Outstanding ☆

Plymouth Community Healthcare CIC

Community mental health services for people with learning disabilities or autism

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558085
Website: www.livewellsouthwest.co.uk

Date of inspection visit: 21 - 24 June 2016
Date of publication: 19/10/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-297622270	Local Care Centre Mount Gould Hospital	Community Learning Disabilities Team	PL2 2PQ

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

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	Outstanding 
Are services safe?	**Good** 
Are services effective?	**Good** 
Are services caring?	**Outstanding** 
Are services responsive?	**Outstanding** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated community mental health services for people with a learning disability or autism as outstanding because:

- The team had won a national award for their successful repatriation of patients.
- Feedback we received from patients, carers and stakeholders described staff going the extra mile and providing compassionate, focused, respectful and attentive patient care. The team asked for feedback from patients and responded to the feedback. Surveys showed high levels of satisfaction.
- The service was fully staffed. Staff worked together across a range of disciplines to provide holistic and individualised care to patients.
- Staff were well trained and experienced. They were up to date with mandatory training and were able to access specialist training.
- Patients could access urgent care when they needed it through bespoke out of hours packages, crisis plans or by contacting the team and requesting help. Patients that needed it were assessed urgently and psychiatrists were available for ad hoc consultation.
- Waiting times were within the target for the service of 18 weeks. The team could assess patients sooner if they felt they could not wait although there was no target for providing urgent assessments. However, staff did not monitor patients for potential increases in risk while they were waiting for an assessment. Patients who were care coordinated by another agency did not always have a risk assessment produced by the team. A new practice of producing threshold assessment grids for every patient was addressing this.
- Care planning was highly individualised, holistic and person centred. Patients and carers were actively involved in care planning.
- The team used medicines and psychological therapies that were recommended by the National Institute for Health and Care Excellence. Psychological therapies were adapted to make them accessible to the patient group.
- Staff had good knowledge and understanding of the Mental Capacity Act.
- The service had good working links with a wide range of teams and services inside and outside of the organisation. This enabled patients to receive holistic and joined up care and to have access to mainstream services. The team carefully planned transitions between services as patients came into or left the service.
- Staff were respectful, caring and compassionate. They treated patients as individuals and provided care that was tailored to meet individual needs.
- Carers were supported to be involved in patients care. They were offered group and one to one support.
- The team made it easy for patients to access the service by seeing them in the city centre, at home or in other familiar places. They made documents easy for them to understand by including pictures and using easy to read language.
- Team morale was good and staff were happy. They were supported by accessible and approachable managers and had regular appraisals and supervision.
- There was a strong commitment to quality improvement and staff were encouraged to be innovative. The team took part in research and audits. They also trained others in working with people with learning disabilities and mental health difficulties.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The service had good alarm systems and a local lone working protocol which had recently been revised following an incident.
- The service was fully staffed and caseloads were of a manageable size and were regularly reviewed through line management supervision .
- Mandatory training compliance was good and this meant staff remained up to date with their knowledge.
- Psychiatrists were embedded in the team and made themselves available for ad hoc consultation and urgent assessments.
- Staff had good knowledge of safeguarding, knew how to make referrals and could describe examples of working with other agencies to safeguard patients.

However:

- Patients waited for a maximum of 18 weeks. The team reviewed new referrals in their team meeting, and they carefully considered which patients they felt could wait.
- Patients who were care coordinated by another agency did not always have a risk assessment produced by the team. A new practice of producing threshold assessment grids for every patient was addressing this.

Are services effective?

Good

We rated effective as good because:

- Care planning was personalised and holistic. Care plans were produced using a comprehensive care plan template in easy read format.
- Patients' access to physical healthcare was a priority and social needs were also assessed and supported.
- The team had produced an end of life care pathway algorithm to health professionals to plan care appropriate to different end of life stages.
- The multidisciplinary team comprised a variety of experienced and qualified clinicians to meet the different needs of service users. Access to specialist training was good.
- Psychological therapies recommended by the National Institute for Health and Care Excellence were used and developed to make them more accessible to.

Summary of findings

- Most staff had completed training in the Mental Capacity Act and when asked about the application of the act, staff showed good knowledge and understanding.
- The service had good working links with a wide range of teams inside and outside of the organisation.

Are services caring?

Outstanding

We rated caring as outstanding because:

- The feedback from patients, carers and stakeholders described care as being compassionate, focused, respectful, attentive and caring. They described staff going the extra mile to help and support patients and carers. Patients were given time to voice their views and influence their care.
- There was a culture within the team of providing highly individualised, holistic, person centred care. Patients and carers were actively involved in care planning and care was tailored to individual needs.
- Staff were very actively engaged in improving the experience for patients. Efforts were made to secure transitions into and out of the service for patients at the earliest possible stage. The team ensured smooth care transitions between services and staff travelled to meet patients who were placed out of area to facilitate them coming out of hospital and returning to the local area so they could be more independent and be near their friends and family.
- Carers were involved in patient care as appropriate and provided with the support they needed through group interventions and individual support whenever they needed it.
- Patients were involved in recruitment for the service and in delivering training that the service provided.
- The team used questionnaires to gather feedback from carers and patients and these showed high levels of satisfaction.

Are services responsive to people's needs?

Outstanding

We rated responsive as outstanding because:

- The team had been recognised for repatriation of people from long stay hospitals out of the area. They were awarded the Nursing Times Award for Learning Disabilities Team of the Year in 2015 in recognition of repatriating 18 patients.
- The service was meeting its 18 week target for treating new patients.
- The team could respond to urgent referrals or offer rapid assessments if there were risks identified in a referral.
- The team offered crisis support.

