Cambridgeshire County Council

Huntingdonshire Learning Disability Partnership

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this service as requires improvement because:

- The service did not meet the target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The referral to assessment waiting time was 47 weeks. The waiting time for referral to treatment was 57 weeks.
- The service did not ensure staff received regular supervision and appraisal.
- Managers did not receive sufficient up to date information to have oversight of specific performance areas.
- The information management systems were burdensome to front line staff. Staff used a mix of electronic systems, with improvements due to take place from August 2022.

However:

- People were protected from abuse and poor care. The service had sufficient, appropriately skilled staff to meet people's needs and keep them safe.
- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- People were involved in managing their own risks whenever possible. Staff developed positive behaviour support plans with people who used the service so that they were aware of any risks they posed to themselves, others or their environment.
- Staff were aware of what strategies to use to minimise and manage risks. Staff anticipated and managed risk. They had a high degree of understanding of peoples' needs.
- People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs. People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- People who used services and those close to them were active partners in their care. We reviewed six care records and saw staff were fully committed to working in partnership with people and making this a reality for each person.
- Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.
- People were empowered to feedback on their care and support. We saw examples where staff had encouraged feedback using an easy read "we welcome your feedback" form. We also saw an easy read version of "our learning disability vision, making a better future together" that had been co-produced and set out agreed next steps for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff supported people through recognised models of care and treatment for people with a learning disability. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community mental health services for people with a learning disability or autism	Requires Improvement 	We rated this service as requires improvement because: • The service did not meet the target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The referral to assessment waiting time was 47 weeks. The waiting time for referral to treatment was 57 weeks. • The service did not ensure staff received regular supervision and appraisal. • Managers did not receive sufficient up to date information to have oversight of specific performance areas. • The information management systems were burdensome to front line staff. Staff used a mix of electronic systems, with improvements due to take place from August 2022. However: • People were protected from abuse and poor care. The service had sufficient, appropriately skilled staff to meet people's needs and keep them safe. • People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood. • People were involved in managing their own risks whenever possible. Staff developed positive behaviour support plans with people who used the service so that they were aware of any risks they posed to themselves, others or their environment. • Staff were aware of what strategies to use to minimise and manage risks. Staff anticipated and managed risk. They had a high degree of understanding of peoples' needs. • People's care, treatment and support plans, reflected their sensory, cognitive and

Summary of findings

functioning needs. People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.

- People who used services and those close to them were active partners in their care. We reviewed six care records and saw staff were fully committed to working in partnership with people and making this a reality for each person.
- Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.
- People were empowered to feedback on their care and support. We saw examples where staff had encouraged feedback using an easy read "we welcome your feedback" form. We also saw an easy read version of "our learning disability vision, making a better future together" that had been co-produced and set out agreed next steps for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff supported people through recognised models of care and treatment for people with a learning disability. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.

Summary of findings

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Summary of this inspection

Background to Huntingdonshire Learning Disability Partnership

Cambridgeshire Learning Disability Partnership has been registered with the Care Quality Commission since November 2016, provides regulated activities for treatment of disease, disorder or injury and had never been inspected. The Cambridgeshire Learning Disability Partnership (LDP) brings together specialist health and social care services for people with a learning disability.

The LDP is responsible for commissioning and providing these services on behalf of Cambridgeshire and Peterborough Integrated Care Board and Cambridgeshire County Council. Social Care staff are employed by the County Council, and health staff are employed by Cambridgeshire and Peterborough Foundation Trust. There is a formal management agreement between both organisations for the Integrated service and all staff are part of the LDP.

The LDP directly provides access to specialist nurses, psychiatrists, psychologists, therapists, allied health professionals, Social Workers and Social Care staff through its integrated community teams, which cover the county from four locations:

- Huntingdon
- East Cambridgeshire
- Fenland
- South Cambridgeshire and City

This report relates to our inspection of Huntingdonshire Learning Disability Partnership. Reports for the other three learning disability partnerships services are available on the providers website. The LDP in-house provider services directly provide daytime support, respite care and some supported living accommodation in various locations across Cambridgeshire. The in-house services referred to are registered with the CQC individually and separately from the community teams referred to in this inspection The majority of daytime support, respite care, domiciliary care and supported living accommodation were commissioned by the LDP from a wide range of independent and voluntary sector care providers, acting in partnership with the LDP to deliver high-quality care options for people with a learning disability. Their aim is to enable people to live as independently as possible in their local communities, accessing mainstream services wherever possible.

