do so.
- Staff told us the annual appraisal system recorded opportunities for training and leadership development. Team leaders attended courses in leadership covering management skills, coaching skills and leading teams. Unqualified staff received support to complete a national vocational qualification that could lead to a foundation degree and a nursing degree.
- Managers told us they had developed a strategy to invest in the assistant role to develop the workforce to fill hard to fill vacancies such as occupational therapist. Assistants received support to qualify in a specific discipline and once qualified remained within the team.
- Staff were aware of the duty of candour and were able to give examples of been honest and open when mistakes had been made, apologise for the mistake and discussed lessons learned at the weekly team meeting.
- Staff told us they were encouraged to make suggestions to changes in practice or introduce new practices that would improve patient care. This had led to staff receiving 'Q awards' from the trust, which the teams and individuals valued. Staff contributed to the development of the service at weekly team meetings, away days and during supervision.

Commitment to quality improvement and innovation

- As part of the trust's strategy project plans implement the NHS England's transforming care programme, the service had developed the service model to deliver the programme to support and meet the care needs of patients with learning disabilities or autism to live in the community and close to home.
- Audits were undertaken to benchmark against national guidance to improve the quality of care patients received. For example, as the result of a recent audit of patients receiving anti-psychotropic medication for behaviour management has resulted in a change of practice. The service had developed an action plan to reduce prescribing of these medication, whilst working with the patient to manage their behaviour and working closely with GPs to support the process.

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- Staff had accessed and secured funding from a local source to provide the team with additional communication tools for the benefit of patients across the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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