Summary of findings

- The team provided group and individual appointments in the city centre which was easier to access and where there were better facilities. Appointment times were flexible.
- The service worked closely with other services to ensure patients' needs were being met. Enabling patients to access mainstream services was central to the team's role
- The team worked flexibly, choosing the most suitable practitioners to work together to support individual patients.
- Patients that failed to attend their appointments were actively re-engaged.
- There were a range of documents and leaflets in easy read format, including appointment letters, easy read descriptions of different medications. Appointment letters also included a photograph of the clinician.

Are services well-led?

Good

We rated well-led as good because:

- Systems were in place to ensure staff were up to date with mandatory training, supervised and appraised regularly.
- Staff found managers accessible and approachable and managers felt connected to senior management.
- Morale within the teams was good and staff worked well together.
- There was a strong commitment to quality improvement and staff were encouraged to innovate.
- Self-assessment against the green light toolkit enabled the service to measure themselves against what a good service looks like.
- The team ran an academic programme for staff to improve their knowledge and help them to provide high quality care for people with learning disabilities and mental health problems.

However:

- Managers recognised they could improve on disseminating learning from complaints and incidents, as there was no current strategy to ensure there was learning across the service.

Summary of findings

Information about the service

Plymouth Community Healthcare's community mental health services for people with a learning disability, provides a Plymouth citywide service and is for people with learning disabilities who have complex needs.

The service is for people aged 18 and above who are registered with a GP in Plymouth. Children from the age of 16 who are accessing children's learning disability services are also engaged in order to prepare for a transition into adult services.

Patients with autism are only treated by the service if they also have a learning disability because treatment for autism is not a commissioned part of the service.

The multi-disciplinary team provides a holistic assessment and, if required, specialist care and treatment. The team provides intensive support for patients in need of behavioural support, psychology services, occupational therapy, nursing, dietetics and speech and language therapy. The team also provide care coordination if complex health input is required. A core objective of the service is to improve health outcomes for people with learning disabilities. They enable people with learning disabilities to access mainstream health services where possible. The service provides treatment for patients who are detained in hospital, detained by the ministry of justice, on a care programme approach or who are eligible for continuing healthcare funding which pays for intensive packages of care to support patients remaining in the community.

There is a team base with consulting rooms and further rented rooms in a building in the city centre. However, the team mainly see people in the community settings such as at college, or at home with their families.

The service operates on weekdays between the hours of 9am and 5pm. However, the team also provide bespoke out of hours support as needed with on call staff available by telephone.

The service has not previously been inspected.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality CommissionInspection Manager: Nigel Timmins

The team that inspected Community mental health services for people with a learning disability or autism comprised a CQC Inspector, a nurse and an occupational therapist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

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

During the inspection visit, the inspection team:

- visited the team base and looked at the quality of the environment
- observed how staff were caring for patients during two home visits and a clinic appointment
- spoke with three patients who were using the service
- spoke with six carers of patients who were using the service
- spoke with two managers of the service
- spoke with 17 other staff members; including doctors, nurses, speech and language therapists, psychologists, behavioural advisors, occupational therapists, a physical health practitioner and social workers
- attended a multi-agency meeting
- spoke with three stakeholders of the service including an advocate and two residential homes
- looked at nine patients' treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

- Feedback about the service from patients and carers was unanimously positive. People said staff were caring and respectful. They said they could access support when they needed it and always felt listened to. They said staff were approachable and responsive and they described them as dedicated.
- Patients and carers felt they were involved in their care.
- Surveys conducted by the service over the past year showed good levels of satisfaction. Ninety-two percent of people said they would want their friends and family to have this service if they needed it, 99% of people said the service had done what they hoped for by working together and 82% of people said they were very happy with the work that had been done.
- A community learning disabilities team survey of patients and carers showed high levels of satisfaction, with 87 out of 106 responders scoring their satisfaction with the service with full marks.

Good practice

- The community learning disabilities team had been recognised for repatriation of people from long stay hospitals out of the area. They had successfully repatriated 18 people from out of area hospitals to their families, friends and communities. They were recognised nationally for this work and were awarded the Nursing Times Award for Learning Disabilities Team of the Year in 2015. They had presented on behalf of NHS England as part of the Transforming Care for People with Learning Disabilities agenda and were sharing best practice with Glasgow NHS Trust.
- The team had produced a comprehensive care plan template in easy read format. They had also produced an end of life care pathway algorithm, which directed health professionals where to refer the patient, and prompted care planning appropriate to different end of life stages. The team ran a two hour end of life course for staff employed by the provider who were involved in overseeing end of life care.
- The team ran an academic programme for staff within the organisation that aimed to improve the care of people with learning disabilities and mental health problems. The programme was open to all staff who support people with learning disabilities. Topics they had covered included 'lived experience of restrictions', 'delivering high quality capacity assessments and Deprivation of Liberty Safeguards'.
- Patients appointment letters were written in easy read format and a picture of the clinician that would be seeing them was included on the letter.

Summary of findings

- The team were assessing themselves against the green light toolkit. This is a method for improving mental health support services for people with learning disabilities. It enables providers to measure themselves against what a good service looks like.
- The nursing team designed and produced passports for learning disabilities patients to improve their experiences when going into police custody or into hospital. The passport told the providers about the patient and enabled them to be made more comfortable.
- Appointment letters were in an easy read format and included a photograph of the clinician who would be meeting the patient.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider a structured system and setting timeframes for assessing cases that were considered urgent.
- The provider should ensure learning from incidents and complaints is shared across the service.

Plymouth Community Healthcare CIC

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
Community Learning Disabilities Team	Mount Gould Hospital

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 learning disabilities team did not have any patients who were subject to a community treatment order at the time of our inspection.

Mental Health Act training had been completed by 39% of the team. Speakers had come to talk to the team about the Mental Health Act. Training in the Mental Health Act was not mandatory but a central team provided advice and support.

