Good

Leeds and York Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDG01	Trust Headquarters	South south-east Community Learning Disability Team	LS10 4BS
RDG01	Trust Headquarters	West north-west Community Learning Disability Team	LS12 3QE
RDG01	Trust Headquarters	East north-east Community Learning Disability Team	LS14 1PP
RDG01	Trust Headquarters	Leeds Autism Diagnostic Service	LS10 4BS

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

Summary of findings

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 Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community mental health services for adults with learning disabilities or autism as good because:

- Staff included patients and carers in their care and treatment. Patients and carers felt involved in their care. Leeds autism diagnostic service involved a patient in training videos which were used in staff training to show living with autism from an individual's perspective.
- Care and treatment was delivered in line with best practice evidence and guidance. Staff followed guidance and recommendations when prescribing medication and physical health monitoring was completed. A range of recognised psychological therapies were available.
- Reasonable adjustments were made for people with learning disabilities or autism. We saw that teams were flexible in location and times of appointments, assessments were delivered in different languages to meet patient needs and adjustments were made such as, the time of fire alarms to reduce the impact and distress of patients attending clinics.
- Teams worked with primary care community health services to improve physical health for adults with learning disabilities. Staff delivered training and supported GP surgeries in improving the uptake and quality of annual health checks and health action plans for patients with learning disabilities.
- Staff participated actively and regularly in research to review, evaluate and improve services for adults with learning disabilities or autism.
- Processes and systems were embedded to ensure reporting of incidents, completion of risk assessments and appropriate safeguarding of adults was in place.

Summary of findings

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

Are services safe?

We rated safe as good because:

Good

- Risks of patients referred to services were assessed and prioritised by teams. Guides were in places for most disciplines and these supported staff when they triaged referrals and prioritised patients. Guides detailed examples of the level of patient need and risk.
- Risk assessments were comprehensive and considered patient risk holistically. Staff considered current and historical risks as part of the risk assessment process. Risk assessments were reviewed regularly to reflect changes in risk.
- Staff and carers told us that they accessed consultant psychiatrists the same day when needed.
- There were clearly defined and embedded systems and processes to keep people safeguarded from abuse. Staff had good knowledge of safeguarding procedures and their responsibility in responding to safeguarding concerns.
- Staff reported incidents correctly. Incidents were appropriately investigated and teams received feedback from investigations. The trust sent communications about the lessons learnt through investigations and these were discussed in team meetings and sent by email to staff.
- Teams were open and transparent when things went wrong and an explanation is given to patients and their carers.
- There were good lone worker protocols in place to safeguard staff when lone working in the community.
- Mandatory staff training was up to date.
- The environments of the teams that we visited were clean and well-maintained.

Are services effective?

We rated effective as good because:

Good

- Patient care and treatment was delivered in line with current guidance. Teams followed guidance from the National Institute for Health and Care Excellence when prescribing medication to patients. Clinicians completed clinical audits to check adherence to guidance around recommended dosages and physical health testing.

- Teams worked with other agencies to improve the physical health of patients that had learning disabilities. Staff from community learning disability teams worked with GP surgeries in the community to increase the uptake and quality of annual health checks and health action place for patients with learning disabilities.
- Staff worked collaboratively to co-ordinate patient care and meet the complexities of patients' needs. Teams were comprised of a range of staff from different professional backgrounds and staff worked together to provide patient care and treatment.
- Regular and effective multidisciplinary meetings took place weekly. Local authority social workers attended multidisciplinary team meetings at community learning disability teams.
- Patients' care records were recovery and independence focussed and contained clear goals and outcomes through care, treatment and intervention.
- There was good access to a range of psychological therapies available that were recognised by the National Institute for Health and Care Excellence.

However:

- Immediate access to accurate and contemporaneous records was not reliable. Some records were stored in paper patient files and other records on electronic patient record systems. We found that staff usage of the electronic patient record system was variable and staff uploaded information to different sections of patient records.

Are services caring?

Good

We rated caring as good because:

- Leeds Autism Diagnostic Service included a patient who used the service in training videos to explain their experiences of living with autism. This was used in delivery of training to staff within and outside of the trust.
- Feedback from patients and their carers was positive about the way staff treated patients. Patients and their carers told us that staff were respectful and polite to them.
- Observations showed that staff involved patients in their care. Staff included patients in discussions about their care. Staff tailored communication so that patients could understand and participate in their care and treatment.

Summary of findings

- Teams worked with and involved carers in patient care. Carers felt included by staff and staff involved carers in care planning processes. Staff provided support and reassurance to carers.
- Patients had the opportunity to give regular feedback about the service that they received through stakeholder surveys.

Are services responsive to people's needs?

We rated responsive as good because:

Good

- Teams worked actively to meet the needs of patients who used the service. Assessments and diagnosis were delivered in different languages to patients that did not speak English. Clinical staff completed assessments in Shona and Persian as an alternative to using interpreter services.
- Easy read care plans were developed for patients with pictures, symbols and basic language.
- Reasonable adjustments were made for patients with learning disabilities or autism. Fire alarm testing was completed at times when clinics were not held to prevent distress for patients hypersensitive to noises.
- Active steps were taken to engage patients in care and treatment. Teams worked flexibly and responsively to individual patient need to encourage engagement with care and treatment. Staff reflected on barriers to engagement and worked on overcoming these in partnership with patients.
- Patients and their carers felt that they could raise concerns and complaints to teams when needed.
- Information that we received showed that waiting lists for community learning disability teams were high. However, information provided by the trust during the factual accuracy stage of the inspection process showed that teams managed the time waiting from referral to assessment and treatment.

Are services well-led?

We rated well-led as good because:

Good

- Teams actively participated in research to review, evaluate and improve patient care for adults with learning disabilities or autism.
- Staff felt supported by their managers and their colleagues.
- Staff had high morale, job satisfaction and a sense of empowerment about the direct care they delivered to patients and the difference that they could make in patients' lives.

Summary of findings

- Processes were ongoing to review community learning disability services. Teams had the opportunity to be involved in the development of the service and provide feedback as part of the review.
- Staff felt able to raise concerns to their managers and knew how to access the whistleblowing policy if needed.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provide community mental health services for people with learning disabilities and autism across Leeds and an autism diagnostic service which can be accessed by adults of all intellectual abilities.

Community learning disability teams consist of staff from a range of different professional backgrounds, which include: community team managers, clinical leads, consultant learning disability psychiatrists, clinical psychologists, learning disability nurses, student nurses, dieticians, speech and language therapists, physiotherapists, occupational therapists and administrative staff.

A range of different services are provided by teams to facilitate and support the independence, health and well-being of people with learning disabilities. The teams provide services to adults with a learning disability that have complex health needs. Assessment, diagnosis and treatment of mental health needs were available. Teams can also provide advice, training and consultation with carers and other health and social care agencies. Support is available around managing needs such as: behaviour, communication, eating and drinking, nutrition, emotional and physical health. Teams can also provide and recommend assistive technology and equipment where needed.Assistive technology and equipment are services or items that can increase independence and accessibility by making tasks easier and safer for people with learning and/or physical disabilities.