What people who use the service say

We spoke with three people using the service and six carers over the phone and reviewed comments and feedback from surveys, speak out forums and local partnership board. All the people we spoke with said staff were respectful and polite.

We saw evidence that staff used a variety of communication tools to engage with people and their supporters and carers.

One person told us that the “speech therapist teaches me how to keep myself safe, by looking at the pictures on my Mac. It can be tedious, she says take small bites, eat food slowly, drink after swallowing and sit up for 30 minutes.”

One person told us how they had been supported to get a job at Tesco which was “amazing”.

One carer told us there had been a best interest meeting which led to the person accessing a specialist dentist.

Summary of this inspection

One carer told us they had agreed care review content, but it was changed without them being informed.

How we carried out this inspection

Our inspection team was led by an inspector.

The team included one inspector and one specialist advisor on site and an expert by experience working remotely.

To get to the heart of people who use services' experience of care, 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 we held about the location.

During the inspection visit, the inspection team:

- spoke with three people using the service and six carers over the phone;
- spoke with the head of service, service manager and registered manager;
- spoke with six other staff members including; the consultant psychiatrist, nurses, occupational therapists, and a speech and language therapist;
- attended and observed one multi-disciplinary meeting;
- reviewed six care and treatment records of people;
- reviewed eight supervision records;
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that there is a plan to reduce waiting time to within the 18-week target. Regulation 17 Good Governance
- The service must ensure managers are supplied with sufficient up to date data to have oversight of specific performance areas. Regulation 17 Good Governance
- The service must ensure that all appropriate staff receive regular supervision and annual appraisal in accordance with their own policy. Regulation 18 Staffing

Action the service SHOULD take to improve:

- The service should ensure all appropriate staff have full access to the two electronic record systems

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community mental health services for people with a learning disability or autism	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Community mental health services for people with a learning disability or autism

Requires Improvement

Safe	Good
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Community mental health services for people with a learning disability or autism safe?

Good

Safe and clean care environments

The service did not see people for clinic appointments on the premises at this location. They visited people at a location suitable to the persons needs and preferences.

Safe Staffing

The service had enough staff, who knew people on their caseload and received basic training to keep them safe from avoidable harm. The number of people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each person the time they needed.

The Huntingdon team had enough nursing, therapy and support staff to keep people safe.

They had low vacancy rates, at the time of the inspection there was one whole time equivalent physiotherapy vacancy.

The team did not use bank and agency nurses.

Managers made arrangements within the team to cover staff sickness and absence. We saw that a lead psychologist from another team had supported people whilst the substantive psychology post was vacant.

Managers supported staff who needed time off for ill health, staff were supported to access occupation health services. Sickness levels across the countywide LDP teams was 6%, managers did not receive a specific breakdown of sickness for their team. However, local team managers managed absences with individual staff.

The Huntingdon team had low turnover rates, over the 12 months prior to this inspection turnover rates were 2%.

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff. There was one full time consultant psychiatrist and access to additional psychiatrists to cover staff sickness or absence.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory compliance was at 96%. The mandatory training programme was comprehensive and met the needs of people and staff and included; treating people with respect, safeguarding adults' level two and children level three, infection prevention, good governance and control and working safely.

The partnership had identified that Oliver McGowan training was now a legal requirement within the Health and Social Care Act 2022 and had begun to scope how this would be rolled out.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and Managing Risk

Staff assessed and managed risks to people and themselves well. When necessary, staff worked with people and their families and carers to develop crisis plans. Staff monitored people on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of risk

Staff completed risk assessments for each person, using a recognised tool, and reviewed this regularly, including significant events, for example a hospital admission. The team supported staff looking after people living in supported housing to update and manage risks.

Staff used the care programme approach risk assessment tool. They also used risk assessment tools within the integrated care record with adult services.

Staff recognised when to develop and use crisis plans and advanced decisions according to people's need. We saw staff used the assessment of sexual knowledge to help them support people with making decisions, specifically in relation to proposed arranged marriages.

Management of risk

Staff continually monitored people on waiting lists for changes in their level of risk and responded when risk increased. Managers held weekly multi-disciplinary meetings to assess the level of risk and any changes in circumstances to people on the waiting list for services.

Staff followed clear personal safety protocols, including for lone working. The service had a lone working policy, staff we spoke with told us how this was used.