There was an independent advocacy service available and patients were encouraged to make use of the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training had been completed by 91% of staff. Staff demonstrated a good understanding of the Mental Capacity Act 2005 and could explain the five statutory principles and relate them to their work.

Staff obtained patients' consent to treatment and recorded this in the patient record.

The team had their own assessment pack to assist their decision making when making Mental Capacity Act assessments. They collaborated with other agencies involved in a patient's care to ensure the most suitable person conducted the assessment.

Detailed findings

There was a Mental Capacity Act and Deprivation of Liberty Safeguards lead who could offer advice and further training.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Staff signed out portable alarms for use when they had appointments. When activated, the alarms informed staff where in the building the alarm had been activated so staff could go to assist.
- GPs undertook physical examinations so there was no equipped clinic room for this purpose. No medicines for patients were stored on site. However, there was a small locked refrigerator which was used annually to store staff flu vaccinations. The fridge temperature was checked and recorded daily when it was in use. A dose of adrenalin was kept locked in an office in case of an adverse reaction to a flu vaccine. A resuscitation bag and defibrillator had been ordered and staff would be trained to use them. However, these were not available at the time of our inspection and staff would call an ambulance as the first and only option if these were needed.
- All areas of the building were seen to be clean and well-maintained although in some areas walls needed repainting.
- Cleaning records showed that the team base was being regularly and appropriately cleaned.
- Staff received mandatory training in infection control and all staff were up to date with this training at the time of our inspection. Hand gel was available in reception and soap was available in the staff and patient toilets.
- Scales were available and these were calibrated regularly with stickers on them to show they had been cleaned. Fire tests were conducted weekly to ensure alarms were working properly.

Safe staffing

- There were 26.2 whole time equivalent qualified nurses, behavioural advisors and allied health professionals and 6.6 non-qualified support workers. There was a service manager and three group managers who managed the clinical staff.
- The team was fully staffed with no vacancies.
- The sickness rate for the team over the previous year was 5.6% which was the same as the average sickness for the provider.
- The turnover of staff was 6.7% in the previous year. This compared favourably to the provider average of 13%.
- Workforce planning was regularly revisited and took into consideration demands on the service.
- The average caseload was 10 cases per care coordinator.
- There were 46 service users awaiting allocation of a care coordinator or lead clinician. Care coordinators were assigned to patients who were eligible for continuing healthcare funding and lead clinicians for those clients who were funded by Plymouth City Council.
- Caseloads were reviewed during management supervision where each case was discussed and the manager checked that care plans, reviews and risk assessments were in place.
- Staff were covered by the team during sickness and leave. Bank and agency staff were not employed in the service. Staff said it was rare for any appointment or activity to have to be cancelled and that the team could manage to cover sickness and leave without the need for agency staff.
- Staff and patients could access a psychiatrist quickly when needed. There were two psychiatrists and a trainee psychiatrist employed in the team. Staff described access to psychiatrists as being good. They said they could approach psychiatrists for support, advice and joint working and that they always attended the multi-disciplinary team meetings. Out of hours, psychiatry was available at the provider's acute mental health hospital and at the local accident and emergency department.
- Staff received mandatory training in accordance with their role. The average mandatory training rate for staff in the team was 90%. The manager had ensured people who needed to complete mandatory training were booked in to do so by the 17th of August 2016.

Good

Are services safe?

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

Assessing and managing risk to patients and staff

- We reviewed nine care records. There was a process to highlight risk in new referrals to enable an urgent appointment to be made ahead of the weekly team meeting if required. During patients' assessments, clinicians completed risk assessments and then updated them as required. Some patients already had risk assessments completed when they came into the service and they were not therefore assessed for risk by the team. Staff in the team had begun using 'Threshold Assessment Grids' for all patients to ensure risks of various kinds were rated regardless of whether the initial risk assessment had been developed by the team or the referrer. The service also used the Historical, Clinical, Risk Management 20 version three which helps mental health professionals estimate a person's probability of violence.
- Crisis plans and advance decisions and advance statements were created for patients. During a home visit we witnessed a discussion about advance decisions and advance statements both of which were explained clearly to the patient. A carer told us about some work the service had done with a patient and their hospice about their end of life care.
- We saw examples of crisis plans in six out of the nine records we reviewed and these were of a good standard. Not all patients had crisis plans, crisis plans were only developed if it was felt necessary for the individual patient. The team worked hard to prevent crises by liaising with other agencies involved. For example, they asked care providers to complete a monthly form to identify if there were any forthcoming destabilising factors, such as a member of staff leaving the facility where a patient lived or spent time.
- The nursing team had developed passports for patients to help them when they came into contact with the police, general and psychiatric hospitals. The passports enabled the receiving team to understand how to support the patient. For example, hospital passports were created for patients who present regularly to accident and emergency departments. The community learning disability team would be involved in writing the passports for patients in an accessible language. They were designed to give staff helpful information about the patient including their likes and dislikes and their interests. This would enable patients to be made more comfortable. We saw an example of a passport which had been set up to provide alternatives to a patient to calling 999. One member of staff described close working and good liaison with police and the ambulance service.
- There was an alert system which meant the community learning disabilities team were alerted when any of their patients presented at the local hospital or moved wards. This enabled the team to liaise with hospital learning disabilities nurses to offer support if it were needed.
- Some patients waited up to 18 weeks for their first appointment although the average waiting time was five weeks. Referrals were discussed in multi-disciplinary team meetings where it was decided how long a patient could wait. Dysphagia referrals were to be seen within two days if they were urgent. Patients were prioritised according to their clinical risk, the support they were receiving in other services and from family and the availability of resources and capacity at the time of the referral. Patients' risks were not monitored further while they were waiting to be seen by the service. The service manager felt the team could improve on monitoring risk while people were waiting.
- Safeguarding training was mandatory and it was repeated every three years. Safeguarding children level one training had been completed by all staff and 94% had completed level two. Over the last 12 months, the team had made three safeguarding alerts and investigated all three. During the inspection we were told of three further alerts that had been made during the previous two weeks. Staff were able to describe the process of making a safeguarding alert to the local authority. The team had links with the adult and child safeguarding lead at the local authority. If the community learning disability team was the first agency to become aware of a risk they would make the alert. Staff told us they often supported other agencies in making safeguarding alerts and sometimes followed up to ensure it had been done. The service had recently integrated with the local authority and social workers operated from the same team base. This enabled the team to provide well joined up holistic care for patients. The social work team confirmed alerts were being raised for learning disabilities patients. Staff were able to give examples of safeguarding processes they have been involved in. There was an early concerns checklist available If they were considering safeguarding needs