Leeds autism diagnostic service is a team which provides assessment and diagnosis for adults of all intellectual abilities who may have autism. The team is comprised of: consultant learning disability psychiatrist, consultant general adult psychiatrist, speciality doctor, clinical psychologist, clinical team manager, autism trained nurses and administrative staff. The team signposts and refers people for ongoing support and involvement to third sector community organisations, community learning disability and community mental health services and local authority social work departments where needed.

We inspected community mental health services for people with learning disabilities or autism in October 2014. We rated this core service as good at the last inspection. There were no compliance actions following this inspection for community mental health services for adults with learning disabilities or autism.

Our inspection team

Our inspection was led by:

Chair: Phillip Confue, Chief Executive Officer, Cornwall Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised of a Care Quality Commission Inspector and five specialist advisors which included: a psychologist, a social worker, a nurse, a speech and language therapist and an occupational therapist. An expert by experience also joined the inspection. This person had a personal experience of supporting family members who were adults with autism.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During this inspection, we visited a sample of mental health services for adults with learning disabilities or autism located at three different sites. The sample comprised. The teams that we visited were:

- south south-east community learning disability team based at Aire Court
- west north-west community learning disability team based at Poplar House
- east north-east community learning disability team based as Asket Court
- Leeds autism diagnostic service based at Aire Court.

During the inspection visit, the inspection team:

- visited the three community learning disability teams and looked at the quality of the team environment and observed how staff were caring for patients
- visited Leeds autism diagnostic service
- spoke with seven patients who were using the service and collected feedback using comment cards
- spoke with 17 carers of patients who were using the service
- spoke with the managers or acting managers for each of the teams
- spoke with 30 other staff members including: consultant psychiatrists, nurses, occupational therapists, speech and language therapists, dieticians, physiotherapists, student nurses, psychologists and administrative staff.
- attended and observed six multidisciplinary meetings
- attended and observed seven home visits to patients
- looked at 26 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

During our inspection we collected feedback from patients and their carers.

During our visits we spoke to seven patients and 17 carers. We also collected feedback from patients using comment cards.

People who used the service and their carers told us that they felt that staff were respectful, polite and took the time to listen and understand. Patients and their carers told us that staff provided flexible care and visited patients and their carers at convenient times and locations. They told us that staff included them in decisions about their care and treatment. Patients and carers told us they can contact the team and speak to staff promptly. All patients and carers told us that they received copies of care plans and information requested.

Good practice

Leeds autism diagnostic service completed assessments and diagnosis for some patients in additional languages.

Summary of findings

Where patients' spoken language was not English the teams had completed assessments in the language spoken by the patient. Staff had completed assessments in Shona and Persian to accommodate the needs of patients as an alternative to using interpreter services.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that patient recording systems are used consistently by all staff and information on electronic patient record systems is accurate and contemporaneous.
- The provider should ensure that all non-medical staff are appraised.

Care Quality Commission

Leeds and York Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South south-east community learning disability team	Trust Headquarters
West north-west community learning disability team	Trust Headquarters
East north-east community learning disability team	Trust Headquarters
Leeds autism diagnostic service	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

During our inspection we looked at adherence to the Mental Health Act and the Mental Health Act Code of Practice.

Training in the Mental Health Act was a mandatory requirement for all staff. We inspected three community learning disability teams. We looked at information available for the community mental health services for adults with learning disabilities or autism that we inspected. Information provided by the trust showed that across the teams that we inspected there was an overall average of 81% of staff that had received training in mental health legislation level one.

Staff told us that they did not regularly work with patients subject to the Mental Health Act by guardianship or community treatment orders. Staff confirmed that they had received training and if needed they told us that they would speak to their managers, colleagues and consultants for advice around the act. Information provided by the trust showed that at the time of our inspection there were no patients subject to community treatment orders receiving services from the teams that we visited.

Detailed findings

Information about access to independent mental health advocates was displayed by most teams. East north-east community learning disability team did not have information displayed about independent mental health advocacy. During our inspection we informed the manager and they told us that they would ensure that this information was displayed.

Community learning disability teams used the care programme approach when working with patients who had a mental health need that impacted on their physical, psychological, emotional or social needs. The Mental Health Act Code of Practice states that the care programme approach should be used by secondary and tertiary mental health services to plan, deliver and co-ordinate care for patients with complex mental health needs. We reviewed 26 care and treatment records and we found evidence that there was appropriate use of the care programme approach used by teams.

Mental Capacity Act and Deprivation of Liberty Safeguards

We do not rate responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We use our findings as a determiner in reaching our overall judgement about the Provider:

During our inspection we looked at the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was a mandatory requirement for all staff. Overall, 92% of staff from the teams we visited had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards at the time of our inspection.

All staff told us that if they needed support with the application of the Mental Capacity Act then they sought advice from:

- the trust's policy on the intranet page
- the trust's Mental Capacity Act trainer
- their colleagues and consultant psychiatrists in the team
- local authority social work teams

We found that consent to care and treatment was obtained in line with legislation and guidance. The Mental Capacity Act has five principles which should be followed. The first principle of the Mental Capacity Act states that capacity should always be presumed unless there is a reason to doubt an individuals' capacity to make a particular decision. The second principle of the act states that all practicable steps should be taken to support an individual to make a decision before deeming the individual as lacking capacity. We reviewed 26 care and treatment records and found that most care records contained consideration and assessment of patients' capacity to make decisions about their care and treatment. We found seven care records that did not refer to patients' capacity to consent to care and treatment. However, staff explained to us individual reasons why patients' records did not reference capacity. Staff told us that where there was no reason to doubt patients' capacity to make decisions about their care and treatment a capacity assessment would not have been completed. In the case of other patients' staff told us that they were in the process of supporting patients' to make their own decision before assessing patients' capacity.

None of the staff that we spoke to knew if there were arrangements in place to monitor the adherence to the Mental Capacity Act.

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

We visited three community learning disability teams and Leeds autism diagnostic service as part of our inspection. Teams provided these services at three different sites. The team bases that we visited were located at: Aire Court, Poplar House and Asket Croft.

Leeds Autism diagnostic service saw all patients at their team base at Aire Court unless a specific patient need required them to complete their involvement in the community. There were no alarms fitted in the interview rooms used by Leeds autism diagnostic service. Staff told us that mobile alarms were available for staff to use.

Staff from community learning disability teams mostly saw patients in the community at their own homes or other community locations. Some patients attended community learning disability teams based at Aire Court and Asket Croft for appointments with psychology and consultant psychiatry. Interview and clinic rooms at Aire Court were mostly fitted with alarms. Staff told us that they had access to mobile alarms as an alternative where static alarms were not fitted.