Community mental health services for people with a learning disability or autism

Requires Improvement

People were involved in managing their own risks whenever possible. Staff developed positive behaviour support plans with people who used the service so that they were aware of any risks they posed to themselves, others or their environment. Staff were aware of what strategies to use to minimise and manage risks. Staff anticipated and managed risk. They had a high degree of understanding of peoples' needs. People's care and support was provided in line with care plans.

Staff identified and responded to any changes in risks to, or posed by, people using the service. We reviewed six people's records which showed staff completed risk assessments on admission to the service and updated them regularly, including after incidents. Staff attended daily safety huddle meetings where those people known to be currently posing the most risk were discussed, and mitigation implemented where appropriate.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff told us how they protected people from abuse and the service worked well with other agencies to do so. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had training on how to recognise and report abuse and they knew how to apply it. Compliance rates for adults' level two training was 96% and level three children was 100%.

The service was fully integrated and co-located with the local authority and were involved in safeguarding investigations. Managers ensured staff reported potential abuse and ensured they reported to CQC and the police when appropriate.

Staff could give clear examples of how to protect people using the service from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

Staff kept detailed records of peoples' care and treatment. Records were up to date however they were not available to all members of the integrated team and staff told us they were not easy to use.

Under a formal management agreement for the delivery of the Integrated Service, the sole and primary case management electronic recording system is hosted via the Adult Social Care system. All staff have access and have been fully trained to use this electronic system for the recording of service user information'.

Each locality team has read only access to the NHS system.

Staff we spoke with said the local authority system was difficult to navigate and had limited functionality with regard to mental and physical health and wellbeing. Staff told us they adapted the system to ensure there was a location for this information.

The health staff at LDP required access to the electronic record system at Cambridgeshire and Peterborough NHS Foundation Trust to record supervision, training, appraisal and rostering. We were told staff faced challenges with the interface between CCC and CPFT IT systems which has been escalated as a risk in each organisation.

Records were stored securely.

Medicines management

The service did not hold medicines, the learning disability specialist consultant psychiatrist held a review with the person and then wrote to their GP suggesting which medicine should be prescribed.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people who used the service honest information and suitable support.

The service kept people and staff safe. The service had a good track record on safety and managed safety incidents well.

We reviewed one serious incident and found that the partnership had provided appropriate support to the person.

Staff accurately described what incidents to report and how to report them.

Managers investigated incidents appropriately in line with the provider's policy. Managers maintained safety to people using the service and investigated incidents and shared lessons learned with the whole team and the wider integrated service via bulletins, email and safety alerts.

Managers held weekly business meetings and monthly clinical governance meetings, during which they discussed recent incidents. Staff completing investigations were trained in route cause analysis.

Managers shared learning from incidents that had occurred in other services who supported people with a learning disability and/or autism. We saw examples of sharing information from LeDeR (Learning Disabilities Mortality Review) and from the county council.

The partnership held monthly complex case huddle meetings which is a multi-disciplinary panel to review and guide complex learning disability and/or autism cases.

Community mental health services for people with a learning disability or autism

Requires Improvement

Are Community mental health services for people with a learning disability or autism effective?

Requires Improvement

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of people who would benefit. They worked with people and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

We reviewed six care records. Staff completed a comprehensive mental health assessment of each person. The assessment recognised strengths and abilities as well as difficulties faced by the person, it identified short and long-term goals considering the levels of support required to facilitate independence, based on the progression model. Staff considered resources available to the individual, including their support networks and local community.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs, however staff told us the local authority record system had limited functionality regarding physical and mental wellbeing. Staff told us they adapted the system to ensure there was a location for this information.

Positive behaviour support plans were present where appropriate and were developed following a comprehensive functional assessment, plans focused on people's quality of life outcomes and met best practice.

Staff regularly reviewed and updated care plans and positive behaviour support plans when a persons' needs changed.

We reviewed six care records, all were personalised, holistic, recorded the persons 'voice and were strengths-based.

People had an up-to-date hospital passport, where identified as required.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. They ensured that people had good access to physical healthcare and supported them to live healthier lives.

Staff understood and applied NICE guidelines in relation to behaviour that challenges.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for people in the service.

Staff supported people to attend their annual physical health assessment and provided training to GP practices. The training included communication, reasonable adjustments and health inequalities for people with learning disabilities. We saw the team had recently alerted GP's of an NHS report highlighting constipation and poor bowel care as a leading cause of premature death in adults with a learning disability. We also saw staff had participated in a learning disability awareness day and had produced an innovative example of the Bristol stool chart made from chocolate brownies.