Good

Are services safe?

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

and staff said they could complete it and use it as a basis for discussion in a multidisciplinary team meeting. Information was shared between the teams by discussion in the multi-disciplinary team meetings. The social workers also had access to the team's care records.

- There were good personal safety protocols to keep staff safe. There were personal alarms for staff going out to visit patients which could also record conversations and call the police. Staff also had mobile phones and could use a code phrase when phoning the team base to denote they needed help. There was also a buddy system for working beyond normal working hours. Staff were required to sign the lone working policy to show they had read and understood it. The clinical records system had the facility to place warnings on patient notes, for example, to show the patient should only be visited in pairs. Staff's personal details and contact numbers were also kept and were in the process of being updated. A pocket sized laminated card was given to all staff which showed the local procedures and how to use alarm systems.

Track record on safety

- The service had had two serious incidents in previous 12 months. These were two recent patient deaths which were being investigated.
- The team had reported 30 incidents between 6 May 2015 and 2 May 2016. Ten of these concerned the service not having a dietician in post and therefore the team were unable to offer this service but a dietician had since been appointed.
- There was evidence the team were learning from incidents. The lone working process had been improved and revised following an incident in a patient's home. The team had undertaken a workplace violence assessment, which investigated how many people were using lone working devices and if they were not using them, why they were not using them. It was decided to give all staff laminated pocket sized cards with information about the lone working devices. The requirement for staff to sign the lone working policy and increased performance management around adherence to the policy was aimed at enforcing it more rigorously.

Reporting incidents and learning from when things go wrong

- Staff reported incidents themselves using a link on the provider's intranet to a provider wide system. An incident form was completed and administrative staff could support people in completing the form if needed. Staff confirmed they knew how to report incidents and what needed to be reported. Once reported the incident was reviewed by the risk team and service manager.
- Managers and staff were aware of the duty of candour and what it meant in terms of the need to be open and transparent, including explaining to patients if things went wrong. We reviewed a complaint and an apology had been issued and the issue quickly rectified.
- Staff involved in incidents were given feedback but the rest of the team were not currently learning from incidents in a systematic way. Managers were planning to include dissemination of learning from complaints and incidents in their monthly staff briefing meeting in future. This would also give staff the opportunity to discuss the feedback.
- Managers were confident debriefing and support where always offered although there was no specific protocol for providing this. Staff said they were offered opportunities to debrief following incidents. Two staff told us about a case they had been involved in which had affected them and they were offered a debrief by the lead psychologist and the service manager as well as their usual supervision and line management meetings.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at nine care records Care plans were present and up to date in seven of the nine records reviewed. In the remaining two cases, the patient's care coordinator was a provider from another agency so they held the risk assessment and care plan. In one of these two cases, however, we did see evidence of on-going physical care, evidence of informed consent and evidence of assessment of mental capacity. The other patient was currently in an inpatient facility out of area so their needs were being care coordinated there.
- Assessments were comprehensive and covered physical, psychological and medical health, sensory, communication and social wellbeing. Occupational therapists provided a baseline Assessment of Motor and Process Skills(AMPS) which was a standardised observation-based evaluation of, the ability to perform daily life tasks. The assessment provides a very detailed breakdown of a person's functional skills and abilities. The patient received a certificate of completion after the assessment. The team did initial assessments to find out if someone was eligible for continuing healthcare funding, which they then presented to a panel to decide on funding. Although treatment for autism was not commissioned, the team consultant had provided assessments for autism when appropriate. The service was in discussion with commissioners about a potential gap in services for patients with autism and mental health needs. These patients are currently In the remit of community mental health teams. Patients with behaviours that challenge were provided with an assessment that took into consideration triggers for their behaviour including physical and mental health conditions and environmental factors. The aim was to support people to develop more positive behaviours. The team had its own challenging behaviour screening and intervention matrix.
- There was a dysphagia assessment process which enabled speech and language therapists to accurately assess the risk to a patient.
- Care plans were personalised, holistic and recovery orientated. Care plans were accessible for patients including the use of capital letters patients own words, large font and symbols. In three of the nine records reviewed, it was not possible to determine from the clinical records whether the patient had been offered a copy of their care plan. In one case there was a rationale for not providing the patient with a copy of their care plan.
- Care records were electronic using a patient records system. Most staff had laptops or could borrow one and this gave them the facility to read but not update records when working remotely.