The west north-west community learning disability team was based at Poplar House which was located at St Marys Hospital. The interview rooms at Poplar House were not fitted with assistance call points however, we were told by staff that when patients needed to visit the team they were seen using facilities at the outpatients department at St Marys Hospital. These facilities were fitted with assistance call points.

Community learning disability teams based as Aire Court and Asket Croft used clinic rooms on site. Clinic rooms were shared with other teams that used the same premises. Clinic rooms were equipped with an examination couch and weighing scales. Hand washing facilities were present in clinic rooms. Information about hand hygiene was displayed. Teams did not routinely complete physical health examination of patients. Teams encouraged patients to attend their GP for physical health examinations and monitoring or attend clinics held by the Intensive Care Service. The Intensive Care Service provided physical health monitoring clinics which patients could access for clozapine, lithium or high dose antipsychotic therapy monitoring. Clozapine, lithium and antipsychotic therapies are types of medication treatments available that can be used to treat mental health needs.

All facilities that we visited were clean and well maintained. Some premises were decorated in neutral and light colours. Poplar House was decorated in mostly bright colours. Furniture and flooring was in a good state of repair for all teams. The decoration at Poplar House used by west north-west team showed signs of wear and tear and the décor appeared dated in comparison with other team bases. However, artwork completed by patients was displayed on the walls. We saw that general maintenance work took place in teams. Whilst we were at Poplar House there were maintenance workers undertaking tasks.

There was good cleaning and infection control procedures in place. Cleaning regularly took place. All teams were clean and tidy. We saw cleaning being completed of areas during our inspection. We saw details of colour coded equipment used to clean specific areas to prevent cross contamination and designated waste disposal bins for different types of waste were used.

Safe staffing

We looked at staffing across the teams that we visited. Managers told us that staffing and skill mix requirements for the three community learning disability teams had been set up when the teams were formed approximately ten years ago. Staff told us that there was not a recognised tool used to forecast staff required per team. Teams told us that when staff left their post was recruited to. Staff told us that the staffing levels for Leeds autism diagnostic service were identified when the service opened. This was based on a monetary budget which had been reviewed at regular intervals by the trust.

Information provided by the trust informed us that work was being undertaken to develop a model for safe staffing. Part of the work completed by the trust was the implementation of a pilot of safe staffing levels across a section of the trust. A working group was also in place to evaluate this and work on a trust level safe staffing

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requirement. We were informed that the time of our inspection the estimated number and grade of staff was determined by professional judgement, knowledge and experience of clinical managers.

Vacancy rates were low. Information provided by the trust as of June 2016 showed that the overall percentage of vacancies for community learning disability teams was 3% and Leeds autism diagnostic service was staffed over establishment hours.

Overall sickness rates were average at 5%. Information from the trust showed that team sickness rates as of June 2016 were: Leeds autism diagnostic service was less than 1%, South South-East team was 4%, West North-West team was 8% and East North-East team was 10%.

Teams covered staff sickness, leave and vacant posts. There was zero agency and bank use across the teams that we visited during our inspection. Managers told us that they applied the trust's leave policy to ensure there was adequate staffing across the teams. Teams covered for sickness, leave and vacancies through existing staff in the team. Teams prioritised cases that required urgent assessment and interventions or patients that had an assessed high risk. Some staff reported that they felt that teams were understaffed. However, vacancy rates were low and we were told by staff that vacant posts had been advertised and the recruitment processes were underway.

Across the teams that we visited there was adequate medical cover. Staff, patients and carers told us that prompt access to psychiatry was available when needed. Teams had consultant psychiatrists integrated into them. Consultant psychiatrists were available in the teams' operating hours. Crisis teams provided out of hours cover for community learning disability teams and Leeds autism diagnostic service. Staff, patients and their carers told us that they accessed a consultant psychiatrist when needed usually the same day or within a few days dependent on their need.

We visited three community learning disability teams as part of our inspection. We looked at information about caseloads and the amount of patients waiting allocation as part of our inspection. We found that the average amount of cases per staff member across the three community learning disability teams was 18. The average caseload for doctors was 116. Information provided by the trust showed that at the time of our inspection there were 266 patients on the waiting list for community learning disability teams. However, this number included some patients that were open to the team but were waiting for allocation to another discipline within the multidisciplinary team. For example, a nurse case manager was working with a patient but they were waiting for psychology input and were counted in the amount of patients on the waiting list. From the information provided, we could not identify clearly the amount of individuals that were on the waiting list for community learning disability teams.

There was a team caseload for Leeds autism diagnostic service. Staff did not carry individual caseloads. The pathway worked where members of the team were allocated to be involved at different stages of the assessment and diagnostic process. Information provided by the trust showed that at the time of our inspection 111 patients were in the process of assessment and diagnosis. A further 38 patients were waiting to start the assessment process. These patients had been sent invitations for their initial screening appointment.

Caseloads were managed and regularly reassessed through supervision. Staff told us that they discussed caseloads in supervision. A caseload weighting tool was not used by community learning disability teams. A caseload weighting tool is used to review caseloads and look at complexity of cases against amount of cases on staff caseloads. However, information provided by the trust stated from July 2016 that allied health professionals would be piloting a caseload weighting tool across community learning disability services for six months.

The trust set out mandatory training requirements for all staff. Information provided by the trust showed that overall mandatory training completion rates were 87%.

Assessing and managing risk to patients and staff

Teams assessed risk to patients and staff promptly. We reviewed 26 care and treatment records and found there was evidence of risk assessment beginning when referrals were received by teams. Staff triaged referrals using guidance provided by the trust. Guidance was in place for each discipline in the multidisiplinary team. Guidance for staff detailed the level of patient risk and need and the priority of the patient for allocation to staff caseload for assessment and treatment. For example, speech and language therapy referral guidance placed patients at high risk of choking as a priority and their waiting time should be shorter than a patient with a lower risk of choking.

Good

Are services safe?

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Staff collected further information about referrals prior to making contact with patients. Staff told us that they checked the electronic patient record system and contacted referrers for further information. Staff told us that they checked for any warning notes that were recorded on the electronic patient record system before making initial contact. Patient warning notes could be added to patient records to represent information about known risks.

Managers reviewed waiting lists. However; teams did not regularly contact patients on waiting lists to review levels of risks. Staff told us that they review waiting lists every week and waiting lists were discussed at multi-disciplinary meetings. We found that the identification of increased level of risk for patients on waiting lists was reliant on the patient, carers or other organisations informing the team. Teams made regular contact by letter to patients on waiting lists. Staff told us that when teams accepted a referral, a letter was sent to patients to inform them that they had been accepted and placed on the team waiting list. Staff told us that the letter invited patients to contact the team if their needs increased. When a patient had been on the waiting list for six weeks a further letter was sent out. This informed patients that they were still on the waiting list and invited patients to contact the team if needed. Unless patients or their carers contacted teams, teams would not be aware of any fluctuation or increase in risk to patients on waiting lists.