Community mental health services for people with a learning disability or autism

Requires Improvement

People's outcomes were monitored using recognised rating scales. For example, occupational therapists used the model of human occupation exploratory level outcome ratings and model of human occupation screening tool to record peoples' progress. Speech and language therapists used the therapy outcome measure tool. Staff also completed the Health of the Nation Outcome Score – learning disability (HoNOS – LD).

Staff worked with social care providers to ensure care was line with best practice and national guidance. For example, quality standard 101, behaviour that challenges National Institute for Heath and Care Excellence (NICE).

Staff used technology to support people. They told us they used talking mats, symbolic understanding tools and accessed tablets and laptops, two carers confirmed this.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. We saw staff had undertaken a supervision and case notes audit. People were supported to attend a speak out day to discuss how people with learning disabilities felt during the pandemic.

The service took part in the NHS research project people with a learning disability and autistic people Learning Disability Mortality Review (LeDeR) and shared national learning across the localities.

The team had also implemented system for maintaining a structured activity routine during the pandemic. It was designed to offer suggestions for activities support people to think of new and different activities to offer the individuals in supported living.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. Staff did not always receive regular appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

People received care, support and treatment from staff and specialists who received relevant training. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, this included learning disability, autism and positive behaviour support training along with, trauma-informed care, human rights and carer awareness. The health professionals included art, music, occupational and speech and language therapists. There were also nurses, healthcare support workers, psychologists and a consultant psychiatrist.

Managers gave each new member of staff a full induction to the service before they started work.

Managers had not ensured staff received an annual appraisal, the appraisal across the countywide learning disability partnership was 49%, managers did not routinely receive a specific breakdown of appraisals for their team, however this information was available upon request. There was an organisation agreement that appraisals were to be suspended during the COVID-19 pandemic. We saw all staff had an appraisal booked within the forthcoming three months following the inspection, however there was a lack of local team oversight.

Managers had not ensured that supervision across the partnership was regularly received. The figures month on month had dropped from 68% in April, 54% in May to 38% in June 2022. However; we looked at 8 supervision records relating to 4 members of staff who had received supervision in the last 8 weeks

Managers had an action plan in place to address this issue, we saw all staff had supervision booked within the next four weeks.

Managers made sure staff attended regular team meetings or gave information from those that could not attend. We looked at six months of team meeting minutes, there was a standard agenda which included quality, performance and governance.

Managers recognised poor performance, could identify the reasons and dealt with these with support from the trust human resource team.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss people who used the service and improve their care.

Speech and language therapists supported other professionals to use different methods of communication with people based on their individual needs. Staff made sure they shared clear information about people who used the service and any changes in their care. The learning disability partnership had effective working relationships with other teams both inside and external to the organisation, these included advocacy, acute and mental health hospitals, housing, education and vocational training and community groups.

Staff made sure they shared clear information about people and any changes in their care, including during transfer of care. We saw a variety of easy read leaflets and videos which were available to people and their families. Staff supported people and their families to participate in care and treatment reviews.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act (MHA) and the Mental Health Act (MCA) Code of Practice and could describe the Code of Practice guiding principles. Compliance rates were at 92%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

As this was a community service, the application of the mental health act applied mainly to community orders, emergency assessment and Section 117 aftercare arrangements.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity. Staff worked with the people's support network to ensure best interest decisions were made when relevant.

Community mental health services for people with a learning disability or autism

Requires Improvement

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance rates at the time of the inspection was 90%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act, this was via the local mental health trust.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff assessed capacity to consent clearly each time a person needed to make an important decision. This was then recorded in the electronic record.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's communication needs, wishes, feelings, culture and history. Staff said they involved families where appropriate and tried different ways to communicate with the person to assess capacity. Records demonstrated in all cases where family were involved that discussions took place regularly.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Are Community mental health services for people with a learning disability or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They understood the individual needs of people and supported them to understand and manage their care and treatment.

People who used services and those close to them were active partners in their care. We reviewed six care records and saw staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who used the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles in delivering care.

We were told that a member of staff visited the home of a newly referred person every evening on their way home from work. This was to establish trust with the person before intervention started, the member of staff did this for a period of three months. Clinical records demonstrated that people's individual preferences and needs were always reflected in how care was delivered. Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood and promoted the wider health and social care to access communication aids if required.

Involvement in care

Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Community mental health services for people with a learning disability or autism

Requires Improvement

Staff informed and involved families and carers appropriately.