Best practice in treatment and care

- Prescribing was done by the patient's GP unless there was an urgent issue In which case the psychiatrist's would prescribe. The consultant would write to the GP with advice about any changes to medication and the GP would prescribe. This enabled the GPs to maintain an overview of what was happening. Psychiatrists attempted to reduce medication where possible. Following The Royal College of Psychiatrists' recent report "Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviour that challenge: practice guidelines." The team were embarking on a new audit of their prescribing for patients with behaviours that challenge.
- Interventions provided by the service were evidence based. The team were working on adapting therapies to make them more accessible to the patient group. They had adapted a Dialectic Behaviour Therapy and Mentalisation approach to people with learning disabilities who attract a diagnosis of borderline personality disorder and they had adapted forensic treatment programmes for sexual offenders with learning disabilities.
- They had developed a 'Crest' group (Camden Street relationship and emotional skills therapy). Long-term treatment was available and a psychologist gave an example of a patient who had been coming for a year and would be offered a further six months of psychotherapy. The team also considered whether patients could access mainstream psychological therapies services and enabled them to have access to those services if possible.
- The physical health worker was developing a pathway for assessment and intervention around pain as a component of physical health assessment and this was underpinned by National Institute for Health and Care

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.

Excellence Guideline 11 and the quality standard Learning Disabilities: Challenging Behaviour (2015). We saw an example of a pain identification support programme initial assessment. This was a very thorough consideration of the patient's circumstances, physical demeanour and needs. The team also followed national guidelines about people with dementia. They had supported people to make memory books based on the evidence base for reminiscence therapy. Staff referred to a best practice guide which came out of a multi-agency review called 'Reducing the risk of choking for people with learning disabilities', published by the safeguarding adults board in 2012. They had also referred to the Royal College of Speech and Language Therapists five good communication standards 2013, and the new royal college of speech and language therapists competency framework 2015 for dysphagia .

- Many of the patients who accessed the service were care coordinated by other organisations and some lived in supported accommodation. Interventions to support patients with employment, housing and benefits were available from the team. The occupational therapists did assessments of motor and process skills. This was an assessment of a patient's ability to perform everyday tasks. They wrote a report and the patient could decide who could see it.
- Physical examinations were undertaken by GPs. The team prompted GPs to complete annual health checks and were monitored on their performance regarding health checks. GPs in turn advised the team if patients did not attend for physical examination. The team had developed an adapted annual health check tool for GPs to use with people with learning disabilities and added a health action plan to it. This tool had been adopted throughout the region. The physical health practitioner used the 'Disability Distress Assessment Tool' and had also devised a form suitable for patients with learning disabilities to record their physical health every day and this included checking food, fluid, bowel, urine current sleep, daily activities, airway, breathing, circulation and medication. The team would sometimes care coordinate patients with complex health needs and work with the liaison team at the local hospital to support their care. Livewell Southwest provides funds to Plymouth Hospitals NHS Trust for them to employ a Learning Disabilities Liaison nurse.
- The team used two main outcome measures the Health of the Nation Outcome scale for people with learning disabilities and the Health Equality Framework. These were repeated periodically in order to gauge effectiveness of their treatment.
- Staff took part in clinical audits. The team had taken part in the provider's child protection records audit in July 2015. The physical health practitioner had done an audit on sickness management and was reviewing this yearly. This had resulted in staff being offered additional support. There had also been Deprivation of Liberties Safeguards and Mental Capacity Act assessment audits. The Mental Capacity Act audit showed there was poor documentation of risks and benefits of treatment being explained to service users. This audit resulted in an action plan and the creation of a best interest meeting template the service now uses.

Skilled staff to deliver care

- The team comprised a full range of mental health disciplines including doctors, nurses, speech and language therapists, psychologists, behavioural advisors, occupational therapists, a physical health practitioner and social workers.
- Staff were experienced and qualified. Staff's experience enabled them to offer a wide range of interventions and to adapt approaches to suit their patient group. This included adapted psychotherapy, family therapy, systemic psychotherapy, Eye Movement Desensitisation and Reprogramming. One of the staff members was specialising in working with women with learning disabilities and personality disorders and one specialised in working with forensic patients. The staff devised and provided a variety of group interventions including crafts, cooking demonstrations and a keeping calm workshop.
- Staff received inductions which covered mandatory training in fire safety, manual handling, infection control, Mental Health Act, Mental Capacity Act, safeguarding adults, safeguarding children, basic life support. They were trained in breakaway techniques, conflict resolution, the Domestic Abuse Stalking and Harassment (DASH) risk assessment and the Deprivation of Liberty Safeguards (DoLS). They were given contact details for relevant staff and agencies such as social care and named nurses. They also had a workshop to raise

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.

awareness of Prevent (WRAP) training to support & protect those susceptible to radicalisation. They also had training in the clinical records system. A member of staff said they were impressed with their induction training.

- Representatives from each staff group attended weekly multidisciplinary team meetings. The team held a monthly whole team meeting for all staff.
- Staff were required to have management supervision four times per year. Supervision records showed that staff were 94% complete in their supervision activity for the period 01/02/2015 to 31/01/2016. Our review of staff records showed that one member of staff was last seen for management supervision on the 12th January 2016 and there was no record of them being supervised since. The manager and a member of staff were unable to find an explanation. Staff told us they peer supervised each other on a day to day basis. Some clinicians had clinical supervision as well as line management supervision. Other types of clinical supervision took the form of team reviews, debriefs, and reviews of clinical activity undertaken at the end of a team meeting. Support workers had a forum every two months where they discussed the health care assistants minimum standards, training, and clinical cases.
- The percentage of non-medical staff that had an appraisal in the last 12 months was 96%. There were two doctors in the service and they had both had an appraisal within the previous 12 months and been revalidated.
- Specialist training was available to staff and requests were overseen by the service manager. The team had used savings in staff costs for posts that were not needed to fund diplomas and masters level trainings in positive behaviour support. Three members of staff had so far benefitted from this. Mindfulness training was available internally. The speech and language therapists provided training in communication needs and a monthly Makaton signing group. Managers could access managers toolkit sessions. One of the managers we spoke to had attended all the recent toolkit sessions which covered recruitment and selection, grievance, managing sickness absence, managing performance and disciplinary. Occupational therapists had been provided with a five day training course in assessment of motor and process skills. A behavioural adviser we spoke to had recently had functional behavioural assessment training.
- There were no examples of poor staff performance which needed addressing. Managers were able to give examples which demonstrated a responsive approach to managing team relationships.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings were held every week and a representative from each discipline attended (usually the lead). Where someone had comprehensive knowledge of a particular case they were also invited and sometimes referrers were invited to the meeting. Complex cases were also discussed at another meeting for managers at provider level. Staff described team meetings as effective. One member of staff said it was useful as a means of sharing issues or concerns early on and agreeing actions with the team.
- The team members who would work with an individual was usually determined at the multi-disciplinary team meeting when the case was first referred.
- The team provided a referral form for other services to complete to refer patients to the service. This helped to ensure the referral would include all relevant information needed in order to screen and triage the referral. Many of the Plymouth community healthcare teams used the same clinical records system which meant the team could access internal records about their patients.
- The social work team had moved into the team base six months ago and been transferred from the local authority. They attended weekly multidisciplinary team meetings with the community learning disabilities team. A social worker from the team told us there was a lot more of sharing of information and contributing to each other's work since they moved into the base, including working on patient's plans together. The social work team also had read only access to the clinical records system used by the community learning disabilities team.
- A key role for the team was to work alongside services across the health and social care community to enable patients with learning disabilities to access mainstream services. The team actively linked with child and adolescent mental health services for patients who had