Community learning disability teams used the Functional Analysis of Care Environments risk profile in the assessment of patient risk. Leeds autism diagnostic service developed a service specific risk assessment. We reviewed 26 care and treatment records. Risk assessments were comprehensive. Risk assessments considered different aspects of patient risk including: personal history, social circumstance, forensic history, treatment related risks, clinical symptoms and behaviour as indicators of risk. The risk assessments that we reviewed showed recording of current and historical risks. Most risk assessments that we reviewed were up to date. Of the 26 care records we reviewed, we found that two risk assessments had not been recently reviewed. We found one care record had no risk assessment. This patient had been receiving services from the team for over a year. During our inspection we informed the team of this finding and the manager told us that this would be rectified and a risk assessment would be put in place.

There was variable use of crisis plans. We reviewed 26 care records and we found that teams used two different types of care plans. Teams used care programme approach care plans and standard care plans. Care programme approach care plans were used with patients who required more intensive and co-ordinated involvement as a result of mental health and/or complex needs. Standard care plans were in place for other patients. Crisis plans were integrated into care programme approach care plans. Patients on a standard care plan did not have crisis plans. We asked staff about crisis planning for patients that did not have crisis plans; staff told us that not all patients the team worked with needed crisis plans. However, staff provided contact details for crisis teams and out of hours services to patients and their carers when needed.

During our inspection we did not see the use of advance decisions.

Leeds autism diagnostic service provided an assessment and diagnostic service. Staff told us that any sudden changes or deterioration in patients' health would be acted upon through involvement of other relevant teams such as crisis services, community mental health teams and community learning disability teams.

Community learning disability teams had systems in place to respond to any sudden changes or deterioration in patients' needs. A designated worker was rostered to be on duty each day in teams. Duty workers responded to incoming contact regarding referrals or patients who use the service. Urgent concerns were triaged by the duty worker and a process was in place for staff to respond to crisis situations. Staff told us that when needed other members of the team supported the duty worker to respond to sudden changes in patients' health. This included completing urgent home visits to patients. Staff told us that multi-disciplinary professionals meetings are called to discuss a team approach to a patient's health deteriorating.

Staff had good knowledge and practical experience of identifying and responding to safeguarding concerns. Safeguarding adults and children training was a mandatory training requirement for all staff. We spoke to 33 staff and staff described to us the different types of safeguarding concerns that they had experienced and are observant for and the action that they took in response. All staff told us that when made aware of a safeguarding concern that they ensured the immediate safety of the patient. Staff told us

Good

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that they reported concerns to their managers and the relevant services such as, police and local authority social work teams. Staff told us that in some situations they had arranged for emergency respite placements for patients that were at immediate risk.

Good personal safety protocols were in place for staff that worked as lone workers. Staff from community learning disability teams worked in the community as lone workers frequently. The trust had a lone worker policy in place. This policy placed local managers responsible for completing local lone worker risk assessments. We saw lone worker practices in place during our inspection. Staff recorded their planned visits on whiteboards which detailed where they would be and the time they expected to return to the team base. If staff did not arrive back at the expected time staff from the team would contact the worker to check their welfare. Staff had a code word which they could state to covertly raise the alarm to their colleague that they needed assistance. All community staff had mobile telephones that they could use to summon help whilst lone working. Where increased risks were identified visits were completed by two staff.

Track record on safety

Trusts are required to report all incidents and accidents. Between 1 July 2015 and 30 June 2016, community mental health services for adults with learning disabilities or autism reported 78 incidents. None of the incidents reported met the criteria for serious incident reporting. The types of incidents reported included: property, medication, accidents and patient deaths. Information provided by the trust showed that the patient deaths reported were not related to patient safety incidents.

Reporting incidents and learning from when things go wrong

A web based reporting system was used for reporting incidents. The trust used the incident reporting system to record incidents, accidents and near misses. During our inspection we spoke to 33 staff. All staff told us that they had access to the incident reporting and used this to report incidents. All staff could tell us what types of occurrences they reported as incidents.

As part of our inspection we reviewed information relating to incidents reported by community mental health services for adults with learning disabilities or autism. We found that a range of different types of incidents were reported and the incidents were reported appropriately. Some of the types of incidents reported included: safeguarding concerns, patient deaths, accidents and medication errors.

Teams were open and transparent and provided an explanation to patients when things went wrong. Investigations of incidents were completed where appropriate. Trained staff completed investigations. Some staff told us that they had attended training on the duty of candour. All staff told us that when something goes wrong patients were informed, involved in updates throughout the investigation, provided an explanation of what went wrong and what changes would be put in place. Patients were sent a letter of explanation and an apology when needed. Staff gave an example of a patient that was prescribed clozapine medication and had a prescription issued despite abnormalities shown in blood results. The team informed the patient, the incident was investigated and an apology was provided. The team received feedback in their multi-disciplinary meeting and by email from the trust about lessons learnt.

Incidents were investigated and lessons learnt. Staff told us that information regarding lessons learnt following investigations of incidents was shared with teams. Teams received feedback about incidents internal and external of the service through team meetings and emails sent out to staff. Staff told us that incidents are discussed in their supervision. Staff told us that changes to practice have been put in place following investigations of incidents. Staff told us that they receive a formal de-brief following incidents from their manager and are supported by their colleagues.

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

During our inspection we visited three community learning disability teams and Leeds autism diagnostic service. We reviewed 26 care and treatment records. We found that assessments were recorded for all patients.

Community learning disability teams completed assessments focussed on the involvement and intervention that the patient required. Different disciplines in the team completed assessments to reflect the need of the patient. For example, low mobility, increase risk of choking and challenging behaviours. Assessments reflected the individual need of the patient. We found that most care records were recovery orientated and focussed on maximising the potential for independence and minimal support for patients with learning disabilities. Most care records were solution focussed and future goals and outcomes were documented.

Leeds autism diagnostic service provided an assessment and diagnostic pathway for people who may have autism of all intellectual abilities. Leeds autism diagnostic service pathway used recognised assessment tools to complete a holistic assessment and diagnosis of patients. Assessments completed looked at the patients' personal history, support, mental health, developmental milestones, familial information that may be relevant in the assessment and diagnostic process. The pathway included information from the patient and their carers about their current needs and developmental years.

Leeds autism diagnostic service used recognised assessment tools in the assessment of patients. These could have included some or all of the following depending the patient's individual need and the team reaching a clinical diagnostic decision:

- Adult Asperger Assessment, Autism Diagnostic Interview – Revised
- Adult Autism Spectrum Quotient
- Diagnostic Interview for Social and Communication Disorders
- The Cambridge Behaviour Scale
- Patient health questionnaires
- Relative's questionnaire adapted from the Childhood Asperger Syndrome Test.