Involvement of people

We reviewed six care records and saw people, and those important to them, took part in making decisions and planning of their care. Staff involved people and gave them access to their care planning and risk assessments and supported them to make decisions about their care. Staff made sure people understood their care and treatment and found ways to communicate with people who had communication difficulties.

People were empowered to feedback on their care and support. We saw examples where staff had encouraged feedback using an easy read "we welcome your feedback" form. We also saw an easy read version of "our learning disability vision, making a better future together" that had been co-produced and set out agreed next steps for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else. We saw evidence that staff had acted on this feedback.

Staff told us they felt able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people using the service. Staff followed policy to keep information about people using the service confidential. Staff maintained contact and shared information with those involved in supporting people, as appropriate.

During the first COVID-19 lockdown, the service provided online and telephone sessions for people.

Staff made sure people could access advocacy services.

Involvement of families and carers

We spoke with six carers and/or relatives over the phone, five said staff were respectful, polite and interested in their loved one's wellbeing. They said staff shared information and provided support when needed. One carer said they would like to have been kept up to date more often.

Staff helped families to give feedback on the service. The service had a single point of contact

for raising concerns and providing feedback about the service. Staff gave carers information on how to find the carer's assessment.

We were told about the 'speak out council' which was a person-led consultative forum that provided people with a learning disability and their families the opportunity to have their voice heard. They had several speak out leaders who worked in specific localities across the county. The speak out leaders participated in the learning disability partnership board to express the views of people with a learning disability.

The service also encouraged people and families to take part in the annual survey that provided a route for suggestions for future service development.

Are Community mental health services for people with a learning disability or autism responsive?

Community mental health services for people with a learning disability or autism

Requires Improvement

Requires Improvement

Access and waiting times

The service referral criteria supported easy access to services. Its referral criteria did not exclude people who would have benefitted from care. Staff followed up people who missed appointments.

We saw the service criteria which described who they would offer services to and offered people a place on waiting lists.

The service did not meet target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The referral to assessment waiting time was 47 weeks. The waiting time for referral to treatment was 57 weeks. There were 73 people on the waiting list at the time of the inspection, 60 of them were awaiting de-sensitisation work for COVID–19 vaccinations. The remaining 13 were waiting for low level interventions.

The service used systems to help them monitor waiting lists and support people. We attended the weekly multi-disciplinary meeting (MDT) which reviewed risks and changes in circumstances of people on the waiting list.

Staff gave examples of how they engaged with people who found it difficult, or were reluctant, to seek support from mental health services, they told us people were encouraged and supported to access the local speak out council where they were able to voice their concerns and opinions.

People had flexibility and choice in the appointment times and were offered a choice of venue where appropriate. Staff worked hard to avoid cancelling appointments and when they had to, they gave people clear explanations and offered new appointments as soon as possible. Staff liaised well with services that provided care in supported living settings, so people received the right care and support.

Staff supported people when they were referred, transferred between services, or needed physical health care. We saw evidence that a person had been supported by the team for a prolonged period whilst in hospital ensuring the person received the most appropriate support.

The organisation had some commissioning responsibilities to identify appropriate support and accommodation to people who used the service. Where an appropriate placement could not be found, this would then be escalated to the national team for their action. We saw there was one occasion that the service had to escalate to the national team due to a lack of suitable alternative services. The Huntingdon service stepped up their support of the person at this time to help mitigate risks to the person at this time of crisis. Unfortunately, the national commissioners were unable to identify alternative support in a timely way due to a lack of bed availability nationally.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The service did not see people for clinic appointments on the premises.

Peoples' engagement with the wider community

Staff supported people with activities, such as work, education and family relationships.

Community mental health services for people with a learning disability or autism

Requires Improvement

The team supported people to access "shared lives" which was an initiative whereby people were helped and supported by a carer who shared their home with them.

We were told about Care Network Cambridgeshire which provided information and guidance, practical support to help people stay at home and to connect with or support their local community.

Staff made sure people had access to opportunities for education and work, and supported people. However, staff told us that during the pandemic they had been limited in their ability to provide these opportunities due to the COVID-19 restrictions and were dependant on the services reintroducing their services which was starting to happen.

Meeting the needs of all people who use the service

People's human rights were upheld by staff who supported them to be independent and have control over their own lives.