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.

reached the age of 16 or 17 and were likely to need further support into adulthood. The team was meeting monthly with the child and adolescent mental health service and the local authority to facilitate this. There were links with schools and members of the community learning disability team attended meetings with schools, physiotherapists, teachers and social workers to enable the transition into adulthood. A speech and language therapist was a link with the forensic service. There were links with a service called Beyond Limits, who support people with learning disabilities and mental health needs in Plymouth in Devon. They could help the team with planning and assessment to prepare patients who were out of county in placements to be repatriated. There were links with the local general hospital to enable learning disabilities patients to access services such as the anaesthetic clinic, long term conditions nurses and the palliative care team. Three patients were currently detained in hospital placements out of the area. The team liaised with inpatient services across the country and staff travelled to hospitals in order to enable patients from Plymouth who were placed in hospital outside of the area to be repatriated to Plymouth. They successfully repatriated 18 people from out of area hospitals between 2013 and 2015. They were recognised nationally for this work and awarded the Nursing Times Award for Learning Disabilities Team of the year in 2015. Carers gave good feedback about transitions from and to other services.

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

- Mental Health Act training had been completed by 39% of staff.
- The learning disabilities team did not have any patients who were subject to a community treatment order at the time of our inspection. Three patients were on Guardianship orders and five were on conditional discharge under the Ministry of Justice.
- Training in the mental health act was not mandatory but the mental health act team were available to provide advice and support. The service manager was confident that those who needed training had received it and that the team had a good working knowledge of what they needed to know because the Mental Health Act team had arranged bespoke training for the team, including some recent training from a solicitor.
- Administrative support and legal advice on implementation of the MHA and its code of Practice was available from a central team. The central team completed community treatment order paperwork. The Mental Health Act code of practice was available in hard copy and on the intranet.
- Review of patients' records showed consent to treatment was being obtained and capacity assessed when this was necessary.
- There was an independent advocacy service provided by Plymouth Highbury Trust. Staff told us they could complete a form to request the service on behalf of a patient. The service included a parent advocacy project. We spoke to Plymouth Highbury Trust and they gave very positive feedback about the learning disabilities service. They said the referral process worked well and that the team were accessible. They were invited to review meetings for patients they were working with and offered copies of letters if the patient consented. This enabled them to help patients better understand their care.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act had been completed by 94% of staff.
- Staff demonstrated a good understanding of the Mental Capacity Act 2005 and could explain the five statutory principles and relate them to their work.
- There was a policy on the Mental Capacity Act the team could refer to and it was also covered in the team's operational policy.
- Where possible staff ascertained during screening whether the patient would be able to consent to their treatment or not. Consent to treatment was recorded in the patient record.
- The team carried out Mental Capacity Act assessments when needed. Following an audit of the Mental Capacity Act, the psychiatrists and speech and language therapists had developed an assessment pack to assist in decision making. Assessment of mental capacity was done on a decision-specific basis about significant decisions and patients were given assistance to make specific decisions for themselves wherever possible. If

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.

the decision involved finances or accommodation, the psychiatrists and psychologists would try to support adult social care in their decision-making. This meant the most suitable service completed the assessment.

- Staff knew who the Mental Capacity Act and Deprivation of Liberties Safeguards lead within the organisation were who could offer advice and access to further training and support as required.
- The team would support homes and hospitals to make Deprivation of Liberties applications if needed.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We witnessed patients being treated with dignity and respect, being given time to express their views and individual needs and goals. We saw patients being given encouragement and we witnessed warm and caring relationships between staff and patients. Staff were non-judgemental and boundaried. We saw patient focused care and plans for future treatment were discussed and made clear. Staff were patient and supportive towards patients.
- Patients and carers we spoke to all gave very positive feedback about the service. They described caring, proactive and approachable staff that delivered consistent care. People described feeling confident in the care they received. One carer said the staff always do what they say they're going to do and another said nothing is too much trouble for them. People said the groups the team ran were informative and they felt encouraged to take part. One carer said their family member was living independently thanks to the team. Several carers told us about care that exceeded their expectations.
- Carers described staff who took time to understand patients' and carers' individual needs and wishes. Staff adapted care to fit patients' needs, for example, visiting them at home or school in order to make attendance easier for them or to learn about how they manage in their own surroundings. Our observations during home visits were of staff that showed good knowledge of their individual patients.
- Staff understood the importance for patients of being close to their friends and family. The team had won an award for bringing patients who were staying in hospitals out of the area, back home to Plymouth. To achieve this they made visits to hospitals that were a long way away in order to offer opinions and to work on plans to enable patients to come home. This demonstrated a willingness to make efforts beyond what was expected to improve the lives of the patients they worked with.
- We spoke to staff about confidentiality and they described how they password protect and encrypt emails when they are sent to other providers. One member of staff gave an example of sending an anonymised care plan to brokerage so it could be circulated to potential providers without breaching confidentiality. The assessment of motor and process skills easy read leaflet explained to patients that they could decide who could see their assessment report.