Once assessment processes had taken place a multi-disciplinary clinical decision would be agreed on the diagnosis.

Leeds autism diagnostic service did not provide ongoing care and treatment to patients post diagnosis. Follow up appointments were offered by the team to patients and their carers. Ongoing support, care and/or treatment were facilitated through referral to other teams and organisations with patient consent.

Information needed to deliver care was stored securely. However, not all information was immediately available to all staff when needed. An electronic patient record system was in place across the teams that we visited. Access to the electronic patient record system was secure. Staff required a user account with password access. All staff had access to the electronic patient record system. Across the teams that we visited we found that some information was recorded in the electronic patient records and some information was recorded on paper records. Teams stored paper records securely in lockable storage at team bases.

During our inspection, we reviewed 26 patient care and treatment records. We reviewed care records with staff present. There were inconsistencies in how different staff used the patient record system to record and store information. This included where information was uploaded to on electronic patient records. We found that all electronic patient files differed because staff uploaded information into different places. Staff told us that they uploaded final plans such as, challenging behaviour plans to the electronic patient record system and plans that were in progress were stored outside of the system. Staff told us that complete paper records were scanned onto the electronic patient record system at intervals. This meant that where cases transferred across to different teams or to different staff information could not always be found easily.

Other teams did not have real time access to information recorded on paper patient records. This included crisis teams and inpatient wards that may need information to deliver care outside of operating hours. This meant that real time access to information on the electronic patient

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.

record system may not show the most accurate and up to date patient information. Information that was present on the patient electronic records would not be easy to locate if there are inconsistencies in how staff use the system.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence guidelines when prescribing medication. Consultant psychiatrists prescribed medication to patients. Some nurses had received non-medical prescribing training, however, there were no nurses actively prescribing medication at the time of our inspection. Staff that we spoke to told us that guidance from the National Institute for Health and Care Excellence was followed. We saw clinical audits which measured the service adherence when prescribing and monitoring medication against guidance from National Institute for Health and Care Excellence and the Food and Drug Administration. A clinical audit was completed to assess whether prescribers were checking for interactions between medications when prescribing lithium. We reviewed a clinical audit into the prescribing of citalopram. This followed guidance issued by the Food and Drug Administration and National Institute of Clinical and Healthcare Excellence around the maximum recommended doses and reduced maximum doses prescribed to older adults and patients with abnormal liver functioning. The findings of the clinical audit showed that prescribing was in line with current guidance around recommended dosage and appropriate physical health checks were completed such as electrocardiogram and liver functioning testing.

There were a range of psychological therapies recommended by National Institute for Health and Care Excellence available. Community learning disability teams that we visited had clinical psychologists and psychological therapies were provided to patients. Psychological therapies available included systemic therapy, cognitive behavioural therapy, dialectical behaviour therapy, acceptance and commitment therapy, cognitive analytic therapy and narrative therapy. Leeds autism diagnostic service did not provide psychological therapies post-diagnosis. However, the team completed referrals for patients requiring therapies to other teams and services.

The teams that we visited provided some support with housing and benefits. Where more specific knowledge was required teams worked with and signposted to other organisations that were more appropriate to advise and support.

The trust had a Commissioning for Quality and Innovation framework for 2015/2016 to increase the take up and quality of annual health checks for people with a learning disability. Staff from community learning disability teams provided training to primary care staff and supported general practitioner surgeries with increasing the quality and uptake of annual health checks and health action plans for people with a learning disability. Some of the health needs identified through annual health checks were in relation to: blood monitoring, lifestyle, medication reviews, ear health, urine tests, continence, skin conditions, memory concerns and smoking cessation advice. Staff from the teams worked with 30 GP surgeries across the Leeds area.

Teams considered the physical health care needs of patients. Teams did not carry out physical health checks at their team bases. Teams arranged for patients to access clinics for monitoring of clozapine, lithium and/or high dose anti-psychotic therapy. Patients access services at the Intensive Care Service provided by the trust and at GP surgeries in the community. Any additional physical health checks were requested to be completed by patients' GP surgeries.

Teams used a variety of clinician and patient rated outcome measures to measure the effectiveness of care and treatment provided to patients. Allied health professionals used a Therapy Outcome Measures tool. This was a clinician rated outcome tool. Psychologists used patient rated outcome measures which included the Clinician Outcomes in Routine Evaluation Learning Disability and Goal Attainment Scoring to measure the effectiveness of interventions. Teams also used the challenging behaviour interview in the assessment of severity of challenging behaviour.

We reviewed the use of clinical audit across the community learning disability teams and Leeds autism diagnostic service. We found that there was variable participation in clinical audit completed by clinical staff. East north-east community learning disability team participated actively in clinical audit. We found that the east north-east team completed audits into:

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- physical health monitoring of patients' prescribed lithium medication
- physical health monitoring and prescribing of citalopram medication
- assessment and the management of challenging behaviour of adults on the autism spectrum

Clinical staff completed these clinical audits and performance was measured in line with guidelines published by the National Institute for Health and Care Excellence. Action plans were produced with timescales and owners for actions identified for improvement.

Skilled staff to deliver care

The staff working in the teams came from a variety of different professional backgrounds. Teams comprised of consultant psychiatrists, psychologists, clinical leads, community team managers, learning disability nurses, student nurses, occupational therapists, physiotherapists, dieticians, speech and language therapists and administrative staff. Teams worked together to share experience and support.

Staff told us that they felt supported by their teams and could ask their colleagues including consultant psychiatrists for advice and support when needed. Community learning disability teams had dedicated challenging behaviour nurses and outreach nurses. These nurses were experienced in providing care and treatment for patients with complex needs resulting in challenging behaviour and patients that were reluctant to engage with services.

The trust had an induction process which included training courses and a local on site induction to the teams. Induction training met with the Care Certificate standards for care. Staff had access to their own training record on the electronic training system that the trust used. This was called the 'I Learn' system where staff could see their own training compliance and available training courses.

Regular team meetings took place. All staff attended team meetings. Team meetings were completed weekly and all members of the multi-disciplinary teams attended these.

Staff performance was measured through the appraisal process. The appraisal process was completed annually. We reviewed data in relation to staff supervision and appraisal. During our inspection we spoke to 33 staff. Most staff told us that they received regular supervision. Some staff told us that they did not receive individual clinical supervision and completed peer supervision due to staff vacancies. Information provided by the trust of percentages of non-medical appraised staff at end of June 2016 was 100% at Leeds autism diagnostic service, 50% at west north-west team, 71% at the east north-east team and 100% at the south south-east team.

Managers told us that specialist training was acquired where there was a need. Managers told us that poor staff performance was managed through the trust's policies.

Multi-disciplinary and inter-agency team work

Regular and effective multi-disciplinary meetings took place. These involved all members of the multi-disciplinary teams. Teams met at least once a week and all staff ensured that they attended team meetings. During our visit we observed different types of multi-disciplinary and inter-agency team work.