The service met the needs of all people using the service, including those with needs related to equality characteristics. Staff helped people with advocacy, cultural and spiritual support. People's communication needs were always met. The service had a policy in place to meet the information accessibility standard. The service had accessible information available in different prints, symbols, photos and images. People were provided with communication information cards if required.

Staff made sure people could access information on treatment, local service, their rights and how to complain. The service had information leaflets available in languages spoken by the people and local community.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. People, and those important to them, could raise concerns and complaints easily and staff supported them to do so.

The service had one formal complaint in the 12 months prior to the inspection. This was investigated and not upheld.

Managers ensured lessons learned from complaints in other localities were shared via the governance meetings. Staff protected people who raised concerns or complaints from discrimination and harassment. Staff described to us how to acknowledge complaints.

Are Community mental health services for people with a learning disability or autism well-led?

Requires Improvement

Leadership

Community mental health services for people with a learning disability or autism

Requires Improvement

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding and were passionate and proud of the services they managed. Staff told us managers and leaders were visible in the service and approachable for people using the service and staff.

Vision and strategy

Staff knew and understood the vision and values of the service and how they were applied in the work of their team. They had a mission, vision and strategy and we saw an easy read version of "our learning disability vision, making a better future together". This had been co-produced and set out plans for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else.

Culture

Staff told us they felt respected, supported and valued. They reported the service promoted equality and diversity in its day-to-day work and provided opportunities for career progression. They felt able to raise concerns without fear of retribution.

Managers told us they actively worked alongside staff to ensure they were aware of the values of the service, knowing how to advocate for people, raised the profile of reporting concerns, ensuring senior management staff had a presence in the service and ensuring staff had sufficient training and supervision to support them in their roles.

Staff were very motivated by and proud of the service. We saw examples of constructive engagement with people and families, at planned events and through face to face meetings. Managers had developed their leadership skills and those of others, to ensure they were empowered to make positive changes.

Governance

The learning disability partnership had governance structures in place to monitor safety and risk.

The service held monthly governance meetings which had an agenda including; safeguarding, health promotion, lessons learned and risk

We were told the ethos around governance at LDP was aimed to create an environment where clinical excellence would flourish and people who used the service reached their potential.

Managers had limited oversight of performance that were team specific unless requested. Reports were produced regarding sickness and appraisal; however, these were service wide and not location specific. Managers did not receive sufficient up to date information to have oversight of specific performance areas.

Management of risk, issues and performance

Effective multi-disciplinary and mulit-agency meetings across the service helped to reduce people's risks and keep people and staff safe.

Staff notified and shared information with external organisations, for example the local authority and Clinical Commissioning Groups (CCGs). People we spoke with said they had good rapport staff and that they liked them a lot.

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Requires Improvement

We saw staff were offered the opportunity to give feedback and input into service development. Staff did this through regular team and governance meetings.

The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities for example Health of the Nation Outcome Scores.

Under a formal management agreement for the delivery of the Integrated Service, the sole and primary case management electronic recording system is hosted via the Adult Social Care system. All staff have access and have been fully trained to use this electronic system for the recording of service user information'.

Staff we spoke with said the local authority system was difficult to navigate and had limited functionality with regard to mental and physical health and wellbeing. Staff told us they adapted the system to ensure there was a location for this information.

The health staff at LDP required access to the electronic record system at Cambridgeshire and Peterborough NHS Foundation Trust to record supervision, training, appraisal and rostering. We were told staff faced challenges with the interface between CCC and CPFT IT systems which has been escalated as a risk in each organisation.

Staff made notifications to external bodies as needed.

Engagement

Managers engaged actively with other local and national health and social care providers to ensure the integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff, people who used the service and carers had access to up-to-date information about the work of the provider and the services they used, through bulletins and newsletters.

The team were very active partners in promoting and increasing awareness of learning disability and the support services available locally.

Learning, continuous improvement and innovation

The Learning Disability Partnership (LDP) produced a virtual exhibition to display the art and music inspired during the first national COVID-19 lockdown.

The Art and Music Therapies Team, within LDP, invited people with learning disabilities, and their supporters, to create art and music to illustrate their experiences of lockdown; including what they worried about and what brought them joy during this difficult period. The work provided a record of learning-disabled people's experience during the pandemic.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have a plan to reduce waiting times to within the 18-week target. Managers were not supplied with sufficient up to date data to have oversight of specific performance areas. Regulation 17. (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure that all appropriate staff received regular supervision and annual appraisal in accordance with their own policy. Regulation 18 (1) (2) (a)