The involvement of people in the care that they receive

- Our review of care plans and discussions with patients and staff showed patients and carers were actively involved in care planning. One carer told us their family member had had a bespoke care plan, which had taken a lot of work.
- Families and carers were involved in patients care as far as the patient wished this to be the case. We heard many examples from carers of ways in which they were involved in patient care. There was a culture of empowering and supporting families whilst promoting independence. Carers said they felt included. One carer we spoke to was attending multi-agency meetings with a patient. Another carer told us they had been to meetings for carers which they had found informative and that they have been invited to several meetings of this kind. We saw some examples in patient records of patients being given copies of their care plans but this was not always recorded.
- Access to advocacy was encouraged. One member of staff told us an advocate was going on a joint visit with them to support a patient who was transitioning from child to adult services. Patients contributed to the Peninsula mental health and intellectual disability academic meetings. A patient had recently spoken about their experience in hospital at one of these events.
- People with learning disabilities could get involved in decisions about the service including being on interview panels for new staff. Patients and carers were consulted on service developments such as new leaflets.
- Patients and carers gave feedback about the service through surveys. A meridian survey for the 12 month period from 1 December, 2015 June 30 of June 2016 was completed by 91 people and 92% of them said they would want their friends and family to have the service if they needed it.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

Access and discharge

- At the time of our inspection the waiting time was 17 weeks and this was within the 18 week target for patients to begin treatment with the service. However, because cases were prioritised in order of urgency, the mean length of wait was 5.4 weeks. New referrals were discussed at the weekly multidisciplinary team meeting where appropriate team members were assigned the case but did not make contact until the first appointment. This meant patients waited up to 18 weeks for an assessment without contact. There were no targets for the time patients waited from assessment to treatment but we did not see any gaps and staff said treatment continued straight after assessment. Patients who were waiting for psychiatry input did not have their case reviewed by group managers while they were waiting. We found a patient who had been waiting for three months and the referrer had been written to for further information but nothing has been done to follow up the lack of response. We brought this to the teams attention and were assured they would respond to this case.
- Urgent referrals were seen quickly and an appointment was arranged as soon as the referral was received. If the referral suggested the patient might be a risk, the referral would be allocated for an urgent assessment. Patients who were not known to the service or where their needs were unclear were generally screened earlier.
- The team responded quickly when patients or carers phoned in for support. Carers told us they could speak to someone or have a visit either the same day or the following day when they phoned in. Another carer told us the speech and language therapists would come out urgently to assess risk of choking. The team had a link with out of hours services including the local authority social workers who were available 24 hours per day. The team contacted the social workers to let them know they might expect a call from someone if they were unstable or unsettled. The team also set up bespoke on call services if needed in exceptional circumstances. A member of the patient's core team, who knew them and their clinical issues and circumstances could provide extended hours support. One carer told us about a patient who had a 24-hour care plan with the team.
- The team were part of a blue light protocol which enabled patients to be fast tracked to receive care when needed. The blue light protocol aimed to keep people cared for at home or as close to home as possible and to avert crises by working across services. Commissioners attended blue light meetings and the team could present cases to the meeting for funding approval for an intervention as required.
- The service had clear criteria for which people would be offered a service.
- The team actively engaged people who struggled to engage with the service by making it easier for them to gain access to it, for example, by visiting them at a place of their choice. If people were reluctant to engage with the service or if they failed to attend appointments, this was respected but they were encouraged and the team would work with referrers to try to facilitate engagement.
- The team was committed to enabling patients who were in inpatient services out of the area to be brought home to their families and friends. They had been recognised for repatriation of people from long stay hospitals out of the area. They were awarded the Nursing Times Award for Learning Disabilities Team of the Year in 2015 in recognition of repatriating 18 patients.
- Patients were offered flexibility in appointment times. The service ran from 9.00am to 5.00pm but staff were flexible around these times.
- We did not hear of any instances where appointments had to be cancelled but we were assured people would receive an explanation and are given help to access treatment as soon as possible if this happened.

The facilities promote recovery, comfort, dignity and confidentiality

- The waiting room provided a welcoming environment. The team premises were clean but were in need of painting in some areas. Furniture was in good condition and there were different types of chairs to choose from. Therapy rooms were comfortable and of a good size.

Are services responsive to people's needs?

Outstanding ☆

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

People were seen in a range of settings including at home, in day services, at college, and at Camden Street where the service rented additional rooms, including a group room.

- Interview rooms were sound proofed.
- A range of information was available in the waiting room including information on autism, fitness and activities, the location of safe places within Plymouth, information on transport, employment and helplines. We noted the complaint leaflet was a generic leaflet for the provider and was not in an easy read format. There was a leaflet about Plymouth Involvement and Participation service which is an active service within the Plymouth area who hear and act upon the experiences of people who use healthcare services across Plymouth.