We attended weekly multi-disciplinary meetings. Teams invited social workers from the local authority to their meetings. We saw that representatives from the local authority social work departments were present. Waiting lists and referrals were discussed as a regular agenda item. We observed that there was opportunity for members of the multi-disciplinary team to discuss cases which they wanted to request joint working with another professional from the team.

We observed professionals meetings. Teams held professionals meetings regularly or when needed to discuss patient needs and concerns. Members of the multi-disciplinary team attended that were involved with the care and treatment of the patient. Meetings were used to develop consistent patient care and treatment plans with input from members of the team involved.

All staff that we spoke with reported to work closely with the local authority community learning disability social work teams. We spoke to carers and patients and they told us that community learning disability teams and local authority social work teams worked together to provide consistent care and support to patients. Carers told us that the staff from community learning disability teams contacted social work teams and vice versa and fed back information to carers. For example, in organising respite services for patients and their carers. Carers told us that they find this reduces their perceived levels of stress.

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

As part of our inspection we reviewed adherence to the Mental Health Act and the Mental Health Act Code of Practice. The trust set Mental Health Act training as a mandatory training requirement for all staff. Across the teams that we visited as part of our inspection, there was an overall training completion rate of 81% for Mental Health Act legislation training level 1.

Staff had a reasonable level of understanding of the Mental Health Act, Code of Practice and guiding principles. Information provided by the trust showed that there were no patients subject to community treatment orders receiving services from the teams that we visited during our inspection. During our inspection, we spoke to 33 staff. Staff told us that they did not regularly work with patients subject to the Mental Health Act by guardianship or community treatment orders. Staff confirmed that they had received training and if needed would speak to their managers, colleagues and consultant psychiatrists for advice around the act. Staff also told us they could contact the Mental Health Act office at the trust for advice.

At the time of our inspection, there were no patients receiving services from the team that were subject to the Mental Health Act. Therefore we did not review any Mental Health Act documentation. We did not review consent to treatment forms or information about the explaining of patients' rights as part of this inspection.

Information about access to independent mental health advocates was displayed by most teams. East north-east community learning disability team did not have information displayed about independent mental health advocacy. During our inspection we informed the manager and they told us that they would ensure that this information was displayed after our visit.

Community learning disability teams used the care programme approach when working with patients who had a mental health need that impacted on their physical, psychological, emotional and/or social needs. The Mental Health Act Code of Practice states that the care programme approach should be used by secondary and tertiary mental health care to plan, deliver and co-ordinate patients' care for those people who have complex mental health needs. We reviewed 26 care and treatment records and we found evidence that there was appropriate use of the care programme approach used by teams.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act is a piece of legislation that maximises an individual's potential to make informed decisions wherever possible and processes and guidance to follow where someone is unable to make decisions. As part of our inspection we looked at the application of the Mental Capacity Act.

Training in the Mental Capacity Act was a mandatory requirement for all staff. We reviewed information relating to staff training records and found that overall 92% of staff across the teams that we visited had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff told us that if they needed support with the Mental Capacity Act then they sought advice from:

- The trust's policy on the intranet page
- The trust's Mental Capacity Act trainer
- Their colleagues and consultant psychiatrists in the team
- Local authority social work teams

We found that consent to care and treatment was obtained in line with legislation and guidance. Two of the main principles of the Mental Capacity Act state that capacity should always be presumed unless there is a reason to doubt a individuals' capacity to make a particular decision and all practicable steps should be taken to support an individual to make a decision before deeming the individual as lacking capacity.

We reviewed 26 care and treatment records and found that most care records contained consideration and assessment of patients' capacity to make decisions about their care and treatment. We found seven care records did not refer to patients' capacity to consent to care and treatment. However, staff explained to us individual reasons why patients' records did not reference capacity. Staff told us that where there was no reason to doubt patients' capacity to make decisions about their care and treatment so a capacity assessment had not been completed. In the case of other patients' staff told us that they were supporting patients' to make their own decision before assessing patients' capacity.

During our inspection we observed staff completing home visits to patients. We observed one home visit where there was consideration of a patient's capacity and observed a discussion with staff about the need for a best interest meeting. This patient had low mobility and lived in an upstairs bedroom and it was to be decided whether it was in this patient's best interests to move into a more accessible ground floor bedroom. There were plans for this best interest meeting to be arranged.

We asked staff if the trust monitor adherence to the Mental Capacity Act. None of the staff that we spoke to knew if there were arrangements in place to monitor the adherence to the Mental Capacity Act.

Are services caring?

Good

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

Our findings

Kindness, dignity, respect and support

The feedback that we received from patients and their carers about the way staff treated patients was positive. During our inspection we spoke to seven patients and 17 carers. Patients told us that staff were polite, respectful and caring. One patient told us that they thought the community learning disability team that worked with them was “fantastic”. Patients told us that staff were interested in their well-being and reported that they were happy with the services that they received from teams. Patients told us that they had good relationships with staff and they told staff about any concerns or issues that they had. Patients said that staff supported them to make things in their lives better. For example, a patient told us that they reported difficulties they experienced with people in the local community to staff. Staff supported them to report the concerns to the police and worked with them to create positive community relationships. Carers told us that staff worked in a person centred way and patients’ well-being was their priority.

Staff delivered compassionate care and understood patients’ needs and feelings. We observed staff interactions with patients and their carers. We saw that staff explained to patients the purpose of their visit. On an initial visit, staff explained the service to patients and their carers.

Communication with patients was clear and individualised. Staff used open questions and simple language that patients understood. Staff gave patients time to respond and provided appropriate levels of verbal prompting to support patients. We observed staff had a warm approach and a good rapport with patients. It was clear that staff knew individual patients well. During our observations we saw staff considered patient’s feelings and regularly asked if they were okay. At the end of visits staff summarised their visit to patients and asked them and their carers if they had any questions. Staff involved carers in discussions and showed empathy and understanding of their concerns and views.

Staff respected patients’ confidentiality. Some carers supported patients that lived in shared accommodation settings. They told us that staff ensured that discussions that took place with or regarding a patient could not be overhead by others. For example, they met with patients in the patients’ bedroom or another room which was unoccupied to maintain patient confidentiality and privacy.

The involvement of people in the care that they receive

We found variable information about patient involvement in care planning. Patients told us that they felt involved in their care and decisions made about their care. Patients that wanted a copy of their care plan told us that they had a copy of their care plan. One patient told us that they had refused a copy of their care plan. However, we reviewed 25 electronic patient records and found that according to the patient electronic recording system that 11 of these patients had not received a copy of their care plan and five patients’ care plans did not refer to the patients’ views. We found that care plans contained interventions aimed at maximising patients’ independence, health and well-being. For example, care plans were in place regarding safe eating and drinking following speech and language assessments of dysphagia. Dysphagia is the difficulty or discomfort in swallowing when eating and drinking. These outlined safe food and drink options. We saw that care plans were written in basic language which patients could understand.

Crisis plans were in place for some patients. One patient told us that they had a crisis plan in place and recalled to us the information that was in their care plan. This patient told us that if they needed support they contacted the community learning disability team during opening hours or the crisis team out of hours. Two patients told us that they felt they had a choice about the different professionals involved in their care.

Teams valued the involvement of carers in the care and treatment of patients. Carers told us that they are involved by staff in patient care. Carers told us that they are invited and included in attending visits and appointments. Teams invited carers to attend multi-disciplinary meetings to discuss patient care and treatment. Carers told us that teams were flexible and would change meetings to a suitable time and day so they could attend outside of their caring and personal commitments. Carers felt that they were supported by staff and the wider teams involved. Carers told us that staff provided them with information that they needed and all carers told us that they received copies of care plans. Carers also told us that staff cared about them and provided them with support. Carers told

Good

Are services caring?

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us that staff spoke to carers regularly about how they were coping, supported carers when patients were in hospital, gave practical advice for patient care and signposted to other organisations.

Information relating to access to advocacy services was displayed by most teams. We visited the east north-east team and we saw that information about access to advocacy services was not displayed. We fed this back during our visit and the manager told us that they would ensure that information about advocacy services was displayed. However, all other teams that we visited had information displayed about local advocacy services. Patients and their carers we spoke to told us that they were aware of local advocacy services available and some of the patients had advocates.

Patients we spoke to told us that they had not been involved in recruiting new staff for the team that they received services from.

Patients had the opportunity to give feedback on the care that they received. Most patients and their carers told us that they received stakeholder surveys in an accessible, easy to read format. Patients could feedback about the care that they received by completing these surveys. Carers told us that they supported patients to complete feedback and send back. However, carers told us that they were not given a regular opportunity to give feedback to teams. Carers told us that they give feedback informally to teams when they want to. Carers told us that they would speak to staff or the team manager to raise a concern or give a compliment.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Teams had service specifications which detailed the aims, functions and remit of the teams. Service specifications outlined referral criteria. Leeds autism diagnostic service referral criteria stated that the service provided assessment and diagnostic services to adults of any intellectual ability for autism. Teams would accept referrals from any source within the Leeds area. Referrals from outside of the area were also accepted where this had been agreed by the trust. An existing diagnosis of autism did not prevent patients from being eligible for the service. The Leeds autism diagnostic service also provided re-assessment and second opinion on diagnoses.

Community learning disabilities teams received referrals through the single point of access. Duty workers screened referrals and triaged against referral criteria. Referral criteria specified that teams would work with adults that had a learning disability. Teams worked with patients whose primary need was linked to a learning disability and where the nature and degree of patient need exceed what primary care services could provide. Referrals were accepted where patient need was not or could not be met by any other more appropriate secondary care service.

During our inspection we visited three community learning disability teams and Leeds autism diagnostic service. Community learning disability teams had a duty system in place. Staff on duty triaged referrals received by the team the same day. When we asked staff if there was a set target time for referral to triage/assessment and assessment to treatment onset, staff told us that they did not know of a specific target time. However, they told us that duty workers triaged referrals the same day. Guidance for referrals used also stated target timescales. These had been developed by the trust. Information provided by the trust showed that for community learning disability teams the amount of cases on the waiting list was 266. This amount of cases on the waiting list for each community learning disability team was:

- South south-east team – 95
- West north-west team – 81
- East north-east team -90

The information reflected the amount of cases. These figures included individuals that were open to the team already and waiting for an additional resource. Following our inspection, during the factual accuracy stage of the inspection process, the trust provided information relating to the waiting times for assessment and treatment. Information provided by the trust reported that the waiting times were as follows:

- South south-east team: 50 days for assessment and a further 39 days to treatment.
- West north-west team: 53 days for assessment and a further 31 days to treatment.
- East north-east team: 43 days for assessment and a further 31 days to treatment.
- Leeds Autism Diagnostic Service: 64 days to assessment. This service did not provide treatment.

Staff told us that when the team received an urgent referral the team could see patients the same day when needed.

Leeds autism diagnostic service provided an assessment and diagnostic service so did not provide services to see patients quickly or urgently. Where patients required urgent services, Leeds autism diagnostic service referred to other teams which included community mental health and community learning disability services, local authority social services and crisis services where appropriate.

The teams responded promptly and adequately to contact from patients and their carers. Patients and their carers told us that when they contact the team they can either speak to staff immediately about their concern and if staff were not available immediately then a member of the team called back promptly afterwards.

Teams worked actively to promote engagement with patients who found it difficult or who were reluctant to engage with services. The trust provided guidance for staff around promoting patient engagement. We visited community learning disability teams and they had dedicated outreach nurses and dedicated challenging behaviour nurses who specifically worked with patients who were reluctant to engage with services. These staff provided more intensive involvement. We spoke to staff and they told us about some of the factors that they considered about patient engagement and this involved understanding why patients were reluctant or found engagement with services difficult. For example, staff considered whether patients could tell the time to know

Are services responsive to people's needs?

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when their meetings and home visits were or if they needed support to attend meetings and be at home for home visits. Teams provided patients with multiple opportunities to engage with services. Staff rearranged appointments, sent out reminder letters and contacted patients by telephone to remind them about meetings and appointments.

Access to services was flexible. Teams operated Monday to Friday each week. Leeds autism diagnostic service saw patients in the community where complex needs resulted in being unable to attend clinic. Administrative staff informed patients if appointments ran behind schedule. Staff provided cover for short notice staff absences to ensure that appointments were completed or rescheduled as a last resort. Staff informed patients of changes to their appointments and provided an explanation and apology for any inconvenience.

The facilities promote recovery, comfort, dignity and confidentiality

We visited two teams that were based at Aire Court. These were south south-east community learning disability team and Leeds autism diagnostic service. Leeds diagnostic service had dedicated space for their team to use. Staff told us that there was adequate space to complete assessment and diagnosis. Staff told us that there were plans in place for Leeds autism diagnostic service to move premises in the future to be located with other neurodevelopmental services.

South south-east community learning disability team used interview and clinic rooms at Aire Court. Staff told us that there was not enough interview rooms as facilities were shared with other teams that were based there. However, patients who use the service were mostly visited by staff in the community. There were three rooms available for use at Asket Croft used by east north-east team. These were shared with other services that were based at the same premises. However, staff mainly visited patients in the community at their own homes. Poplar House did not use their facilities to see patients. Outpatient facilities were used at St Marys Hospital when needed. Staff mostly visited patients at their own homes in the community.

We found all interview rooms had adequate sound proofing to protect patients' confidentiality.