Meeting the needs of all people who use the service

- The team building was accessible for people with reduced mobility, there were ramps for wheelchair users and adapted toilet facilities were available.
- Materials were provided for patients in easy read format. One carer said the team had done some work with their family member to enable them to understand the symbols being used in easy read documents. The team had easy read medicines leaflets which covered a wide range of specific medications. The leaflets explained how to say the name of the medicine, what it is used for and what it would do. Appointment letters were in easy read format and included a photograph of the clinician.
- Foreign language leaflets were rarely needed by the service because of the local demographics. The provider showed us examples of leaflets on depression and mental health in Arabic which were available from the mental health charity, Mind. Staff could also book an interpreter themselves through a translation provider.

Listening to and learning from concerns and complaints

- There had been one formal complaint about the community learning disabilities service in the period 01/02/2015 - 31/01/2016. The complaint was upheld, the matter rectified responsively and an apology was given in accordance with the duty of candour. The service received five compliments in the same twelve-month period.
- Patients and carers reported that they knew how to make a complaint. There were leaflets on how to complain in the waiting room at the team base although these were not in easy read format.
- Staff knew how to handle complaints. There was a positive attitude towards complaints, for example, one member of staff explained they encourage complaints because it can help the patient get the service they need.
- Relevant staff received feedback on the outcome of the investigation of complaints and acted on the findings and there were plans to ensure learning from complaints be disseminated to the wider team.

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

- When asked about the organisation's values, staff did not have a clear sense of them. However, the team had created their own team vision using staff's own words and this was in their operational policy. The values reflected the organisations aims.
- The team manager had regular contact with senior management in the organisation and the Chief executive had recently visited the service at their monthly team meeting. One member of staff, described their induction as brilliant and they said they were made very welcome, especially because the chief executive attended their induction and they found them to be transparent, friendly and approachable.

Good governance

- Effective governance structures were in place to ensure that staff completed and kept up to date with mandatory training. These structures ensured staff were regularly appraised and supervised. Administrative staff handled the system for booking mandatory training and managers received a monthly report to show when staff were due for training. This meant the process was efficient, standardised and compliance could be monitored by managers. Staff could not cancel mandatory training without their manager's approval. Administrative staff provided sufficient support to ensure staff were able to focus on delivering care.
- There was limited learning from incidents and complaints but there were plans to formalise disseminating learning to all staff.
- The provider was meeting the requirement to keep waiting times for new patients to within 18 weeks.
- The team manager felt they had sufficient authority and administrative support for their role.
- Staff could submit items to the local risk register. Any member of staff could raise a risk and this was encouraged. Staff knew how to report incidents and the team risk register showed progress was being made to reduce risks to staff and patients. The team risk register linked to the provider risk register and risks were rated and regularly monitored.

Leadership, morale and staff engagement

- The sickness rate for the team over the previous year was 5.6% which was slightly above the average sickness for the provider which was 5.5%.
- There had not been any reported cases of bullying or harassment.
- Staff told us they felt able to raise concerns with their managers without fear of victimisation. Staff unanimously told us they would use the whistle-blowing process if they needed to.
- Morale and job satisfaction were good. Staff told us they loved their work, and that they felt motivated. They described their work as satisfying, challenging and varied. They spoke of an open culture. They said they were encouraged to contribute to the development of the service. One member of staff told us they could develop personally and professionally in the service and they said management made them feel welcome to develop interventions. There were some complaints about the recruitment process being too lengthy and it taking a long time to fill posts and agree new posts. We heard from many staff about their autonomy in their work and also about how supported they felt by their team members and managers. There was an open door policy so staff could approach their managers as required.
- Staff told us managers were supportive of their development and that there were opportunities for leadership. One of the managers had developed from a band five nursing position and the provider had funded their nursing degree and provided leadership training through the NHS leadership academy for all three group managers.
- Teams worked well together and were supportive. Staff generally described relationships within in the team as supportive. A stress audit had been completed on the staff and occupational health was available to support staff if they were stressed in their work.
- Staff understood the duty of candour and were open and transparent with patients..
- There were opportunities for staff to give feedback on services and input into service development. The team

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.

were encouraged to innovate and it was understood that doing so improved the service and helped to retain staff. The monthly team meetings were an opportunity to give feedback on the service.

Commitment to quality improvement and innovation

- The team were assessing themselves against the green light toolkit. This is a method for improving mental health support services for people with learning disabilities. It enables providers to measure themselves against what a good service looks like.
- The team provided an academic programme to share best practice in working with people with learning disabilities. The programme was aimed at improving the care of people with learning disabilities and mental health problems and was open to all staff who support people with learning disabilities. Topics they had so far covered included lived experience of restrictions, delivering high quality capacity assessments, Deprivation of Liberty Safeguards and the community learning disabilities team's repatriation work.
- The team was taking part in a study led by Newcastle University into the lives of adults with autism and their relatives. They reviewed physical, mental health, social support, employment and lifestyle choices with a view to trying to improve the quality of care and were recruiting to a questionnaire-based national research study called the autism spectrum cohort study.
- The team psychiatrist had worked on an audit of the care programme approach in learning disabilities in Plymouth Community Healthcare. The audit aimed to identify the deficiencies and then be repeated after one year to see if there is an improvement. The audit reviewed the quality of care plans and found them to be of good quality but identified some discrepancies. The audit resulted in some recommendations to improve and standardise care programme approach care delivery in the team.
- The team had conducted an audit to evaluate the quality of clinical care for people with Down syndrome who develop dementia in two services against national best practice and to compare the care provided in the two services. Following this the team psychiatrist had published a paper on prospective screening for dementia in Down syndrome and the quality of clinical care. People with learning disabilities are at greater risk of developing dementia compared to the general population.
- A new clinical audit had been agreed to review antipsychotic prescribing in patients with a Learning Disability. The study would address concerns that psychotropic medications may be used inappropriately in people with learning disability for the treatment of behaviours that challenge. The audit would be in response to the Transforming Care agenda which recommended that services should have systems and policies in place to ensure that psychotropic prescribing is done safely and regularly audited