Leeds autism diagnostic service had facilities in place such as a two way mirror and video recording facilities. The purpose of the facilities was to enable the multi-disciplinary teams to observe assessments without being present in the same room. Staff told us that some patients did not like numbers of staff present in assessments and it affected the accuracy of the assessment. Staff told is that it would be difficult to assess natural behaviours if a person was uncomfortable during the assessment. The team ensured that patients gave their informed signed consent of any observations that took place as part of the assessment and diagnostic process.

Accessible information was available for patients. Patients were provided with easy read format information for their care plans, information leaflets, customer stakeholder surveys and information about complaints procedures.

Meeting the needs of all people who use the service

Reasonable adjustments were made for people requiring disabled access. All locations that we visited had disabled toilet facilities. South south-east community learning disability team and Leeds Autism Diagnostic service based at Aire Court were situated on the ground floor and there was level access at the main entrance. East north-east team based at Asket Croft and west north-west team based Poplar House were based upstairs. Lift access was available for visitors to the team bases if needed. At Asket Croft, staff saw patients in clinic and interview rooms on the ground floor. The team based at Poplar House used outpatient clinic and interview rooms at St Marys Hospital when needed.

Leeds autism diagnostic considered patients' individual needs in the delivery of the service. The team had arranged the test of the fire alarm at Aire Court to take place between outside of their clinic opening hours. This had been requested in order to avoid unnecessary distress for patients attending clinic that may be hypersensitive to noise. The team organised for assessments to be completed in patient's spoken languages where possible. Staff told us that they had previously completed autism assessments in Persian and Shona led by their own clinical staff instead of using interpreters.

Teams had access to interpreter and sign language services. Teams accessed this through the trust and the trust made arrangements for an interpreter or signer to assist.

Are services responsive to people's needs?

Good

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Listening to and learning from concerns and complaints

The trust provided information regarding complaints received about community mental health services for adults with learning disabilities or autism. Two complaints had been received between 1 April 2015 and 31 March 2016. These related to south south-east community learning disability teams. These complaints were not upheld.

We spoke with patients and their carers who used the service. Most patients and their carers said that they did not know the complaints process however, if they needed to complain they would speak to their worker or contact the team and ask how they could do this. Information was displayed by teams about how to make a complaint.

Staff had good knowledge about how to deal with complaints appropriately. Staff told us that they saw complaints as a way of improving the service and reflecting on how things were done to learn lessons for the future. Feedback from complaints was discussed in team meetings. The trust sent out email communication to staff in the form of memos to share learning across services.

Feedback from patients was requested by teams through surveys. Teams sent out surveys to patients to ask them to provide feedback on the service. Carers told us that they supported patients to complete surveys and return them back to the teams. Leeds autism diagnostic had medical students who completed a service evaluation based on feedback from patients about their satisfaction of the service and the outcome of their assessment and diagnosis.

Are services well-led?

Good

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

Our findings

Vision and values

The trust had purpose, ambition and values statements. The purpose statement was to improve health and improve lives. The ambition statement was: working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives.

The values were:

- Respect and dignity
- Commitment to quality of care
- Working together
- Improving lives
- Compassionate
- Everyone counts

The organisational values were not fully embedded into teams. We did not see information displayed about the trust values at all of the teams that we visited. During our inspection we spoke to 33 staff. Staff told us that the trust had organisational values. However, many could not recall specifically what these values were.

Staff told us who their line manager were and knew some senior managers. Staff told us that senior managers visit their teams occasionally.

Good governance

The trust had systems in place to ensure that staff received mandatory training. Managers had access to team training records and could identify when staff required training. All staff had access to their own training records through the electronic training system called 'I Learn'. Staff could book places on training through this system to ensure that they were compliant with training requirements. Across the teams that we visited the average completion rate for mandatory training was 87%.

Systems were in place to ensure that staff were appraised and supervised regularly. Key performance indicators were in place. Staff told us that the new appraisal process had integrated values and performance indicators into the appraisal format. The appraisal system in use at the time of our inspection measured staff performance against objectives. Most staff told us that they received regular supervision and all staff told us that they had been appraised. Some staff told us that due to key roles being vacant they were receiving peer supervision. However, vacant posts had been advertised and recruitment processes were underway and information the trust provided as of 30 June 2016 showed that staff received regular supervision.

Managers told us that they had sufficient authority to make decisions and escalate issues to senior management. Managers attended regular clinical governance meetings. Managers told us that they escalated concerns and issues and where necessary items were agreed to be place on risk registers. Managers had worked to deploy resources effectively. The work was organised to free up clinical staff to complete direct care and patient contact with more effective use of administrative staff. Some teams had increased the amount of their administrative staff to support the team.

Safeguarding, Mental Capacity Act and Mental Health Act procedures were followed. Incident reporting procedures were embedded into teams. All staff reported incidents using the electronic incident reporting system. Incidents and complaints were investigated by the trust appropriately by band seven and above staff. The findings of incidents were communicated back to teams through team meetings and electronic mail communication from the trust to all staff.

There was evidence of clinical audits taking place across some teams. South south-east community learning disability team completed audits into:

- physical health monitoring of patients' prescribed lithium medication
- physical health monitoring and prescribing of citalopram medication
- assessment and the management of challenging behaviour of adults on the autism spectrum

Leeds autism diagnostic service had medical students who completed service evaluations which looked at the quality of the service and assessment of risk and feedback from patients on their satisfaction of the service against whether or not they had received a diagnosis of autism.

Leadership, morale and staff engagement

Staff felt that they could raise concerns or issues to their managers at the first instance. Staff were aware that there

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Good

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was a whistleblowing policy and they told us that they could find information on the staff intranet. Teams displayed information about speaking out safely about concerns. Staff told us that teams were supportive. Teams had good morale which they attributed directly to their work with patients which they told us gives satisfaction and they felt empowered by being able to make a difference in patients' lives.

Overall sickness rates were average at 5%. There were no reported cases of bullying and harassment.

When something went wrong there was openness and transparency during the process of investigation. Patients were informed if something went wrong with their care. They received an explanation and an apology where this was appropriate.

Teams were offered the opportunity to contribute and be involved in a review of community services that the trust was completing at the time of our inspection. Staff told us timescales when they expected to receive updates and information about the status of the review.

Commitment to quality improvement and innovation

At the time of our inspection the trust was completing a review in the community learning disability services. The aim of the community review was to look at the existing services and their effectiveness and efficiency. The review aimed to look at where the trust saw community learning disability services in the future and propose how changes would be implemented. The review was due to be finalised in November 2016 and the expected changes to be implemented by April 2017.

The trust held bi-monthly learning disability research forum and journal club meetings for staff to attend. We reviewed information in relation to involvement and participation in research and found that there was evidence of active participation in research. Participation in research focused on various different aspects relevant to patients with learning disabilities or autism. Some examples included: the effectiveness of assessment and diagnostic tools, the management of specific health conditions, the effectiveness of therapies, service evaluations based on feedback from patients. Research forum and journal club meetings discussed how the findings of research completed could be acted upon to improve services for patients with learning disabilities.